ACT Government | ACT Health

Recommendations for reform of care, treatment and support provided to people found not guilty because of mental impairment and released from custody into the care of mental health services

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Chief Psychiatrist

January 2024

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Letter to the Minister for Mental Health presenting the report

Emma Davidson
ACT Minister for Mental Health
GPO Box 1020
Canberra ACT 2601

Dear Minister

Re: Recommendations for reform of care, treatment and support provided to people deemed not guilty because of mental impairment and released from custody into the care of mental health services

Following the incident on 18 September 2023, when an inpatient residing at the Gawanggal Mental Health Unit, while on approved leave, went to ANU and allegedly assaulted multiple people, you asked me to undertake a review into the circumstances surrounding the incident.

This review was undertaken in 2 parts:

1. A Special Purpose Quality Assurance Committee was formed to complete a clinical review of the care and treatment provided to this person. The report of this review has been submitted to the Chief Executive Officer of Canberra Health Services (CHS).
2. An expanded review to explore matters concerning people who are found not guilty because of mental impairment and released from custody into the care of mental health services. This expanded review was undertaken with the support of a panel of external experts.

This report contains the recommendations arising from these reviews and includes proposals to review legislative provisions and make changes to clinical practices and processes to ensure the delivery of better and more effective care to people deemed not guilty because of mental impairment and released from custody into the care of mental health services.

Yours sincerely

Dr Dinesh Arya
Chief Psychiatrist

19 January 2024

Foreword

The review into care, treatment and support provided to people deemed not guilty because of mental impairment and released from custody into the care of mental health services was announced by the Minister for Mental Health on 20 September 2023.

Two review panels with expertise in forensic mental health practice and mental health law assisted this review. Ms Camille Falkiner (Office of Chief Psychiatrist) provided project management and logistics support. Ms Catherine Trevorrow and Ms Sue Morberger (Office of Chief Medical Officer) provided investigative and process support to the Quality Assurance Committee investigation and Ms Sharon Steele, Mr Matthew Kearney and Ms Sarah Cramond (Office of Chief Psychiatrist) supported the expanded review.

Many stakeholder organisations across the Australian Capital Territory (ACT) shared their experiences and provided their perspectives which enabled the review panel to consider the information presented and make recommendations for improvement.

It was quite clear to both review panels that all public service agencies, especially the public mental health services are providing high-quality care and support to people deemed not guilty because of mental impairment and released from custody into the care of mental health services. It is hoped that the recommendations contained in this report will help strengthen legislative provisions and improve clinical practice.

I take this opportunity to express my gratitude to the review panels and the team from the Office of Chief Medical Officer and Chief Psychiatrist who assisted me in completing this review.

Dr Dinesh Arya
Chief Psychiatrist and Chief Medical Officer, Australian Capital Territory

Recommendations

1. Consideration be given to providing guidance in the *Crimes Act 1900* to courts to the circumstances where the court should make an order that the accused be detained in custody for immediate review by the ACT Civil and Administrative Tribunal (ACAT) under section 180 of the *Mental Health Act 2015*, and the circumstances in which the court should make an order that the accused submit to the jurisdiction of ACAT to allow ACAT to make a mental health order or a forensic mental health order.

2. Clarify by way of a legislative amendment that if some conditions are considered necessary to have in place under a Conditional Release Order (CRO) because of the potential risk the person may pose to self, others or to the community, then these are introduced under some form of involuntary order. Consideration can be given to providing ACAT with the power to make an order requiring a person to be compulsorily detained in an approved mental health facility where the person poses an unacceptable risk, at the time it considers making an order for the release of a person from detention in custody under section 180 of the *Mental Health Act*, with appropriate safeguards including provision for the regular review of such an order.

3. If the person is also considered to be in need of treatment for underlying psychopathology or criminogenic factors and ensuring compliance with treatment is considered necessary and essential (and conversely non-compliance with the prescribed treatment is likely to increase the risk to the person, to others or to the wider community), ACAT is also provided with the power to make a concurrent forensic mental health order to ensure treatment, care, support and protection to manage such a risk. To enable this to occur a legislative amendment is introduced to change the definition of a 'forensic patient' in the Mental Health Act to include people under a section 180 order.

4. Consideration be given to harmonising the criteria or considerations under section 308(b) of the Crimes Act and section 180(3)(c) of the Mental Health Act.

5. Consideration be given to making it clear by way of a Chief Psychiatrist Advisory Note that for purposes of assessment of risk, the risk of serious harm to others is inclusive of risk to safety of the community.

6. That ACAT be required to consider, under section 180 (3) of the Mental Health Act, the psychopathology and other criminogenic factors that contributed to the person's offending by way of a comprehensive forensic psychiatric or psychological report.

7. That matters to which ACAT must have regard, when deciding whether to impose conditions upon the release of a person under section 180(4) of the Mental Health Act, and what conditions to impose and when deciding whether to vary or revoke those conditions under section 182(5), be specified in the Mental Health Act.

8. That ACAT be constituted by a presidential member and a second member who is a forensic mental health professional when reviewing the detention of a person and considering the person's release under section 180 of the Mental Health Act.

9. That ACAT be constituted in the same way when reviewing the conditions of a person's release under section 182 of the Mental Health Act and when deciding whether to order that a person be detained in custody until ACAT orders otherwise, under section 182(6) of the Mental Health Act.

10. Consideration be given to requiring ACAT to notify the carer (as defined in the *Carers Recognition Act 2010*) of a subject person of a hearing under section 180 of the Mental Health Act, at least if ACAT is aware that the person has a carer and of the carer's identity and giving a subject person's carer a right to appear and give evidence at such a hearing.

11. That ACAT be required to notify a person representing the interests of community safety, such as the Victims of Crime Commissioner or the Director of Public Prosecutions, of a hearing under section 180 of the Mental Health Act and that that person be given a right to appear and give evidence at such a hearing.

12. That the Mental Health Act be amended to stipulate that the person representing community safety and ACAT are provided necessary information by the police and ACT Corrective Services for the purpose of better informing ACAT about matters relevant to any risk the person may pose to community safety.

13. Provision be made to ensure that ACAT obtains a comprehensive forensic mental health assessment report (including a clinical risk assessment) from a forensic psychiatrist or psychologist about the subject person before it makes a decision as to whether to release the person from detention in custody under section 180(2) of the Mental Health Act.

14. Consideration be given to facilitating the making of orders requiring a person to reside in an appropriate facility on an interim basis, following a hearing under section 180 of the Mental Health Act, pending a further hearing.

15. The Mental Health Act be amended to make provision for the types of conditions that may be imposed on an order of release for a person, and to clarify whether ACAT may impose a condition requiring a person to reside in a secure mental health facility, or to take medication, in the absence of a forensic psychiatric treatment order or other order authorising detention or involuntary treatment.

16. The Mental Health Act specify that ACAT must hold a hearing when reviewing a condition of an order of release for a person under section 182 of the Mental Health Act.

17. That the persons entitled to be notified of a hearing under section 180(2) of the Mental Health Act and who have an entitlement to appear and give evidence at such

a hearing also be entitled to be notified of a hearing under section 182 of the Mental Health Act and to appear and give evidence at that hearing.

18. Any advice provided to ACAT must be informed by a comprehensive forensic mental health assessment that includes a longitudinal history, risk assessment and collateral information that is relevant to understand the person's psychopathology, criminogenic behaviours as well as potential risks that the person may present to themselves, others and the community.

19. A template is created to define information to be provided to ACAT when it is making and reviewing a conditional release order, applications for leave or leave appeals. This template must include information on public safety and the likelihood of reoffending and consider not only mental health issues but also broader criminogenic factors. It should include the results from defined suitable evidence-based assessment risk assessment tools and a report from the leave Panel on leave decisions made and the rationale for these. Information provided to ACAT about the person's psychopathology, need for compliance with prescribed treatment (including risk of non-compliance), criminogenic factors and any potential risks to the community must be provided in a structured format.

20. For every person under the care of a mental health service, a comprehensive forensic mental health assessment, risk assessment and treatment/management plan (mental health assessment and plan) must be documented. This must also be updated on a regular and frequent basis. This mental health assessment and plan should also form the basis for reports, advice or recommendations provided to other decision-making bodies, including ACAT.

    The mental health assessment and plan must include longitudinal information on:

    a. The person's psychopathology that led to the not guilty because of mental impairment verdict.
    b. Other psychopathology (independent of that which led to the not guilty because of mental impairment verdict) that may be relevant to understanding risks as well as the person's treatment and rehabilitation needs.
    c. Criminogenic factors that are relevant to understand the offending behaviour and potential risks.
    d. The person's response to treatment, including whether the person has achieved remission with or without treatment.
    e. Whether the person has achieved remission with or without treatment in relation to this psychopathology.
    f. If remission has been achieved with compliance on medication, risk of relapse with non-compliance.

21. A template is used to document the structured forensic mental health assessment and plan to ensure consistency in the documentation of this information.

22. The forensic mental health assessment and plan is updated 3 monthly (or sooner if there is a significant change in clinical presentation) and should be audited by the health services for timeliness and completion.

23. Treatment should follow best practice forensic mental health assessment and treatment principles. Interventions should include treatment of identified psychopathology and offense specific interventions. This should be reflected in the model of care and individual treatment plans.

24. Decision making in relation to the level of restriction that must be placed on a person found not guilty because of mental impairment and receiving care from mental health services must consider:
    a. Psychopathology that was relevant for the NGMI determination.
    b. Other psychopathology that may be the reason for an increase in the risk of the person to themselves, others, or the wider community.
    c. The significance of compliance with prescribed treatment to minimise the risk of relapse.
    d. The extent to which the person has gained insight into their mental illness and criminogenic factors.
    e. Other factors that may be relevant to understanding the risks in relation to the person, including risk of non-compliance, affective instability, the presence of criminogenic factors (e.g. volatile behaviour, poor frustration tolerance, alcohol/substance abuse and cluster A/B personality traits).

25. Include formal procedures relating to supporting carer involvement and participation in leave-related processes.

26. The leave panel is chaired by a person independent of the treatment team or staffing of the facility in which the person resides. The Chair should have forensic mental health expertise and an understanding of the risks that a person with a mental illness may present to themselves, others and to the wider community.

27. The leave panel should also include at least one other independent member who is able to provide input about community safety considerations.

28. Leave enforcement of a person on a Conditional Release Order (CRO) from a facility at which they are not involuntarily detained should be reviewed to ensure there is no infringement on the person's liberty.

29. The leave panel must provide a report to ACAT when it is considering revision of leave conditions.

30. Canberra Health Services to review its missing person procedure to ensure this reflects inpatients under the care of Dhulwa Mental Health Unit (DMHU) and Gawanggal Mental Health Unit (GMHU).

31. Clarify by way of an amendment to the legislation the legal authority for the person on a CRO to be apprehended and detained where the person has breached conditions of their conditional release order (including absconding or failure to return from approved leave) and when their approved leave is revoked.

32. A risk rating is developed in consultation with the police and ambulance services to make explicit communication of the level of the risk to the person, others and the community to enable effective triage and response by police and ambulance services.

33. A template is developed and implemented for staff to use when notifying police/ ambulance services where a person has absconded or is absent without permission.

34. An opportunity for leave decisions to be appealed must be made explicit at every decision point.

35. Consideration be given to including in the Mental Health Act a separate provision setting out the processes for granting and/or reviewing the grant of leave to persons subject to conditional release orders from a secure mental health facility. It is also necessary to clarify who has relevant powers to intervene if there is a significant breach, particularly in the event that urgent intervention is required.

Abbreviations

ACAT	ACT Civil and Administrative Tribunal
ACT	Australian Capital Territory
ANU	Australian National University
CHS	Canberra Health Services
CRO	Conditional Release Order
DASA -IV	Dynamic Appraisal of Situation Aggression: Inpatient Version
DMHU	Dhulwa Mental Health Unit
FMHO	Forensic Mental Health Order
GMHU	Gawanggal Mental Health Unit
HCR-20	Historical Clinical Risk Management-20
MDT	Multi-Disciplinary Team
MHO	Mental Health Order
NGMI	Not Guilty Because of Mental Impairment
PTO	Psychiatric Treatment Order
QAC	Quality Assurance Committee
SAPROF	Structured Assessment of Protective Factors for Violence Risk
SCALE	Security Category and Leave Entitlement
TPRIM	Treatment, Placement, Restrictions, Implementation, Monitoring and Review

Background

On 18 September 2023, an inpatient residing at the Gawanggal Mental Health Unit (GMHU), while on approved leave, went to the Australian National University (ANU) and allegedly assaulted multiple people. This person was later charged with 2 counts of attempted murder, common assault and possession of objects to be used to kill or cause grievous bodily harm.

This person had previously been found not guilty because of mental impairment in relation to 5 counts of attempted murder on 25 August 2017 and was subsequently released by ACAT into the care of mental health services.

Due to the seriousness of this incident, the ACT Government announced that the Chief Psychiatrist would undertake a review of the circumstances surrounding the incident. The review was undertaken in 2 parts:

1. A Special Purpose Quality Assurance Committee (QAC), authorised by the Minister for Health on 30 September 2023, completed a clinical review of the care and treatment provided to this person. The report of this clinical review was submitted to the Chief Executive Officer of Canberra Health Services.
2. The Chief Psychiatrist also conducted an expanded review to explore legislative provisions and clinical practices and processes in place to support people who are released from custody into the care of mental health services. The purpose of this expanded review was to consider best practices concerning the provision of mental health treatment, care and management of persons found NGMI and released from custody into the care of mental health services in the ACT.

Both reviews were supported by review panels comprising experts from outside the ACT. Both review panels considered relevant evidence, expert opinions and views and perspectives of relevant stakeholders involved in the provision of mental health care to the person (QAC review panel) as well as more widely to people deemed NGMI who are released from custody by ACAT into the care of mental health services in the ACT (expanded review panel).

The QAC panel met with people directly involved in supporting the person under the care of the mental health services. Invited stakeholders for the expanded review included: ACT Policing, ACT Ambulance Service, ACAT, the Public Advocate, Director of Public Prosecutions, Victims of Crime Commissioner, Justice and Community Services, the ACT Public Advocate and other identified persons to ensure consumer and carer perspective (including Carers ACT, Healthcare Consumers Association and Mental Health Consumers Network). ANU provided a written submission.

The following were members of the expanded review panel:

- Dr Dinesh Arya, ACT Chief Psychiatrist
- Distinguished Professor James Ogloff, AM, Clinical and Forensic Psychologist and Dean, School of Health Sciences, Swinburne University of Technology

- Dr John Crawshaw, New Zealand's Director of Mental Health and Addiction and Forensic Psychiatrist
- Dr Juliet Lucy, Barrister and Senior Member of the NSW Civil and Administrative Tribunal
- Ms Lisa Kelly, CEO, Carers ACT

Introduction

Since 2005, a total of 16 people have been found not guilty because of mental impairment in the ACT.

Since 1 March 2016 (when the current *Mental Health Act 2015* came into effect), 6 people with a verdict of not guilty because of mental impairment have been released from custody by the Australian Capital Territory Civil and Administrative Tribunal (ACAT) on a Conditional Release Order (CRO). All were males between 20 and 49. All had a primary diagnosis of schizophrenia, except for one who had a diagnosis of bipolar affective disorder. Two people were also subject to a Forensic Psychiatric Treatment Order (FPTO) and one was subject to a Psychiatric Treatment Order (PTO). The 3 remaining persons were not subject to an involuntary mental health order.

All 6 people released from custody under a Conditional Release Order since March 2016 were released either at the first ACAT hearing or the subsequent hearing (following an initial adjournment). All people were released to either Dhulwa Mental Health Unit (DMHU) or Brian Hennessy Rehabilitation Centre (before the opening of DMHU or Gawanggal Mental Health Units). In April 2021, the Brian Hennessy Rehabilitation Centre was redeveloped and renamed as the Gawanggal Mental Health Unit (GMHU).

All 6 people were granted various types of leave from their treating mental health facility by ACAT at the time their CRO was made. Terminology in the orders varied with respect to leave and included supervised, escorted, accompanied or unescorted leave.

Areas of exploration for this review

Considerations for ACAT, when a person found not guilty because of mental impairment is referred for release from custody

In the ACT, in the matter of a person who is deemed not guilty because of mental impairment, under Part 13 of the Crimes Act, the court can order the person to be detained in custody for immediate review by ACAT.

Under section 324 and section 329 of the *Crimes Act 1900*, if a special verdict of not guilty because of mental impairment is entered concerning a serious offence, the court must:

a) Order that the accused be detained in custody for immediate review of the detention by ACAT under section 180 of the *Mental Health Act 2015* to consider the release of the person; or
b) If, considering the criteria for detention in section 308, it is more appropriate – an order that the accused submit to the jurisdiction of ACAT to allow it to make a mental health order (MHO) or a forensic mental health order (FMHO) under the *Mental Health Act*.

The focus of this review is on the group of people who, under the *Crimes Act* or an equivalent provision, have been ordered by the court and detained in custody for immediate review of the detention by ACAT under section 180 of the *Mental Health Act* to consider the release of the person.

Section 180 of the Mental Health Act provides for the powers of ACAT to conduct an immediate review of the detention of a person in custody. ACAT must review the detention and consider the release of the person no later than 7 days after the day of the order. If, on review under section 180, ACAT does not order the release of a person, ACAT must review the detention of the person at least monthly while the detention continues. However, ACAT may not detain a person longer than the term indicated by the referring court under the Crimes Act (section 183 of the Mental Health Act)

With the view that detention in custody is to be regarded as a last resort and ordered only in exceptional circumstances, in reviewing the detention and considering the release of a person, ACAT must consider (Mental Health Act s180(3)):

a) the nature and extent of the person's mental disorder or mental illness
b) whether the person would be at risk to themselves or others if released
c) the views of any affected person and the victims of the crime commissioner.

If ACAT orders the release of a person, it may impose any condition it considers appropriate. This is colloquially known in ACT as a CRO. Under section 180(4), ACAT may require the person to comply with an MHO or FMHO, if made, as a condition of the person's release.

If ACAT does not order the release of a person from custody, section 180(5) of the Mental Health Act provides that ACAT may make an MHO or FMHO in relation to the person, including additional orders, or vary or revoke any mental or forensic mental health order in force in relation to the person. However, section 58 and section 101 provide, respectively, for preconditions for making an MHO or FMHO, and it is not plain that section 180(5) removes the need for those preconditions to be met. In other words, on one construction of the legislation, ACAT does not have power to make an MHO or FMHO under section 180(5), unless those preconditions have been met.

When a person is subject to a CRO, ACAT must review the conditions of the person's release at least every 6 months, or within 72 hours of being notified that the person has contravened a condition (Mental Health Act s182). As part of the review, ACAT must take any statements made by the affected person (if they are on the affected person's register) and the views of the Victims of Crime Commissioner if there is an affected person (Mental Health Act s182(4)). Where a person has contravened a condition, ACAT can also order that person to be detained until it determines otherwise (Mental Health Act s182(6)).

Whilst a person is the subject of a CRO under Mental Health Act s180, ACAT does not have power to authorise the involuntary treatment of the person (such as the forcible giving of medications) through the imposition of conditions. ACAT's power to impose such conditions of release as it considers appropriate under the Mental Health Act s180(4) may extend to requiring a person to submit to treatment or to take medications as a condition of release. However, the power to impose conditions relates only to the person the subject of the order; it does not confer power upon health professionals to administer medication in the event that a person objects to treatment (whether in breach of the person's conditions or not).

Similarly, ACAT has no power, when imposing conditions under s180, to authorise staff to detain a person involuntarily. Whilst it may be open to ACAT to require a person to reside in a mental health facility as a condition of release, the conditions of release apply only to the person concerned. They do not give authority to others to act in a way which would otherwise be unlawful.

If, on the other hand, ACAT makes an FMHO which expressly requires a person to undergo psychiatric treatment and/or be detained at a stated approved mental health facility, the Mental Health Act confers powers on the Chief Psychiatrist to use force, or to authorise someone else to use force, to give the medication and to detain the person (Mental Health Act s107).

Contravention of conditions of release

If a person contravenes ACAT's conditions for the release of a person, the Chief Psychiatrist must notify ACAT of the contravention in writing as soon as practicable after becoming aware of the contravention (*Mental Health Act*, section 181).

Mental Health Orders and Forensic Mental Health Orders

The Mental Health Act makes provision for MHOs in Chapter 5 and FMHOs in Chapter 7. An MHO can be made for anyone with a mental disorder or mental illness needing treatment, care and support, but an FMHO can only be made for people connected to the criminal justice system, such as detainees, people on bail or people serving community-based sentences, or people ordered to submit to the jurisdiction of ACAT by the Supreme Court or the Magistrates Court under Part 13 of the Crimes Act.

A central requirement for either an MHO or FMHO is that ACAT must be satisfied that the treatment, care or support cannot be adequately provided in another way that would involve less restriction of the freedom of choice and movement of the person.

The key difference between the pre-conditions for making an MHO compared with an FMHO is that, in making an FMHO, ACAT is not required to consider a person's decision-making capacity, and therefore whether they have consented to the treatment. Having noted that, in previous decisions, ACAT has found that where a patient is being considered for an FMHO, and that the person is willing to voluntarily accept treatment and voluntarily reside at a mental health facility, the requirement for making an FMHO i.e. that treatment, care or support cannot be adequately provided in another way, will not be met (see Mental Health Act s101(2)(f) and s108(2)(g)). Consequently, where a patient who otherwise meets the FMHO preconditions, but who voluntarily agrees to treatment and to reside in a facility, ACAT has previously taken the view that an FMHO cannot be made.

To make an application for an MHO or FMHO, the Chief Psychiatrist (or another relevant person) must apply to ACAT and provide a statement addressing the criteria ACAT must consider under the *Mental Health Act* for the relevant orders. Two kinds of mental health orders are possible for both people under both schemes, Psychiatric Treatment Orders (PTOs) or Community Care Orders (CCOs).

PTOs are the most common form of mental health order and are made when a person has a mental illness requiring psychiatric treatment and support. A mental illness is a condition that seriously impairs the mental functioning of a person in one or more areas of thought, mood, volition, perception, orientation or memory (Mental Health Act s10).

PTOs allow for ACAT to order a person to be admitted to an approved mental health facility and to undergo treatment for mental illness. ACAT can also make a restriction order which may specify where a person is to live, detain a person in a mental health facility, restrict the person's communication with particular people and order the person not to approach or engage with particular people, places or activities (*Mental Health Act* s61). The Chief Psychiatrist can also detain a person under a PTO without a restriction order being in place under s62 and s65.

When a person is subject to an involuntary treatment order, involuntary treatment authorised under the Mental Health Act can be provided if specific requirements are met.

The Mental Health Act also provides for CCOs for people with mental disorders and confers similar powers authorising the restriction and detention of such people. A mental disorder is a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion, but does not include a condition that is a mental illness (Mental Health Act s9).

An MHO or FMHO can be made when ACAT believes on reasonable grounds that because of the mental illness or mental disorder the person is likely to do serious harm to themselves or others and will endanger public safety and that treatment will reduce the risk posed by the person to themselves or others. ACAT can also make orders in circumstances where a person does not pose a risk but is suffering serious mental or physical deterioration because of their mental illness or mental disorder and treatment will improve their psychiatric condition. However, in each case, ACAT must be satisfied that the treatment, care or support cannot be provided in another way which would involve less restriction of the freedom of choice and movement of the person.

Before making an MHO or FMHO, ACAT must consider the assessment of the person, consult relevant people such as guardians of the person, the corrections director-general (if needed) and the Chief Psychiatrist and hold a hearing into the application. ACAT must also consider the criteria in s56 (for MHO) and s99 (for FMHO) of the Mental Health Act including the plan for the proposed treatment, the wishes of the person, the likelihood the person will cause serious harm to others if not detained and the views of the relevant people who ACAT must consult. These criteria are to be considered in addition to the specific criteria for the type of MHO or FMHO being sought.

MHOs may be made for up to 6 months and associated restriction orders can be made for up to 3 months. ACAT can review an MHO at any time on its own initiative or by application of the person. It must also review orders within 72 hours if notified that the order is no longer appropriate or has been contravened. FMHOs can be made for up to 3 months. If there have been consecutive FMHOs in place for at least one year, an FMHO can be put in place for one year.

Where an MHO or FMHO is contravened by a person who is not detained in a facility, the person can be taken to an approved mental health facility to ensure compliance with the order. Before a person is taken to a mental health facility, the authorised officer must notify the person of the consequences of contravening the MHO or FMHO.

If the MHO or FMHO has been contravened by a person absconding from a facility, s78 and s125 of the Mental Health Act give powers to the police, paramedics, mental health officers or doctors to apprehend the person to return them to the facility. When the person is apprehended, ACAT and the Public Advocate must be notified within 12 hours of the apprehension and the order must then be reviewed within 72 hours.

Important decision points

Where a person is found not guilty because of a mental impairment and ACAT subsequently makes a CRO in relation to the person under section 180 of the *Mental Health Act*, there are several points at which a clear and explicit decision has to be made about:

1. The conditions that should be imposed on the person.
2. The care, treatment, support and rehabilitation the person may receive while under the care of the mental health services.

At these decision points, matters concerning the person's mental impairment (which was found to be the reason for a verdict of not guilty because of mental impairment) and any other psychopathology that may be relevant to the risk that the person may pose to themselves, or others remain important considerations. For persons with risk of future offending behaviours, criminogenic factors must also be a feature of clinical treatment and intervention. Criminogenic factors refer to conditions or elements that contribute to the development or perpetration of criminal behaviour by an individual. Examples include substance abuse, antisocial attitudes, lack of education, dysfunctional family environments and personality dysfunction as these factors can increase the likelihood of individuals engaging in criminal activities.

1. The decision by ACAT to release the person from custody with or without conditions

When deciding whether to release a person from custody under s180 of the Mental Health Act, ACAT must have regard to the following:

- Whether the person should be released from custody.
- The nature and extent of the person's mental disorder or mental illness, including the effect it is likely to have on the person's behaviour in the future.
- Whether or not, if released, the person's health or safety would be, or would be likely to be, substantially at risk, or the person would be likely to do serious harm to others.
- If there is a registered affected person in relation to the person, any statement of the registered affected person and the views of the Victims of Crime Commissioner.
- If the court has nominated a term under the Crimes Act, part 13—the nominated term.

To make this decision, ACAT conducts a hearing. The only requirement for ACAT to consult before deciding whether to order the release of the person is that if there is a registered affected person in relation to the person, ACAT must take into account any statement by the registered affected person and the views of the Victims of Crime Commissioner.

In practice, in making this decision ACAT considers the information provided to it by the court and the medical report provided by the treating team. ACAT must give certain people written notice of the hearing, including the subject person, the representative of the subject person (if any), the Chief Psychiatrist, the Care Coordinator, the Public Advocate, the

Director-General of the administrative unit responsible for providing care and any registered guardian or nominated person (*Mental Health Act*, s188(1)(a)). The Victims of Crime Commissioner and registered affected person must also be given notice of the hearing if there is a registered affected person. ACAT also has the power to give written notice of the hearing to anyone that it considers appropriate (*Mental Health Act*, s188(1)(b)).

2. The provision of mental health care by responsible mental health service

For a person who is released from custody on the condition that the person must reside in a mental health inpatient facility, the process of assessment, including risk assessment, treatment planning and rehabilitation should be a systematic and careful process.

This requires a comprehensive mental health assessment and a clear management plan that addresses the treatment needs of the person aimed at treating the psychopathology that was the reason for the person to be found to be NGMI, other identified psychopathology and criminogenic factors that may increase the risk for the individual or others.

Considering that non-compliance with treatment (both medication and therapeutic interventions) may increase risks, compliance with prescribed treatment remains an important consideration. In addition, an ongoing and regular assessment of the extent to which the person has gained insight into their illness and socially acceptable norms and expectations must also remain essential considerations.

Treatment may include psychopharmacological, psychological, psychotherapeutic, rehabilitation and psychoeducational interventions to enable the resolution of symptoms, the person gaining an understanding of their behaviour and its impact on others as well as supporting them to develop the necessary skills and expertise to become self-sufficient and live independently. Interventions are also necessary to address criminogenic factors aimed at reducing offence specific and offence related behaviour.

At every transition point (including granting of leave from the inpatient unit and discharge from an inpatient facility to lower levels of supervision) systematic, repeated and consistent assessment of psychopathology, compliance with treatment to address the individual's psychopathology as well as risks the individual may pose to themselves and others are important considerations to determine when a person is ready to make a safe transition from an inpatient setting to a community setting.

Current procedures for mental health assessment, risk assessment and treatment planning for secure mental health services

Secure mental health services in the ACT are managed by CHS and encompass 2 facilities, DMHU and GMHU. DMHU operates as a low to medium-secure mental health unit. GMHU is considered to be DMHU's primary step-down inpatient unit and is intended to function as a rehabilitation unit to support people with mental health illness to transition to living in the community.

CHS mental health service policies and procedures describe the values that underpin its intended service delivery processes. These values include:

- Fostering hope, empowerment and inclusion.
- Promote autonomy and self-determination.
- Recognising lived experience and individualisation of goals.
- Holistic approach to treatment and care, including physical, social and occupational domains.
- Recognising and including family systems in treatment and care.
- Community equivalent care, meaning that persons detained in secure or prison. environments receive equivalent treatment and care as persons in the community.
- Treatment and care provided in the least restrictive manner.
- Collaboration between services or agencies involved in providing support or services to the person.
- Work to end discrimination and reduce stigma towards persons who experience a mental illness.
- Ensure staff are highly trained and equipped to provide recovery-focused care for each person.

Relevant procedural documents indicate that both facilities are staffed by a multidisciplinary team, including forensic psychiatrists, psychologists, nurses, social workers, exercise physiologists, art therapists and allied health assistants. Information provided by stakeholders to the review panel indicated that there have been difficulties recruiting and ensuring staff are trained in forensic instruments and criminogenic-based interventions.

At a minimum, each person receiving mental health care should have an individualised and current care plan for each episode of care. This care plan should include, wherever possible, input from the person, their family, carers, other nominated people and other professionals involved in their care.

CHS policies and procedures indicate that the frequency for completing care plans should occur on a "regular basis" with the frequency determined by the treatment setting. It appears that intensive care plan meetings occur on a three-monthly basis at DMHU and GMHU. Multidisciplinary meetings to review current treatments occur on a more frequent basis, however the specific frequency could not be determined. The document states, "A selection of consumers will be reviewed each week at MDT (*multidisciplinary team*)/WR (*Ward Round*) meetings".

Clinical risk assessment procedures

The Dhulwa Mental Health Unit Procedure (2021) indicates that multiple risk assessment tools are available to staff to assess and manage the risk of violence. These tools include:

- Dynamic Appraisal of Situation Aggression: Inpatient Version (DASA-IV).
- Historical-Clinical-Risk Management- 20 (HCR-20).
- Structured Assessment of Protective Factors for Violence Risk (SAPROF).
- Psychopathy Checklist- revised.
- Anamnestic Assessment utilising the 5W's approach.

- Other additional risk assessments may be utilised based on clinical judgement for other violence risk assessments such as stalking, sexual offending and arson but are not specified.

The DMHU procedure indicates that risk assessment informs the person's observation and level of restriction and feeds into a document titled Treatment, Placement, Restrictions, Implementation, Monitoring and Review (TPRIM).

It appears that GMHU's risk assessment procedures are the same as those documented in the DMHU Procedure (2021) due to GMHU being part of secure mental health services, however, this is not specified in current documentation.

The DMHU procedure states that comprehensive risk assessment must be conducted at the following points:

Admission

- DASA IV completed at the time of admission (and on an ongoing basis).
- HCR-20 within 6 to 8 weeks of admission for forensic consumers.

Ongoing review

- TPRIM updated at each ward round (the frequency of ward rounds was unable to be determined in procedural documents).
- Structured professional judgement (such as HCR-20), SAPROF and TPRIM to be updated every 3 months, with "full risk assessment" every 6 months.

Leave

- Risk assessment must inform leave requests and be included in leave applications, with a safety plan included as part of the leave application.

Preparation of reports

- A risk assessment and updated TPRIM must be completed to inform reports to ACAT or other bodies.
- The procedure further indicates that risk assessment should be revised for any person who has been managed in the de-escalation area and has had any increase in DASA scores, at any time when risk factors are perceived to have changed (including via feedback from carers or family members), when a clinician has a low level of confidence in the current risk assessment, whenever a patient absconds from the Unit returns, transfer between acute and rehabilitation areas if staff observe any concerning behaviour and before discharge from the unit.
- It does not appear that there are specific procedural guidelines for sharing information with ACAT for persons subject to a CRO.

3. Granting of leave from the mental health facility

While the person is receiving treatment, care, support and rehabilitation at a mental health facility and in preparation for their discharge from the facility, leave serves an important function. Leave from the facility helps integration into community living as well as provides an opportunity for the person to access resources and develop day-to-day living skills (that may not be possible in a mental health treatment facility). Reconnecting with the family and the community and participating in the activities of daily living to be able to live independently are important purposes of leave.

However, permitting leave is an important decision that must balance the treatment, rehabilitation and independence needs of the individual as well as the necessity to ensure the safety of others, including community safety. That is also the reason that several protections including a gradual leave program need to be built into the process of granting leave.

ACAT

ACAT determines the broader scope and boundaries for leave for people on a CRO through conditions of the order for release. ACAT conditions may include a provision of different types of leave and leave limitations such as the maximum number of leave days per month, the maximum length of time leave may occur on each occasion, who must accompany the person on leave and any geographical restrictions.

For persons subject to a CRO, for any change in leave conditions, following the leave panel's approval, the treating team writes to ACAT who then decides about the suitability of leave. It is noted that the person or their legal representative can also write to ACAT to make a leave application in the absence of a leave panel decision.

DMHU and GMHU leave panel

Working within ACAT guidelines for each person, a DMHU and GMHU leave panel meets weekly to discuss leave provisions and requests for inpatients and gives permission for the exact amount of leave that may be taken based on risk assessments for each individual. This allows for flexibility based on individual needs and contemporaneous local expert assessment. The leave panel considers whether an improvement in the person's clinical presentation has occurred to such an extent that the person can be granted leave within the boundaries set by ACAT. The leave panel considers the leave request and recommendation of the multidisciplinary team and if it agrees, approves leave to be granted.

According to the Dhulwa and Gawanggal Leave Management Procedure (August 2023), the core DMHU and GMHU leave panel consists of the following:

- Clinical Director, Forensic Mental Health (Chair)
- Assistant Director of Nursing
- Allied Health Manager
- Clinical Nurse Consultant(s)
- Clinical Nurse Educator
- Clinical Development Nurse

- Consultant Psychiatrist(s)
- Psychiatry Registrar

Other attendees include:

- Nursing Team representatives
- Allied Health team representatives
- CHS Assistant Security Director and or delegate
- Other people as deemed relevant by the leave panel committee

The leave management procedure indicates that the committee operates as a collaborative and consensus-based decision-maker, however, specifies that the Forensic Mental Health Services Clinical Director and Chair retains the authority to make a binding decision. The decision includes whether the leave is consistent with a person's therapeutic leave plan, leave outcome (granted, granted on an ongoing basis or as a one-off) and the leave category.

External Leave Categories
A- Escorted leave
A.1 Controlled escorted – with or without the use of mechanical restraint
A.2 With DMHU/GMHU staff escort
A.3 With a responsible person (DMHU/GMHU Staff, Support Worker, Carer, Family Member)
B- Unescorted leave

Day to day leave management

Procedurally, any change of circumstance for the person (such as a change in safety or risk level) is discussed at the daily clinical "huddle." Before the person can proceed on leave, an assessment of the person's mental state is conducted, including a risk assessment and a pre-leave checklist is completed before leave occurs.

There is also a post-leave checklist with the procedure indicating that this is done on the person's return to the unit. There is also a post-leave feedback form for National Disability Insurance Scheme (NDIS) workers to complete when they accompany the person on leave.

4. Transitioning from secure mental health services to a less restrictive setting

The eventual discharge or transfer of care to a less restrictive setting involves many different professionals and people integral to the person's ongoing care. According to the DMHU - Referral, Admission and Transfer of Care procedure, the transfer or discharge of a person must involve multiple steps including, care planning, risk assessment and management plans, referral to appropriate services, contingency and relapse response planning and ensuring that security and safety considerations are met.

For persons subject to a CRO, the discharge of a person to a lesser restrictive setting (such as from DMHU to GMHU or to the community) requires a decision to be made by ACAT. In the majority of cases, the treating psychiatrist (as delegate of the Chief Psychiatrist) writes to ACAT to advise about the suitability of discharge or transfer. ACAT then conducts a hearing to decide on varying the prior condition regarding where the person must reside.

Analysis and recommendations

People who are found not guilty because of mental impairment and released from custody (also sometimes referred to as acquitted on an insanity plea in other jurisdictions) have been commonly found to have serious mental illness. In this cohort, almost three-quarters have a diagnosis of schizophrenia. [1,2,3] Other psychiatric disorders reported include mood disorders, personality disorders and intellectual impairment[4,5,6,7]. Even though the association between psychopathology and severity of offence is uncertain, the severity of offence does tend to predict the duration at an inpatient facility.[8]

Once the person who is found not guilty because of mental impairment moves from the correctional system to the health system, the focus of the treating team is to ensure that the person receives appropriate mental health and non-mental health care, treatment, support, rehabilitation and protection and it is provided in a safe manner.

Even though rates of reoffending by this group of patients (those found to be not guilty because of mental impairment and released into the care of mental health services) is lower than for released prisoners[9], every incident of reoffending by a person under close supervision of mental health services raises the question of whether the person received appropriate care and treatment and whether necessary protections were in place to protect the person from reoffending and for the community to be kept safe. In an Australian study, 6.3% of people who were found to be had an offence recorded within 12 months. [10]

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1 Parker GF. Outcomes of assertive community treatment in an NGRI conditional release program. J Am Acad Psychiatry Law. 2004;32(3):291-303.

2 Skipworth J, Brinded P, Chaplow D, Frampton C. Insanity Acquittee Outcomes in New Zealand. Australian & New Zealand Journal of Psychiatry. 2006;40(11-12):1003-9.

3 Chan LF, Phang C-K, Loo TH, L.Y O, I T, S S, et al. Factors Influencing Inpatient Duration Among Insanity Acquitees In A Malaysian Mental Institution. Asean Journal of Psychiatry. 2010;11.

4 Almeida J, Graça O, Vieira F, Almeida N, Santos JC. Characteristics of offenders deemed not guilty by reason of insanity in Portugal. Med Sci Law. 2010;50(3):136-9.

5 Miraglia R, Hall D. The effect of length of hospitalization on re-arrest among insanity plea acquittees. J Am Acad Psychiatry Law. 2011;39(4):524-34.

6 Nielssen OB, Yee NL, Millard MM, Large MM. Comparison of first-episode and previously treated persons with psychosis found NGMI for a violent offense. Psychiatric Services. 2011;62(7):759-64.

7 Vitacco MJ, Vauter R, Erickson SK, Ragatz L. Evaluating conditional release in not guilty by reason of insanity acquittees: a prospective follow-up study in Virginia. Law Hum Behav. 2014;38(4):346-56.

8 Dirks-Linhorst PA, Kondrat D. Tough on crime or beating the system: An evaluation of Missouri Department of Mental Health's not guilty by reason of insanity murder acquittees. Homicide Studies: An Interdisciplinary & International Journal. 2012;16(2):129-50.

9 Fazel S, Fimińska Z, Cocks C, Coid J. Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis. Br J Psychiatry. 2016;208(1):17-25.

10 Dean K, Singh S, Kemp R, Johnson A, Nielssen O. Characteristics and Re-Offending Rates Amongst Individuals Found Not Guilty by Reason of Mental Illness (NGMI): A Comparison of Men and Women in a 25-Year Australian Cohort. International Journal of Forensic Mental Health. 2020;20(1):17-30.

The relationship between mental illness and offending

An association of an increase in episodes of violence has been reported with mental illnesses,[11] hence effective treatment of mental illness is important to minimise such an occurrence. Incidents of violence are higher with a mental illness co-occurring with substance abuse and even higher with a co-morbid personality disorder.[12] Effective treatment of people with a psychotic disorder is particularly important as up to 20% of patients with psychosis who also are violent may do so in response to their delusions and hallucinations.[13,14,15,16]

To minimise any risk of violence the treating team must be well aware of all static and dynamic risk factors. In this context, the person's psychopathology, criminogenic factors, history of substance abuse, non-compliance with treatment and access to means of violence are important to identify, monitor and control.

Having noted the above, the vast majority of people with serious mental illnesses, including schizophrenia, do not engage in violence and do not engage in criminal activity. Tragically, there is still an unacceptable level of stigma and misunderstanding of mental illness – including the mistaken belief that people with mental illness are violent. Australian studies that have investigated the relationship between schizophrenia and violence show, for example, that 90% of people with schizophrenia do not commit a violent crime and more than three-quarters do not engage in any type of offending behaviour.[17,18]

While it is the case that the majority of people with schizophrenia and other forms of serious mental illness, do not engage in violent offending, there is also some evidence that people with serious mental illness, such as schizophrenia, are more likely than other people in the community to engage in crime and violence.[19,20] The relationship that has been found is modest but clinically significant (i.e., people with schizophrenia are three to five times more likely than others to engage in violent offending).

A study from Victoria investigated the prevalence of offending in a sample of more than 4,000 people with schizophrenia identified in five-year blocks from 1975 to 2005 compared to a matched community control group.[17] The majority of people in this study had no violent outcomes, however, when considering violent offences collectively (e.g. assault, robbery,

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11 Petit JR. Management of the acutely violent patient. Psychiatr Clin North Am. 2005;28(3):701-11, 10.

12 Steadman HJ, Mulvey EP, Monahan J, Robbins PC, Appelbaum PS, Grisso T, et al. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry. 1998;55(5):393-401.

13 Taylor PJ. Motives for offending among violent and psychotic men. Br J Psychiatry. 1985;147:491-8.

14 Junginger J. Command hallucinations and the prediction of dangerousness. Psychiatr Serv. 1995;46(9):911-4.

15 Buckley PF, Noffsinger SG, Smith DA, Hrouda DR, Knoll JLt. Treatment of the psychotic patient who is violent. Psychiatr Clin North Am. 2003;26(1):231-72.

16 Link BG, Stueve A, Phelan J. Psychotic symptoms and violent behaviours: probing the components of "threat/control-override" symptoms. Soc Psychiatry Psychiatr Epidemiol. 1998;33 Suppl 1:S55-60.

17 Short T, Thomas S, Mullen P, Ogloff JR. Comparing violence in schizophrenia patients with and without comorbid substance-use disorders to community controls. Acta Psychiatr Scand. 2013;128(4):306-13.

18 Wallace C, Mullen PE, Burgess P. Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders. Am J Psychiatry. 2004;161(4):716-27.

19 Douglas KS, Guy LS, Hart SD. Psychosis as a risk factor for violence to others: a meta-analysis. Psychol Bull. 2009;135(5):679-706.

20 Fazel S, Gulati G, Linsell L, Geddes JR, Grann M. Schizophrenia and violence: systematic review and meta-analysis. PLoS Med. 2009;6(8):e1000120.

indecent assault, rape, attempted murder, murder), almost one-quarter of people with schizophrenia (24.6%) were charged with such an offence compared with fewer than ten per cent (8.6%) in the community sample. Thus, people with schizophrenia were approximately five times more likely than the comparison group to be convicted of a violent offence.

It is important to understand the relationship between offending and mental illness to be able to treat people with serious mental illness and in order to provide them with services that are likely to ameliorate their symptoms, other social disadvantages and complex factors that can lead to offending and violence.[21] Research has found that the negative social factors associated with serious forms of mental illness overlap with the negative social factors that increase the probability of being convicted of a criminal offence.[22] Those people with a psychotic illness who have backgrounds characterised by social and family disruption and disadvantage together with abuse, conduct disorder, substance use and educational failure are significantly more likely to offend than those with a psychotic disorder who do not have such disturbances in their backgrounds. Of course, most people with a psychotic illness do not come from such disadvantaged backgrounds, but more do than would be expected by chance.[22]

Studies in Victoria and Western Australia have found that offending precedes diagnosis in most cases where people with schizophrenia offend (60%-73% of cases). It may well be that the offending reflects in part the influence of prodromal features of schizophrenia.

Schizophrenia usually starts with a prodromal phase when symptoms are vague and easy to miss and are often like common adolescent behaviour and other mental problems such as depression or anxiety disorders. These symptoms may not seem unusual for teenagers or young adults and schizophrenia is rarely diagnosed at this time. Many if not most are not seen by a psychiatrist or psychologist until they have a psychotic episode that brings them into contact with the mental health system.

Research has identified that the patterns of the association between mental illness and offending differ from case to case.[21] However, there are three general categories of people with mental illness who offend. Understanding the general mentally disordered offender type should enable clinicians in general psychiatric services to provide appropriate treatment:

1 **People who offend because of their mental illness**

This group is the smallest of the 3 groups. Their offences occur as a direct result of mental illness. Typically, the illnesses that are present in people who fall into this category are psychosis or serious affective disorders accompanied by psychosis. Their mental illness is both a necessary and sufficient explanation for their offence. They only offend when they are acutely unwell and the offence behaviour is a product of their mental illness (e.g. acting on delusions or hallucinations). In ACT, they may be found mentally impaired at the time of the alleged offence.

21 Ogloff JRP. Mental Disorders Among Offenders in Correctional Settings. 2nd ed. Oxford: Oxford University Press; 2009.

22 Mullen P. Schizophrenia and violence: From correlations to preventive strategies. Advances in Psychiatric Treatment. 2006;12:239-48.

2 People who offend as a result of the sequelae of mental illness

The second general group is comprised of those whose mental illnesses are a necessary but not sufficient explanation for their offending. It is by far the largest group of people with disorders and illnesses who offend. As is typical for many people with serious mental illnesses, this group of people begin to spiral downward socially because of their mental illnesses. They can become estranged from family and pro-social support networks. Their lives become unstable; housing, basic needs and their need for non-judgmental personal support may go unmet. They may end up being accepted by groups of people who are themselves unstable. They often resort to engaging in illicit drug abuse. These social factors contribute to their resultant offending. While their mental illness may be a catalyst during events that lead to the offending, the mental illness itself is not the direct cause of the offending. Had they not had a mental illness, they likely would not have begun offending. However, by the time they develop offending behaviour, their lives have become so disorganised, and their maladaptive coping and survival strategies have become so entrenched as to make the reversal of these processes difficult over the long term. Psychiatric treatment, while a necessary starting point, will not be sufficient alone to eliminate the offending behaviour.

3 People who offend despite their mental illness

The final group includes those who would offend irrespective of whether they have a mental illness. Although not as large a group as the second group, many more people who offend fall into this category than into the first. The fact that they have a mental illness is neither a necessary nor sufficient explanation for their offending. People in this group are typically characterised by early onset antisocial and illegal behaviour. They differ from other mentally ill offenders by having a pervasive and stable pattern of offending regardless of their mental state.[23] This behaviour almost always precedes the onset of mental illness. While people with a psychopathic or antisocial/dissocial personality disorder will be included in this group, most of the people in the group will not be so disordered. It is important to acknowledge, though, that the broad range of people that may fall into this group, including psychopaths, may well develop psychiatric illnesses. We must avoid the tendency to deny this group proper services or to acknowledge their mental illnesses. These people's mental illnesses may well exacerbate their offending or lead to unusual offending; however, they may continue to offend, even when they are asymptomatic.

These broad categories of relationships need to be kept in mind when considering the potential risks that people can pose, as well as the benefits of mental health and other interventions.

In relation to a CRO made by ACAT, the purpose of any conditions is to ensure that necessary restrictions and protections are in place for the person's safety and the safety of others.

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23 Hodgins S, Müller-Isberner R. Preventing crime by people with schizophrenic disorders: the role of psychiatric services. Br J Psychiatry. 2004;185:245-50.

Legislative overview

As mentioned above, accused persons who are found to be mentally impaired at the time of the alleged offence, may be referred by the criminal courts to ACAT. ACAT may then make certain orders including, in some cases, an order with conditions under s180 of the *Mental Health Act* referred to as a conditional release order.

The following is a brief overview of the relevant legislative regime.

***Crimes Act 1900* (ACT)**

If a person is found not guilty because of mental impairment, the Supreme Court may make the orders it considers appropriate, including:

1. that the accused be detained in custody for immediate review by ACAT under the *Mental Health Act 2015*, s180 or
2. that the accused submit to the jurisdiction of ACAT to allow it to make an MHO or an FMHO under the *Mental Health Act 2015*.[24]

Similar provisions apply in the Magistrates Court.[25]

The courts may also require an accused to submit to ACAT's jurisdiction to enable it to make recommendations as to how the accused should be dealt with in certain circumstances.[26]

Where the offence is a summary offence or an indictable offence tried summarily, the Magistrates Court may, in certain circumstances, make similar orders referring matters to ACAT.[27]

***Mental Health Act 2015* (ACT)**

Chapter 10 of the *Mental Health Act 2015* (ACT) ("Referrals by courts under *Crimes Act* and *Children and Young People Act*") confers powers on ACAT where courts have made referrals to it because a person is unfit to plead or has been found not guilty of a crime because of mental impairment.

The key provision in Chapter 10, for the purposes of this review, is s180, which empowers ACAT to make what are known in the ACT as "conditional release orders." The provision applies where a court has ordered, under part 13 of the Crimes Act, that a person be detained in custody for immediate review by ACAT.[28]

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24 Crimes Act 1900 (ACT), s 323.

25 Crimes Act 1900 (ACT), ss 328, 329.

26 See, for example, Crimes Act 1900 (ACT), ss 323(1), 328(1), 331(1).

27 Crimes Act 1900 (ACT), ss 334(2), 335(2), (3), (4).

28 Mental Health Act 2015 (ACT), s 180(1).

ACAT is required by s180 of the Mental Health Act to review the detention and consider the release of the person within 7 days after the court's order.[29] In doing so, it must have regard to certain considerations set out in section 180(3). Those considerations are:

a) that detention in custody is to be regarded as a last resort and ordered only in exceptional circumstances

b) the nature and extent of the person's mental disorder or mental illness, including the effect it is likely to have on the person's behaviour in the future

c) whether or not, if released—

    I. the person's health or safety would be, or would be likely to be, substantially at risk or

    II. the person would be likely to do serious harm to others

d) if there is a registered affected person in relation to the person—

    I. any statement by the registered affected person and
    II. the views of the Victims of Crime Commissioner

e) if the court nominated a term under the *Crimes Act*, part 13— the nominated term.

An order for the release of a person may be made subject to conditions, including a requirement to comply with a stated mental health order or forensic mental health order.[30]

The conditions must be reviewed by ACAT at least every 6 months and within 72 hours of being informed by the Chief Psychiatrist of a contravention of a condition.[31] If there is a registered affected person in relation to the person subject to the order, ACAT must consider any statement by the registered affected person and the Victims of Crime Commissioner's views.[32] A registered affected person is, broadly, someone who has suffered harm connected with a forensic patient's offence and whose information is entered in the affected person's register.[33]

When reviewing the detention of a person and considering the person's release under s180 of the *Mental Health Act*, ACAT is to be constituted by a presidential member (a lawyer)[34] and a non-presidential member with a relevant interest, experience, or qualification.[35]

29 Mental Health Act 2015 (ACT), s 180(2).

30 Mental Health Act 2015 (ACT), s 180(4).

31 Mental Health Act 2015 (ACT), ss 181, 182.

32 Mental Health Act 2015 (ACT), s 182(4).

33 Mental Health Act 2015 (ACT), ss 128-130.

34 ACT Civil and Administrative Tribunal Act 2008 (ACT), s 94.

35 Mental Health Act 2015 (ACT), s 186.

ACAT is generally required to notify certain people before holding a hearing.[36] These include the subject person, the Public Advocate and the Chief Psychiatrist. In the case of a hearing under s180 to review a court order detaining a person in custody, if there is a registered affected person, that person and the Victims of Crime Commissioner are to be given notice of the hearing.[37] The provision requiring notification of those persons does not apply in relation to a review of the conditions of release.[38] As the panel understands it, persons having a right to appear at a hearing to consider the release of a person under s180(2) of the Mental Health Act (including registered affected persons) are generally provided with only three days' notice of the hearing, which restricts those persons' ability to provide ACAT with considered submissions.

Certain persons are entitled to appear and give evidence at the hearing of a proceeding.[39] They include the subject person, the Public Advocate, the Chief Psychiatrist and the Discrimination Commissioner. If the proceeding is a review of a conditional release order and there is a registered affected person, that person and the Victims of Crime Commissioner may appear. The hearings must generally be held in private.[40]

Restrictions on disclosure of health information

The *Health Records (Privacy and Access) Act 1997* (ACT) regulates the use and disclosure of health information.

The privacy principles in the *Health Records (Privacy and Access) Act 1997* (ACT) have the force of law and a person to whom a privacy principle applies must not, without lawful authority, contravene the privacy principle.[41]

Privacy principle 10(1) provides that a record keeper who has possession or control of a health record must not disclose personal health information about a person to an entity other than the person. That principle does not apply in certain circumstances. Those circumstances include that the information is being shared between members of a treating team only to the extent necessary to improve or maintain the person's health or manage a disability.[42] They also include that the disclosure is required or allowed under a law of the Territory.[43]

36 Mental Health Act 2015 (ACT), s 188(1).

37 Mental Health Act 2015 (ACT), s 188(1)(viii).

38 Mental Health Act 2015 (ACT), s 188(3)(f).

39 Mental Health Act 2015 (ACT), s 190.

40 Mental Health Act 2015 (ACT), s 194.

41 Health Records (Privacy and Access) Act 1997 (ACT), ss 5 and 6.

42 Privacy Principle 10(2)(a) in Schedule 1 to Health Records (Privacy and Access) Act 1997 (ACT).

43 Privacy Principle 10(2)(e) in Schedule 1 to Health Records (Privacy and Access) Act 1997 (ACT).

The Mental Health Act contains provisions authorising the sharing of "relevant information." "Relevant information" is defined to mean "information needed for the safe and effective care of a person who has, or may have, a mental illness or mental disorder."[44]

An "information sharing entity" may enter into an arrangement with another information sharing entity to allow each entity to request and receive relevant information held by each entity; and to disclose relevant information to each other entity.[45] An "information sharing entity" is defined to include certain directors general, the Chief Police Officer and the Chief Officer (ambulance service).[46] The arrangement is known as an information-sharing protocol.

An information-sharing entity may share relevant information under an information-sharing protocol only if satisfied, and to the extent, it is reasonably necessary for the safe and effective treatment, care, or support of the person to whom the information relates.[47]

If an information-sharing protocol were in place, and an information-sharing entity shared information in accordance with it, this would be a permitted disclosure under the *Health Records (Privacy and Access) Act 1997* (ACT).[48]

Carers Recognition Act 2021 (ACT)

The *Carers Recognition Act 2021* was passed, and came into force, after the Mental Health Act. It contains principles concerning the treatment of carers, including that a carer should be respected and recognised as an individual with their own needs, a carer and someone with knowledge of the person receiving care.[49] It also places obligations on each "care and carer support agency," a term which includes a public sector support agency.[50]

A "public sector support agency" is a public sector entity that is responsible for the assessment, planning, delivery, management and review of support services, programs, or policies in relation to people in care relationships.[51] A person is in a care relationship with another person if a carer provides care to another person because, relevantly, the other person has a mental disorder or mental illness.[52]

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44 Mental Health Act 2015 (ACT), s 218.

45 Mental Health Act 2015 (ACT), s 219(1).

46 Mental Health Act 2015 (ACT), s 218.

47 Mental Health Act 2015 (ACT), s 219(2).

48 See Privacy Principle 10(2)(e) in Schedule 1 to Health Records (Privacy and Access) Act 1997 (ACT).

49 Carers Recognition Act 2021 (ACT), s 8(1)(a).

50 Carers Recognition Act 2021 (ACT), s 7.

51 Carers Recognition Act 2021 (ACT), Dictionary.

52 Carers Recognition Act 2021 (ACT), s 6(1)(b).

A carer and carer support agency must take all practicable measures to ensure that certain people, including the agency's employees, are aware of, and understand, the care relationship principles under the Carers Recognition Act.[53]

Considerations in relation to the legislative scheme

1. Referral to ACAT from criminal courts

There is no clear guidance to courts in the *Crimes Act 1900* as to the criteria for making an order that the accused be detained in custody for immediate review by ACAT under s180 of the Mental Health Act or an order that the accused submit to the jurisdiction of ACAT to allow ACAT to make an MHO or FMHO.

The legislature contemplates that the more restrictive order is an order that the accused be detained in custody for immediate review by ACAT. That order contemplates detention for up to 7 days, the period ACAT has to review the detention and longer if it does not order the release of the person.[54] An order for detention is, of course, an order with serious human rights consequences as it takes away a person's liberty.

The lack of legislative guidance (or clear legislative policy) as to which order a court is to make and under what circumstances, makes the task of ACAT more difficult when considering the conditional release of a person under s180 of the Mental Health Act.

Recommendation 1
Consideration be given to providing guidance in the Crimes Act 1900 to courts to the circumstances where the court should make an order that the accused be detained in custody for immediate review by ACAT under section 180 of the Mental Health Act 2015, and the circumstances in which the court should make an order that the accused submit to the jurisdiction of ACAT to allow ACAT to make a mental health order or a forensic mental health order.

2. Orders available to ACAT when considering a person's release from custody

When a court makes an order that the accused be detained in custody for immediate review by ACAT under Mental Health Act s180, ACAT may order the release of the person unconditionally, decide not to order the release of the person or order the release of the person subject to the conditions ACAT considers appropriate, including a requirement to comply with a stated mental health order or forensic mental health order.[55] The word "stated" may imply that this applies if the mental health order or forensic mental health

53 Carers Recognition Act 2021 (ACT), s 10(1).

54 Mental Health Act 2015 (ACT), s 180(2).

55 Mental Health Act 2015 (ACT), s 180.

order is already in existence. Section 180(4) of the Mental Health Act does not appear, on its face, to confer a power on ACAT to make an MHO or FMHO in relation to a person referred to ACAT under s324(2)(a) of the Crimes Act.

Several factors make it improbable that ACAT would be able to make a forensic mental health order at the time it is considering making a conditional release order anyway unless an application had been made sometime earlier for making an FMHO. Before making an FMHO, ACAT is required to consider an assessment of the person conducted under an assessment order or another assessment of the person that it considers appropriate.[56] There may be no such assessment at the time ACAT must consider a person's release (within 7 days of the court's order).

Further, ACAT is required to consult with a variety of people "as far as practicable" before making an FMHO.[57] It must take into account various matters and factors, including a plan for the proposed treatment, care or support of the person, mentioned in the Mental Health Act s94(3)[58] (which may not be in existence at the time ACAT considers a person's conditional release).

An FMHO may only be made concerning three categories of people. These are:

a) a detainee or a person serving a community-based sentence assessed under an assessment order or

b) a person referred to ACAT for a forensic mental health order under division 7.1.2 of the Mental Health Act or

c) a person required by a court to submit to the jurisdiction of ACAT under the *Crimes Act*, part 13 or the *Crimes Act 1914* (Cwlth), part 1B.

An accused person subject to a court order that he or she be detained in custody for immediate review by ACAT under the Mental Health Act s180 would be a "detainee" until such time as ACAT made a conditional release order.[59] Thus, at least in theory, ACAT could make an FMHO, then immediately afterwards make a conditional release order, a condition of which was compliance with the FMHO. However, the preconditions to the making of a FMHO may make it impracticable for ACAT to make the FMHO before the CRO.

Once the CRO was made, the person would no longer be a "detainee" in respect of whom a forensic psychiatric treatment order could be made.

One of the criteria for making an FMHO is that ACAT believes on reasonable grounds that, because of the person's mental illness, the person is doing, or is likely to do, serious harm to themself or someone else, or is suffering, or is likely to suffer, serious mental or physical deterioration. The test is forward-looking and depends upon the likelihood of serious harm

56 Mental Health Act 2015 (ACT), s 96.

57 Mental Health Act 2015 (ACT), s 97.

58 Mental Health Act 2015 (ACT), s 99(1).

59 See Mental Health Act 2015 (ACT), Dictionary and Corrections Management Act 2007 (ACT), s 6(1).

or serious deterioration (a high bar) and that harm being caused by the person's mental illness. It does not contemplate the need for detention of a person or restrictions on a person for a reason other than mental illness (such as criminogenic factors).

It is also unlikely that ACAT would be in a position to make an MHO when deciding whether to order the release of a person under the Mental Health Act s180. Before making a mental health order in relation to a person, ACAT must consider an assessment of the person conducted under an assessment order or another assessment of the person that it considers appropriate.[60]

ACAT must also, as far as practicable, consult with a significant number of persons before making an MHO.[61] It must take into account specified matters, including the views of certain persons.[62]

ACAT may only make an MHO in relation to 4 categories of person, being:

a) a person assessed under an assessment order

b) a person in relation to whom an application for a mental health order has been made under part 5.2 of the Mental Health Act

c) a person in relation to whom an application for a forensic mental health order has been made under division 7.1.2 of the Mental Health Act

d) a person required by a court to submit to the jurisdiction of ACAT under the *Crimes Act*, part 13 or the *Crimes Act 1914* (Cwlth), part 1B.

A person detained in custody for immediate review by ACAT under the Mental Health Act s180, may not fall into any of those categories.

What this means is that, if a court orders that the accused be detained in custody for immediate review by ACAT under the Mental Health Act s180, ACAT may only have very limited powers to authorise the detention of the person in an approved mental health facility, even if ACAT considers that person to be a risk to the community.

In that situation, ACAT may decline to order the release of the person, with the effect that the person remains in prison. However, it may only do so having regard to the criteria in the Mental Health Act s180(3). Those criteria include that detention in custody is to be regarded as a last resort and ordered only in exceptional circumstances. They also include whether or not, if released, the person's health or safety would be or would be likely to be, substantially at risk, or the person would be likely to do serious harm to others. This places a high bar for assessing risk. There must be a *likelihood* of a person's health or safety being *substantially* at risk, or of the person doing *serious harm* to others. That test is not apt to

60 Mental Health Act 2015 (ACT), s53(1).

61 Mental Health Act 2015 (ACT), s54(1).

62 Mental Health Act 2015 (ACT), s56.

capture the circumstance where there is an unacceptable risk (lower than a likelihood) of serious harm eventuating.

It may be doubted that ACAT may order as a condition of a person's release from custody, that the person reside in an approved mental health facility (that is, effectively, that the person be detained). However, even if this is authorised by s180(4), there are several reasons why making an order for detention under this provision is undesirable, including that:

a) there are no stated criteria or mandatory considerations for ACAT when deciding what conditions to impose under section 180(4), notwithstanding the significant restriction of a person's human rights if the person is detained,

b) the *Mental Health Act* does not contain the same safeguards upon the review of a person's continued detention under that provision as it contains about reviews of detention under forensic mental health orders or restriction orders

c) the order does not expressly authorise a third party to detain the person, in contrast to the express statutory authority conferred upon the Chief Psychiatrist and Care Coordinator to detain a person subject to a forensic mental health order or restriction order which authorises the person's detention.

This creates the undesirable situation that ACAT may not be able to order the detention of a person in a mental health facility when conducting a review of the person's detention in custody under the Mental Health Act s180 (2), even if ACAT considers that person to pose an unacceptable risk to the community.

One possibility is that ACAT may, in this situation, decline to order the person's release from custody but instead make an MHO or FMHO in relation to the person (assuming there is power to do so in the circumstances).[63] However, it is not clear whether the effect of such an order, if the order stated that the person was to be detained at a mental health facility or community care facility, would be that the person could be transferred from custody to such a facility. That seems doubtful in the absence of a conditional release order.

If the person is under an MHO, the person is required to accept involuntary treatment. Therefore, a person who is unable to consent or fulfils the criteria for involuntary treatment has an opportunity to receive involuntary treatment, care, support rehabilitation and protection under the close clinical supervision of mental health providers. However, a person who is not under an MHO and has the capacity to consent to treatment is still required to abide by conditions imposed by ACAT even though the expectation is for them to adhere to these conditions voluntarily.

This creates an interesting requirement for a person to remain at a facility as that would allow them to remain out of custody. Imposing such conditions by ACAT may be seen to be necessary, but not necessarily essential for the care and treatment of the person. If so,

63 Mental Health Act 2015 (ACT), s180(5).

questions arise as to whether a person's apparent consent to remain in a mental health facility is being given under duress and whether a mental health facility is an appropriate facility to exert such social control.

This arrangement also poses a significant challenge for the mental health team supporting such a person in that the team can only notify ACAT of any contravention of conditions of release, rather than actively managing the contravention.

Recommendations 2 & 3
Clarify by way of a legislative amendment that if some conditions are considered necessary to have in place under a CRO because of the potential risk the person may pose to self, others or the community, then these are introduced under some form of involuntary order. Consideration can be given to providing ACAT with the power to make an order requiring a person to be compulsorily detained in an approved mental health facility where the person poses an unacceptable risk, at the time it considers making an order for the release of a person from detention in custody under the Mental Health Act s180, with appropriate safeguards including provision for the regular review of such an order.

If the person is also considered to be in need of treatment for underlying psychopathology or criminogenic factors, and ensuring compliance with treatment is considered necessary and essential (and conversely non-compliance with the prescribed treatment is likely to increase the risk to the person, to others or to the wider community), ACAT is also provided with the power to make a concurrent FMHO to ensure treatment, care, support and protection to manage such a risk. To enable this to occur a legislative amendment is introduced to change the definition of a `forensic patient' in the Mental Health Act to include people under a s180 order.

3. Criteria for making a conditional release order

ACAT's power to make a CRO is contingent upon a court having ordered that the accused be detained in custody for immediate review by ACAT under the Mental Health Act *s180*. This usually means that the court has not decided to make the principal alternative order contemplated by the Crimes Act, being that the accused submit to the jurisdiction of ACAT to allow it to make an MHO or FMHO.

The legislation contains various tests for the degree of risk that must be considered before making an order for detention, an order releasing a person from detention or an order under which detention in a mental health facility may be authorised.

The criteria for detention in the Crimes Act s308(b), which are set out above, include criteria relating to the risks the accused poses to the community and the nature and circumstances of the offence with which the accused is charged, namely:

a) whether or not, if released—
    i. the accused's health and safety is likely to be substantially impaired
    ii. the accused is likely to be a danger to the community

b) the nature and circumstances of the offence with which the accused is charged.

The factors to which ACAT must have regard to when determining whether to release a person from custody, in *the Mental Health Act* s180 (3), do not include, expressly, factors relating to the offence or offences of which that person was accused. ACAT must have regard to, relevantly, whether or not, if released:

a) the person's health or safety would be, or would be likely to be, substantially at risk

b) the person would be likely to do serious harm to others.[64]

There is no requirement that ACAT consider the nature and circumstances of the offence with which the accused is charged.

There are no stated criteria or mandatory considerations governing the imposition, variation, or revocation of conditions when ACAT is making or reviewing a conditional release order. ACAT has a broad, unstructured discretion in that regard.

It is also relevant to consider the criteria for making an FMHO because it may also apply to persons found not guilty because of mental impairment. ACAT may also require a person to comply with such an order as a condition of the person's release from imprisonment.

The various tests are set out in the table below:

Criteria for detention, Crimes Acts308(b)	**Criteria for release from custody, Mental Health Act s180(3)(c)**	**Criteria for imposing or varying conditions of order for release, Mental Health Act s180(4)**	**Criteria for making a forensic psychiatric treatment order or forensic community care order (which may authorise detention)**
whether or not, if released— i. the accused's health and safety is likely to be substantially impaired, or	whether or not, if released: a. the person's health or safety would be, or would be likely to be, substantially at risk or	Any orders ACAT considers appropriate	ACAT believes on reasonable grounds that - because of the person's mental illness or mental disorder - the person is doing, or is likely to do, serious harm to themself or someone else, or is

64 Mental Health Act 2015 (ACT), s 180(3)(c).

ii. the accused is likely to be a danger to the community	b. the person would be likely to do serious harm to others		suffering, or is likely to suffer, serious mental or physical deterioration

The management and disposition of people found NGMI requires a careful balance between respecting the individual's rights and autonomy and enforcing restrictions necessary for public safety. It is acknowledged that the different tests for risk are due to considerations for public safety (i.e. social control) rather than treatment for a mental illness or disorder. Nonetheless, since the consideration is the release of the person into the community, there is merit in considering whether these tests can be harmonised.

Recommendations 4, 5, 6 & 7
Consideration be given to harmonising the criteria or considerations under the Crimes Act s308(b) and the Mental Health Act s180(3)(c).

Consideration be given to making it clear by way of a Chief Psychiatrist Advisory Note that for purposes of assessment of risk, the risk of serious harm to others is inclusive of risk to the safety of the community.

That ACAT be required to consider, under section 180 (3) of the Mental Health Act, the psychopathology and other criminogenic factors that contributed to the person's offending by way of a detailed forensic psychiatric report.

That matters to which ACAT must have regard, when it is deciding whether to impose conditions upon the release of a person under the Mental Health Act, and what conditions to impose and when deciding whether to vary or revoke those conditions under section 182(5), be specified in the Mental Health Act.

4. Constitution of ACAT when it is considering making or reviewing a CRO

Currently, ACAT is constituted by a presidential member and a non-presidential member with a relevant interest, experience or qualification when reviewing the detention of a person and considering the person's release under the Mental Health Act *s*180.[65] The review panel was given to understand that, in some circumstances, the non-presidential member who constitutes the panel is a legal member without any particular experience in mental health. The phrase "relevant interest, experience or qualification" is very broad and could include non-presidential members without any expertise in assessing the risk posed by persons with mental impairment and without legal qualifications.

65 Mental Health Act 2015 (ACT), s 186.

The Mental Health Act does not specify how ACAT is to be constituted when reviewing the conditions of release of a person under s182. This means that a non-presidential member of ACAT could constitute it for a review of the conditions of a person's release.[66] On a review under s182, such a non-presidential member is not required to be a lawyer or a person with a relevant interest, experience, or qualification in relation to the making of the order.[67]

That is a very undesirable situation because it means that a non-legal member with no legal qualifications and no experience in mental health legislation or treatment of forensic patients could be responsible for reviewing and imposing the conditions to which an order for the release of a person is subject.

In making a CRO, currently ACAT requires some people under a CRO to reside in a secure mental health facility as a condition of the person's release. That is effectively a detention order. ACAT also imposes as a condition of release, a condition that persons may have specified leave from the secure mental health facility if the leave panel permits this.

The review panel considers it important that ACAT be constituted by a presidential member and by a second member who is a forensic mental health professional when reviewing the detention of a person and considering the person's release under the Mental Health Act s180. A forensic mental health professional would bring to ACAT an understanding of the particular risks posed by persons found not guilty because of a mental impairment. Such a person would be able to interpret risk assessments and would be likely to have a good understanding of the material ACAT needs to make an informed decision.

It is very important that ACAT is constituted in the same way when reviewing the conditions of a person's conditional release. At present, it is possible that a non-lawyer with no relevant experience could undertake such a review (although that may be unlikely to occur in practice). The conditions may significantly impact a person's liberty and only a legal member, sitting with a forensic psychologist or forensic psychiatrist, should be in a position to vary or revoke them.

It is noted that section 182(6) of the Mental Health Act provides that, if a person contravenes a condition of an order of release, ACAT may order that the person be detained in custody until it orders otherwise. It appears that such an order may be made by ACAT in the course of reviewing the conditions of an order of release. That makes it even more important that ACAT is constituted by persons with the requisite knowledge and experience to make such an order. A legal member and a forensic mental health professional are likely to have the relevant knowledge and experience.

66 ACT Civil and Administrative Tribunal Act 2008 (ACT), s 89(2); Dictionary, definition of "application," paragraph (b).

67 ACT Civil and Administrative Tribunal Act 2008 (ACT), ss 90, 96.

Recommendations 8 & 9
That ACAT be constituted by a presidential member and a second member who is a forensic mental health professional when reviewing the detention of a person and considering the person's release under the Mental Health Act s180.

That ACAT be constituted in the same way when reviewing the conditions of a person's release under the Mental Health Act s182 and when deciding whether to order that a person be detained in custody until ACAT orders otherwise, s182(6).

5. People entitled to be notified and to appear when ACAT is considering making a CRO

As indicated above, when ACAT is reviewing the detention in custody and considering the release of a person, under the Mental Health Act s180(2), it is required to give written notice of the hearing at least 3 days before the hearing to a number of people.[68] They include the subject person, any representative, guardian or attorney of the person, the Public Advocate, the Chief Psychiatrist and the Care Coordinator.[69] If there is a registered affected person for the person, the registered affected person and the Victims of Crime Commissioner must also be given notice of the hearing.[70]

ACAT may also give notice of the hearing to anyone else it considers appropriate.[71]
The persons entitled to appear and give evidence at a hearing are similar to those entitled to notice.[72]

The review panel considers that the Mental Health Act should be amended to require ACAT to give notice to additional categories of persons and for those persons to have a right to appear and give evidence at hearings.

The first category is the carer of the subject person. The principle that a carer should be respected and recognised as a person with knowledge of the person receiving care is endorsed in the *Carers Recognition Act 2021* (ACT). While that act does not have direct application to ACAT's decision-making, the principle has force in relation to decisions about a person with a mental disorder or mental illness. Carers could be expected to have knowledge about a subject person which goes beyond the information which would be provided to ACAT from the court file and which would be likely to be placed before ACAT. ACAT's decision-making could be enhanced by hearing from a person's carer. Giving the carer notice of a hearing and a right of appearance would also provide an opportunity for that person's role to be recognised.

68 Mental Health Act 2015 (ACT), s188(1).

69 Mental Health Act 2015 (ACT), s188(1)(a).

70 Mental Health Act 2015 (ACT), s188(1)(a)(viii).

71 Mental Health Act 2015 (ACT), s188(1)(b).

72 Mental Health Act 2015 (ACT), s190.

It is to be noted that a person's carer must be notified on the review of a community care order or restriction order[73] and if the Chief Psychiatrist or Care Coordinator considers that a Forensic Psychiatric Treatment Order (FPTO) or Forensic Community Care Order (FCCO) is no longer appropriate.[74] That reinforces the suitability of a carer appearing at a hearing under the Mental Health Act s180.

There may be a difficulty about ACAT identifying a subject person's carer in the short time available before a review of the person's detention in custody must be undertaken (7 days). That difficulty could possibly be addressed by introducing a system for the registration of carers, similar to the register of affected persons. Alternatively, ACAT could be required to give notice to any carer of whom it is aware. n any event, carers should be given a right to appear and be heard at the hearing, so that if the carer is aware of the hearing without having been notified of it by ACAT (for example, if the subject person told them about it), the carer may appear and give evidence or make submissions.

Close family members are in a similar position to carers, in that their knowledge and understanding of the subject person could be valuable to ACAT in its decision-making. There could be an issue about identifying the relevant family members to whom notice was required to be given. ACAT's obligation could potentially be to notify any parent or spouse of the person known to ACAT. Again, those persons could be given a right to appear and be heard at the hearing, irrespective of the notice provisions.

The potential benefit to ACAT and to the family members of the family members attending the hearing would need to be balanced against the subject person's wishes (in the event that the subject person did not want a family member to be involved). This could possibly be addressed by giving ACAT a discretion not to allow a family member to attend if the subject person objected. However, given that it is relevant for ACAT to consider risks to the community when deciding whether to make a conditional release order, it may be that the subject person should not have a right to object to the presence of a family member, as the family member may be in a position to provide ACAT with information relevant to risk.

It would be of assistance to ACAT to have before it, in a hearing held under the Mental Health Act s180 (2), a person representing the interests of community safety. That person should be able to put before ACAT relevant information about the subject person's criminal history.

It is the review panel's understanding that the criminal courts generally provide ACAT with the court's file about the subject person. However, that file is likely to contain only limited information about the person's criminal history. Patterns of behaviour, relevant to risk, may be apparent from police records but police records may not be available to ACAT (and, as the panel understand it, are generally not made available to it).

ACAT is required to notify the Victims of Crime Commissioner of a hearing, but only if there is a registered affected person for the subject person. The role of the Victims of Crime

73 Mental Health Act 2015 (ACT), s 72.

74 Mental Health Act 2015 (ACT), ss 105, 106, 112, 113.

Commissioner appears to be largely to make submissions in respect of victims, and in respect of particular victims of the subject person who are registered as affected persons. The Victims of Crime Commissioner reports that the Commissioner sometimes makes submissions to ACAT relevant to the public interest in community safety, however, the Commissioner would generally not have access to the police file concerning the subject person. The Victims of Crime Commissioner is also not generally notified or invited to a hearing unless there is a registered affected person. In practice, this means that there is often no person at the hearing specifically providing information and scrutinising information with respect to community safety.

The review panel's view is that ACAT would be assisted in its decision-making by the attendance at all hearings under the Mental Health Act s180(2) of a person on whom the function of representing the interests of community safety is conferred, such as the Victims of Crime Commissioner, the Director of Public Prosecutions or a member of the Australian Federal Police, with access to police records about the subject person. This would be supported by the amendment of the Mental Health Act s180(3) to require ACAT to have regard to the question of whether the person poses an unacceptable risk to the safety of the community.

The Victims of Crime Commissioner, who already appears in ACAT when there is a registered affected person, may be an appropriate person to be given the function of representing the interests of community safety more generally, if the legislation is amended to make this a relevant factor for ACAT to consider. The Commissioner's existing right of appearance would need to be extended to all hearings under the Mental Health Act s180(2), not just those for which there is a registered affected person.

Another possibility is for the Director of Public Prosecutions to perform this role. The Director is probably more suited to doing so than a member of the Australian Federal Police because the Director is an ACT statutory office holder, rather than a Commonwealth officer. While this function is different from the Director's prosecution function, it is not dissimilar to the Director's function when appearing at bail hearings or in the drug and alcohol court. Should the legislation be amended to require notice of a hearing to be given to the Director, it should be made express that their function at the hearing is to represent the public interest in community safety.

Provision should also be made for the police to provide ACAT and the person representing the interests of community safety with the subject person's full criminal record (including all records the police have about the subject person). That would include information showing patterns of behaviour where a person may not have been arrested or charged. ACAT could then provide this material to persons appearing before it, to allow for the making of submissions or reports about its relevance. The provision of such information may require an amendment to the Mental Health Act, which would authorise the collection and/or disclosure of personal and health information in these circumstances for the purposes of the *Information Privacy Act 2014* (ACT) and *Health Records (Privacy and Access) Act 1997* (ACT).

Similarly, if the subject person has been incarcerated, provision should be made for the person acting in the interest of public safety to be provided with the subject person's prison

files (i.e. incident reports, behavioural reports, activities undertaken whilst incarcerated, treatment programs undertaken, etc.).

Recommendations 10, 11 & 12
Consideration be given to requiring ACAT to notify the carer (as defined in the Carers Recognition Act 2010) of a subject person of a hearing under section 180 of the Mental Health Act, at least if ACAT is aware that the person has a carer and of the carer's identity and giving a subject person's carer a right to appear and give evidence at such a hearing.

That ACAT be required to notify a person representing the interests of community safety, such as the victims of crime commissioner or the Director of Public Prosecutions, of a hearing under section 180 of the Mental Health Act and that that person be given a right to appear and give evidence at such a hearing.

That the Mental Health Act be amended to stipulate that the person representing community safety and ACAT are provided necessary information by the police and ACT Corrective Services for the purpose of better informing ACAT about matters relevant to any risk the person may pose to community safety.

6. Timeframe for making a CRO

As indicated above, ACAT must review the detention and consider the release of a person ordered by a court to be detained in custody for immediate review by ACAT, within seven days of the court's order. That does not necessarily require ACAT to hold a hearing within that time or to make an order within that time. The legislation should stipulate, in the review panel's view, that a hearing is required. A hearing is necessary to ensure that the person is provided with procedural fairness and to allow other interested parties to be heard.

The short time frame for considering whether to release a person from custody is no doubt a recognition of the human right to liberty.[75] A person who has been found not guilty of an offence because of mental impairment should only be detained in custody if this can be justified on very limited grounds (such as for their own safety or the safety of others). There would be very few circumstances where it would be justifiable to detain such a person in a prison, as opposed to a secure mental health facility. That is recognised in the Mental Health Act s180(3)(a) which provides that ACAT must have regard to the principle that detention in custody is to be regarded as a last resort and ordered only in exceptional circumstances.

The difficulty with such a short time frame, however, is that ACAT is not likely to be as well informed as it might otherwise be when making a decision as to the person's release from custody. It is the review panel's understanding that a court usually provides ACAT with its file. The court file would likely contain reports about the person's mental illness or mental

75 See Human Rights Act 2004 (ACT), s18.

disorder. These may not be up to date. Moreover, the court file is unlikely to contain any risk assessment reports by a psychologist or psychiatrist. In the review panel's opinion, such reports would be invaluable when ACAT is deciding whether or not to release a person from custody. It is also unlikely that ACAT would have a complete police record about the person, as discussed above.

The limited time frame is also likely to mean that interested parties will not be able to prepare submissions or evidence adequately.

There may be situations where it is plain on the material before ACAT that there is no justification for the subject person to remain in custody and the 7 day time frame may be sufficient. However, where there is a real question as to whether the person should be either in custody or in a secure mental health facility, seven days is not likely to be adequate for ACAT to make a properly informed decision. That creates a situation where ACAT may order that a person posing a significant risk to the community be released from prison.

Provision needs to be made to facilitate ACAT considering where the person resides while it is considering making an order to release the person from custody. This is needed such that persons who pose a significant risk to the community or to themselves are not released into the community, as a result of ACAT having insufficient information before it to make a properly informed decision, or as a result of it lacking power, at the time it considers a person's release from custody, to make an order that a person resides in a secure mental health facility.

This could be done in a variety of ways. One possibility is for ACAT to be given the power to make an interim order, releasing a person from custody and placing the person in an appropriate facility, pending a further hearing. At the further hearing, ACAT could be provided with risk assessment reports and more information about any risks the person poses (both as a result of the person's mental health condition and as a result of criminogenic factors).

Recommendations 13 & 14
That provision be made to enable ACAT to obtain a comprehensive mental health assessment and clinical risk assessment report from a forensic psychiatrist about a person before it makes a decision as to whether to release the person from detention in custody under section 180(2) of the Mental Health Act.

That consideration be given to facilitating the making of orders requiring a person to reside in an appropriate facility on an interim basis, following a hearing under section 180 of the Mental Health Act, pending a further hearing.

7. Review of conditions of a CRO for release from custody

ACAT must review a condition under section 180(4) of the Mental Health Act, to which an order for the release of a person is subject, at least every 6 months while the order is subject to the condition.[76] It must also review such a condition if the Chief Psychiatrist tells ACAT the person had contravened a condition, within 72 hours of being notified.[77] A possible outcome of a review where a person has allegedly contravened a condition of an order for release is an order that a person be detained in custody.[78]

A review of a condition of a conditional release order may be conducted without a hearing.[79]

The conditions of a release order may have a significant impact on the subject person's liberty and human rights. At present, ACAT sometimes requires a person to reside in a secure mental health facility or other mental health facility as a condition of release. ACAT also imposes leave entitlements from that facility as a condition of release. Further, ACAT may decide to return a person to prison if it finds the person has contravened his or her conditions of release. It is not appropriate that ACAT be entitled to make such significant decisions in the absence of a hearing. It is also appropriate that a greater range of persons be given a right to be heard.

The persons entitled to be heard on a review of a condition of an order of release for a person are very limited. The only persons who are expressly given any right to be heard are the registered affected person (if there is one) and the Victims of the Crime Commissioner (if there is a registered affected person). In that case, ACAT must consider any statement by the registered affected person and the views of the Victims of the Crime Commissioner.[80]

The persons who may have an interest in being heard as to the conditions of release are very similar to those who may have an interest in being heard as to the person's release from detention in custody. It is essential that the subject person be given an opportunity to be heard. If it is proposed that the person's leave conditions be significantly altered, or that the person be released from a secure facility into the community, persons such as the Victims of Crime Commissioner and the Director of Prosecutions (if given a right to appear at the section 180(2) hearing) would have an interest in being heard. In the review panel's view, the persons who are entitled to be notified of a hearing under section 180(2) should also be notified of any hearing under section 182 of the Mental Health Act and given a right of appearance and right to adduce evidence.

ACAT's powers to impose conditions are, at present, unconfined. It would be beneficial for the legislation to provide some clarity as to the kinds of conditions that may be imposed,

76 Mental Health Act 2015 (ACT), s 182(1).

77 Mental Health Act 2015 (ACT), ss 181, 182(2).

78 Mental Health Act 2015 (ACT), s 182(6).

79 Mental Health Act 2015 (ACT), s 182(3).

80 Mental Health Act 2015 (ACT), s 182(4).

including whether ACAT may require a person to reside in a secure mental health facility or require a person to submit to taking medication as a condition of the person's release, in the absence of a forensic mental health order or other order authorising detention or involuntary treatment.

Recommendations 15, 16 & 17
That the Mental Health Act be amended to make provision for the types of conditions that may be imposed on an order of release for a person, and to clarify whether ACAT may impose a condition requiring a person to reside in a secure mental health facility, or to take medication, in the absence of a forensic psychiatric treatment order or other order authorising detention or involuntary treatment.

That the Mental Health Act stipulates that ACAT must hold a hearing before making a decision as to whether to release the person from detention in custody under section 180(2) of the Mental Health Act.

That the persons entitled to be notified of a hearing under section 180(2) of the Mental Health Act and who have an entitlement to appear and give evidence at such a hearing also be entitled to be notified of a hearing under section 182 of the Mental Health Act and to appear and give evidence at that hearing.

8. ACAT must be comprehensibly informed about risks to the community

An important aspect of ACAT's decision making as to whether to release a person from custody has to be the consideration of risk to the community. That consideration is not expressly addressed in section 180(3) of the Mental Health Act, although ACAT must consider whether the person, if released, would be likely to do serious harm to others. Consideration of community safety is not in opposition to consideration of an individual's human rights and rights to receive appropriate care and treatment. Keeping the community safe is a key consideration in keeping a vulnerable person with a mental illness safe from actions that may have devastating outcomes to all concerned, the victims, the person with the mental illness and the respective families.

For ACAT to be able to make informed and balanced decisions to adequately manage the risk to the community it must have all relevant information.

The purpose of imposing conditions with or without a mental health order is to ensure community safety. In making its decision, the legislation does not require ACAT to consider any specific information, although in making its decision ACAT members make every possible effort to consider recommendations made by clinicians to ensure that conditions imposed are in line with the recommendations made by clinicians. The recent amendment to the Mental Health Act (s1803(f)) now requires ACAT to consider the recommendation made by the Chief Psychiatrist about the facility where the person who has been released on conditions can reside.

There is no set template that the treatment team need to use in forming their recommendations for ACAT. There is no requirement to consider factors other than those identified as important to the treatment team. There is no requirement for the treatment team to consider issues of criminal propensity outside of the subject person's mental health. There are no requirements to consider the risk to self, others and the community at large. There are also no mechanisms for the scrutiny of the information provided by the treatment team and thus there is no independent advice on the verbosity or validity of the information provided. This is particularly the case when there is no member of ACAT panel with forensic mental health training or experience.

The above are the reasons why the advice provided by clinicians to ACAT must be structured appropriately to ensure that any advice about psychopathology, risks, importance of compliance with treatment, need for supervision, supports that the person will benefit from and any other conditions to support the person as well as to manage any risks are clear, explicit and helpful. This would enable ACAT to comprehensively consider this advice before making any decision about any conditions that need to be placed on the person being released from custody into the care of mental health service providers.

Recommendations 18 & 19
Any advice provided to ACAT must be informed by a comprehensive mental health assessment that includes a longitudinal history, risk assessment and relevant collateral information that is relevant to understand the person's psychopathology, criminogenic behaviours as well as potential risks that the person may present to themselves, others and the community.

A template is created to define the information to be provided to ACAT when it is making and reviewing a Conditional Release Order, applications for leave or leave appeals. This template must include information on public safety and the likelihood of reoffending and consider not only mental health issues but also broader issues of criminality. It should include the results from defined suitable evidence-based assessment tools and a report from the leave panel on leave decisions made and the rationale for these. Information provided to ACAT about the person's psychopathology, need for compliance with prescribed treatment (including risk of non-compliance), criminogenic factors and any potential risks to the community must be provided in a structured format.

Ongoing mental health support, care and treatment following release from custody by ACAT

Even though the rate of reoffending of people who are found to be not guilty because of mental impairment and released into the community remains low, it is important that every effort is made to eliminate reoffending. This requires active intervention that may range from supervised leave and intensive case management to treatment in the community with engagement in psychosocial and vocational rehabilitation programs.

The literature may suggest an association of recidivism in this cohort with age at release, ethnicity, gender and history of offending behaviour before being deemed not guilty because of mental impairment[2], however, socio-demographic profile, diagnosis or duration in a treatment facility does not predict recidivism. [7,81] Moreover, it is a societal expectation that even a single event of recidivism will be prevented. It is important for clinical decisions or recommendations about lesser restraint of movement, are made to ensure the safety of that person as well as community safety. In making such decisions it is also important that the possible risk of re-traumatisation of previous victims is identified, they are kept informed of any possible increase in risk to them with the lessening of restraint of movement on the individual and if there are risks to unidentified members of the community, appropriate and necessary measures are taken to ensure that individual rights to freedom and independence and appropriately balanced with community safety considerations.

To make an informed decision about progressive release and rehabilitation as well as gradual integration of the person into the community, the responsible clinicians must have exact and detailed information about the psychopathology and mental impairment that was the reason for the person to make a judgement that resulted in the offence. This must be documented in a structured manner.

Decision-making about giving the person progressively greater responsibility to maintain their own safety and that of others may need to be delayed until that psychopathology is considered to be in remission and/or appropriate protections are in place to eliminate the risk of reoffending. Only after this stage is reached clinicians can consider whether any other factors require further consideration of risk to the person and/or others that may still require continuing limitations to be placed on the person and their reintegration into the community.

Standardised risk assessments are available for use. These include the commonly used HCR-20 and Classification of Violence Risk (COVR).[82,83] There is emerging evidence that such tools

81 Vitacco MJ, Erickson SK, Kurus S, Apple BN, Lamberti JS, Gasser D. Evaluating conditional release in female insanity acquittees: A risk management perspective. Psychological Services. 2011;8(4):332-42.

82Monahan J, Steadman HJ, Appelbaum PS, Grisso T, Mulvey EP, Roth LH, et al. The classification of violence risk. Behav Sci Law. 2006;24(6):721-30.

83 Webster CD, Douglas KS, Eaves D, al. e. HCR-20: Assessing risk for violence, version2. Burnaby, BC, Canada: Simon Fraser University Mental Health, Law and Policy Institute; 1997.

and guides improve the accuracy of clinician decision-making about risk.[84,85] However, it is difficult to develop standardised protocols for the use of these risk assessments to guide decision-making primarily because of the significant differences between the individual needs of people in this cohort. Even after the risk has been assessed, it is important that the assessed risk is documented and communicated effectively to ensure that any and every clinician involved in the provision or transition of care can easily form an opinion about assessed and identified risks.[86]

Remission of psychopathology with prescribed treatment and ongoing compliance with prescribed treatment are considered to be the most important factors to assist with decision-making about easing restrictions.[87] However, interventions are also required to ameliorate criminogenic factors that contributed to the offending behaviour and are relevant to future risk of offending and violence.

National Statement of Principles Relating to Persons Unfit to Plead or Not Guilty by Reason of Cognitive or Mental Health Impairment

The National Statement of Principles Relating to Persons Unfit to Plead or Not Guilty by Reason of Cognitive or Mental Health Impairment was established in November 2015 under the Law, Crime and Community Safety Council.[88] The national statement of principles was a product of the cross-jurisdictional Working Group on the Treatment of People Unfit to Plead or Found Not Guilty by Reason of Mental Impairment. The principles, which reflect a commitment to safeguarding the rights of individuals with cognitive or mental health impairment while addressing concerns related to community safety, are outlined below.

Acknowledging the delicate balance required in these cases, the principles emphasise the importance of early intervention, prevention and diversionary programs. The principles were informed by the recommendations and commentary of law reform reviews conducted between 2012 and 2015, ensuring a nuanced understanding of issues related to fitness to plead and the defence of mental impairment in Australian jurisdictions.

Definitions and overarching principles

Key definitions outlined in the document provide a foundational understanding of terms such as "community-based alternatives", "detention" and "order." The overarching principles underscore the need to distinguish between cognitive and mental health impairment, encouraging a broad definition that focuses on the impact of the functional impairment rather than specific diagnostic criteria. The principles specify that detention is

84 Monahan JT, Steadman HJ. Violence Risk Assessment: A Quarter Century of Research. The Evolution of Mental Health Law: American Psychological Association; 2001. p. 195–211.

85 Edens JF, Otto RK. Release decision making and planning. In: Ashford JB, Sales BD, Reid WH, editors. Treating Adult and Juvenile Offenders With Special Needs. Washington, DC: American Psychological Association; 2001. p. 335–71.

86 Arya D, Nicholls D. Identifying and communicating clinical risk. Australasian Psychiatry. 2005;13(4):366-70.

87 McDermott BE, Scott CL, Busse D, Andrade F, Zozaya M, Quanbeck CD. The conditional release of insanity acquittees: three decades of decision-making. J Am Acad Psychiatry Law. 2008;36(3):329-36.

88 Departement AGs. The National Statement of Principles Relating to Persons Unfit to Plead or Not Guilty by Reason of Cognitive or Mental Health Impairment Canberra; 2019 9 August 2019.

not limited to incarceration, rather "detention includes detention in a secure mental health facility, secure disability facility or in a correctional facility as an option of last resort."

Decision-making processes are guided by principles that prioritise the least restriction of rights for individuals with cognitive or mental health impairment, balanced against the potential harm they may pose to themselves or others. Furthermore, the principles advocate for an inclusive and recovery-oriented setting for detention, recognising the unique meaning of recovery or habilitation for each individual in the forensic context (i.e., taking into account the offending behaviour).

Tailored services, collaboration and culturally appropriate services

A pivotal aspect of the national statement of principles is its emphasis on tailored services. It recommends the development of personalised case management plans for individuals subject to orders, soon after the original order is made. These plans are designed to be inclusive and, where relevant, recovery oriented. Recovery in the forensic context includes mechanisms, strategies and interventions to reduce offending behaviour. They outline clinical oversight, treatment and care, support services and pathways towards less restrictive arrangements.

Collaboration is identified as a cornerstone for effective implementation of these principles. Government agencies, along with relevant non-government service providers and professional associations, are encouraged to work together to safeguard the rights of individuals found unfit to plead. This collaborative approach extends to information sharing and coordination among relevant agencies, even across jurisdictions when necessary.

The principles stress the importance of cultural appropriateness in all aspects of its application. It urges consideration of the needs of specific population groups, including Aboriginal and Torres Strait Islander peoples. Culturally appropriate approaches, involving the participation of elders, family and relevant agencies, are recommended when making orders in relation to these populations.

Reasonable adjustments are highlighted to ensure individuals with cognitive or mental health impairment have access to assistance, service pathways, and accommodations needed for effective participation in the criminal justice or forensic mental health systems. The document suggests the practical implementation of specialist courts or court lists to deal with proceedings related to cognitive or mental health impairment.

Reasons for decisions, orders and reviews

The principles also stress the importance of providing reasons for any decision, order, or condition related to a person found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment. These reasons should be communicated in a format and mode appropriate to the person.

When making orders, the principles emphasise the need to detain individuals for the minimum period necessary to address the risk they pose to themselves, victims, or others (i.e. the public). It must be noted that the term "detain" does not specifically pertain to incarceration in prison but includes periods of secure hospitalisation. Time limits on orders

should align with the maximum term of imprisonment that could have been imposed if the person had been convicted of the offence charged.

Once a person is found unfit to plead or not guilty by reason of cognitive or mental health impairment, decisions about detention, care, treatment, or release should be made by the relevant reviewing authority or court. Detention should occur in facilities appropriate to the person's needs, with all relevant parties given the opportunity to make submissions to the reviewing authority regarding the care, treatment, conditions, or release of the person.

The purpose of the order must be clarified, emphasising support and intervention tailored to address the individual needs of the person with cognitive or mental health impairment including managing and mitigating the risks they may pose (e.g. criminogenic factors). The principles advocate for measures that support independence and participation in daily life within the place of detention. Habilitation, rehabilitation, and other appropriate programs should be individualised to reflect the unique needs of persons with cognitive or mental health impairment.

The section on reviews stresses the importance of mechanisms for ongoing clinical reviews by relevant experts, ensuring individual case management plans are updated accordingly. Independent oversight of places of detention, including Official Visitors, is considered a key safeguard to uphold the rights and responsibilities of those involuntarily detained.

Leave, release, discharge, alternative detention options and training

Persons subject to detention orders should be informed about ways in which they can secure their leave or release (again, detention is a broad term in the principles, pertaining primarily to detention in secure hospitals). Criteria for leave and release should consider a person's recovery, program participation, treatment progression, rehabilitation and the risk of harm they pose to themselves or the community.

Decision-makers should have flexibility in extending and suspending leave or release and in imposing conditions. The principles advocate for entitlement to treatment and support in the least restrictive environment that effectively protects against serious risk of significant harm.

Alternative detention options are recommended, emphasising that detention should occur as far as possible in facilities appropriate to the person's needs. Step-down accommodation options should facilitate the transition to the community for persons with mental health or cognitive impairment who are discharged from detention.

Training and resources are considered critical components of effective implementation. The principles emphasise the need to provide training and resources to build the skills and capacity of relevant agencies and reviewing authorities to work with individuals who are found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment.

Courts and the legal profession are encouraged to have access to information about reasonable adjustments and the supports available to persons with cognitive or mental

health impairment. Victims, their families and support groups should also have access to information about processes and procedures for determining individuals unfit to plead, of unsound mind, or not guilty by reason of cognitive and mental health impairment, as well as the appropriate support and treatment these individuals require.

In conclusion, the national statement of principles stands as a comprehensive and nuanced guide to develop and implement policies and practices that balance the rights of individuals with cognitive or mental health impairment with the imperative to ensure community safety. The document highlights the need for collaboration, cultural sensitivity, and continuous improvement in forensic mental health and cognitive impairment systems, emphasizing the importance of tailoring services to individual needs.

Best practice regarding mental health assessment, risk assessment and risk assessment informed reports for individuals found not guilty because of mental impairment

When individuals are found not guilty because of mental impairment, the legal and mental health systems face the challenge of balancing public safety with the treatment and rehabilitation needs of the person. This overview explores the process and practices involved in assessing psychopathology and managing the risk of offending and violence for individuals in this unique legal situation.

Consistent with the review of relevant legislation, the finding of not guilty because of mental impairment acknowledges an individual committed an offence but due to a recognised mental impairment lacked criminal responsibility.

As part of the court proceedings leading to the finding of not guilty because of mental impairment psychiatric and/or psychological assessments are conducted to determine whether the person's conduct and mental health at the time of the offending satisfy the legal criteria. These assessments focus on the mental state at the time of the offending and generally do not address matters such as the future risk for violence, including consideration of criminogenic factors and the need for treatment/rehabilitation to manage their risk of harm to others, which are generally irrelevant to the finding of guilt or not guilty because of mental impairment.

Subsequently, a comprehensive forensic mental health evaluation is required to assess the individual's mental health status, the factors that contributed to the offending, the formulation to understand the offending, risk scenarios for future offending, the risk of reoffending and the potential for violence. The evaluations include a review of the individual's psychiatric history, current mental state and the relationship between the mental disorder and the criminal behaviour.

The reports also must provide an opinion regarding the individual's treatment and rehabilitation needs, broadly speaking and recommended treatment approaches based on

available services. Importantly, as reflected in the consideration of the relationship between mental illness and offending, the assessment is not restricted to mental illness or psychiatric treatment (i.e., medication). Rather, the broad criminogenic factors (i.e., factors that contribute to the offending) must be canvassed and articulated.

Specialised risk assessment tools, such as theHCR-20, are commonly used to evaluate the risk of violence. These tools consider factors such as past criminal history, psychiatric symptoms and contextual variables to predict the likelihood of future violent behaviour. Moreover, there are validated risk assessment measures for specific types of offending such as sexual offending, intimate partner violence and stalking.

The findings (including the formulation and risk scenarios) from the specialist assessments are then employed to develop individualised treatment plans, as specified in the National Statement of Principles, targeting the specific mental health needs and risk factors identified.

Treatment may include psychotropic medication, psychological interventions, offense specific interventions and rehabilitation programs aimed at reducing the risk of offending and promoting overall well-being.

Close supervision and monitoring are essential components of managing the risk associated with individuals found not guilty because of mental impairment. Mental health professionals and other people involved in the care and control of people on orders, should collaborate to ensure compliance with treatment plans and mitigate potential risks.

Best practice involves the gradual reintegration of people on orders back into the community. Community reintegration is a phased process that involves transitioning individuals from secure mental health facilities to less restrictive settings, based on their capacity to manage themselves in a less restrictive environment and to ensure that their risk to others is managed.

Gradual reintegration allows for ongoing assessment of the individual's progress and the adjustment of risk management strategies as needed. Access to community support services, such as housing, professional support, personal support, employment assistance and continued mental health care, is crucial for successful reintegration.

Collaboration between mental health providers, legal professionals and community agencies enhances the support network for individuals transitioning back into society.

During the interviews, the review panel was informed that the standard of evidence provided to ACAT drawn from clinical risk assessments and treatment plans is variable. Often a brief summary is provided that provides conclusory information about matters including risk for violence, but not a more detailed explication of the factors and processes underlying the assessment. Members of ACAT did not appear to be get complete information at hearings about the risk assessment and management processes undertaken by staff. In particular, there did not appear to be an opportunity to canvas and consider the criminogenic factors that contributed to the offending behaviour, risk scenarios, and the

need for treatment/intervention beyond stabilising and managing the person's mental state. Taken together, it did not appear that ACAT was generally made aware of the clinical evidence necessary to address the test concerning the risk of harm to others. The risk to public safety should be interpreted based on the comprehensive assessment undertaken, treatment outcomes (mental health and criminogenic (e.g. substance misuse, problem behaviours, family and other relationships)), recovery measures including stability, medication adherence, therapeutic rapport and working alliance (observed through programs for physical health, self-care and activities of daily living, education occupation and creativity) and changes in dynamic risk factors relevant to the patients' offending characteristics.

Assessing and managing the risk of offending and violence for individuals found not guilty because of mental impairment requires a collaborative and multidisciplinary approach. By integrating forensic mental health evaluations, evidence-based risk assessment tools, and targeted treatment plans, the legal and mental health systems can work together to balance the safety of the community with the rehabilitation and recovery of those with mental impairments. Ongoing supervision, monitoring, and community support play pivotal roles in facilitating the successful reintegration of individuals into society while mitigating the risk of further offending.

The Individual Care Plan Review MDT Progress Report template for the DHULWA Mental Health Unit did not appear to provide adequate consideration or detail regarding the formal risk assessment that was undertaken, the identification of risk factors, or measures of changes/amelioration of risk factors over time. There is an item to record when the last HCR-20 was undertaken but no results from the HCR-20. In particular, it would be helpful to have an indication of the dynamic factors (i.e. C and R variables) in each review. It is positive that the Dangerousness, Understanding, Recovery and Urgency Manual (DUNDRUM) 3&4 team rating and self-rating are provided. It is not clear, however, how this information is communicated to ACAT.

Recommendation 20, 21, 22 & 23

For every person under the care of a mental health service, a comprehensive forensic mental health assessment, risk assessment and treatment/management plan (mental health assessment and plan) must be documented. This must also be updated on a regular and frequent basis. This mental health assessment and plan should also form the basis for reports, advice or recommendations provided to other decision-making bodies, including ACAT.

The mental health assessment and plan must include longitudinal information on:

a) **The person's psychopathology that led to the not guilty because of mental impairment verdict.**
b) **Other psychopathology (independent of that which led to the not guilty because of mental impairment verdict) that may be relevant to understanding risks as well as the person's treatment and rehabilitation needs.**
c) **Criminogenic factors that are relevant to understand the offending behaviour and potential risks.**

d) are relevant to understanding of the offending behaviour and potential risks and should be a key focus in therapeutic intervention.
e) The person's response to treatment, including whether the person has achieved remission with or without treatment.
f) Whether the person has achieved remission with or without treatment in relation to this psychopathology.
g) If remission has been achieved with compliance on medication, risk of relapse with non-compliance.

A template is used to document the structured mental health assessment and plan to ensure consistency in the documentation of this information.

The mental health assessment and plan is updated three monthly (or sooner if there is a significant change in clinical presentation) and should be audited by the health services for timeliness and completion.

Treatment should follow best practice forensic mental health assessment and treatment principles. Interventions should include treatment of identified psychopathology and offense specific interventions. This should be reflected in the model of care and individual treatment plans.

Assessment of whether the person has gained insight should be an important decision-making determinant

To ensure that the assessment of mental state as well as risks the person may present is consistent there is a perceived need as well as a desire to use evidence-based method.[89,90,91]

- The treating team's interest is in making sure that a person who has been deemed NGMI has treatment for mental impairment to such an extent that the risk of reoffending is eliminated.
- If it cannot be eliminated, there are clear systems and processes in place to make a decision that is in that person's best interest but also balances the risk to society.

There is ample literature to suggest that the assessment and treatment of this cohort of patients' needs to consider primary psychopathology[10,90] as well as comorbid mental impairments[10,92]. Many other considerations can interfere with treatment and rehabilitation programs progressing as desired. These include low motivation to participate in any

89 Edens JF, Boccaccini MT. Taking forensic mental health assessment "out of the lab" and into "the real world": Introduction to the special issue on the field utility of forensic assessment instruments and procedures. Psychol Assess. 2017;29(6):599-610.

90 Völlm BA, Clarke M, Herrando VT, Seppänen AO, Gosek P, Heitzman J, et al. European Psychiatric Association (EPA) guidance on forensic psychiatry: Evidence based assessment and treatment of mentally disordered offenders. Eur Psychiatry. 2018;51:58-73.

91 Tully J. HCR-20 shows poor field validity in clinical forensic psychiatry settings. Evid Based Ment Health. 2017;20(3):95-6.

92 Krona H, Nyman M, Andreasson H, Vicencio N, Anckarsäter H, Wallinius M, et al. Mentally disordered offenders in Sweden: differentiating recidivists from non-recidivists in a 10-year follow-up study. Nord J Psychiatry. 2017;71(2):102-9.

treatment and rehabilitation programs.[93] Many people may also have low levels of literacy which makes them gaining benefits from psychoeducational and vocational rehabilitation programs more challenging.[94]

Even though there is a significant amount of research on comparative community outcomes and rates of recidivism about people who have been deemed not guilty because of mental impairment and released from custody under the care of mental health providers[95,96,97] every single undesirable incident that could have been prevented is important to prevent. It is of no comfort to the victim that `the rate of recidivism is low.' The community expects that if a person has acted in a manner because of their mental impairment, their mental impairment will be treated effectively, and everything will be done to ensure that the person is no longer a risk to themselves or the community as a result of the same mental impairment.

From a clinical perspective, ongoing care, treatment, rehabilitation and support of the person as well as placing of any limitations that may be needed to minimise the risk to others must consider the psychopathology that may interfere with or impair the person's judgements to keep themselves and others safe and by extension consideration of the risk that the person may pose to the community[98]. As noted in Jones v. United States, the U.S. Supreme Court held that such a person should be committed to a psychiatric hospital until `he has regained his sanity and is no longer a danger to himself or society'.[99]

The extent to which the person has gained insight must always be an important consideration in the assessment of the risk the person may pose to themselves, others and to the wider community.

Insight is considered to have developed when the person has a clear grasp or understanding of meaningful relationships within a situation.[100] For a person experiencing a mental illness, insight is considered to have returned when it relates to them having regained an

93 Kip H, Bouman YHA, Kelders SM, van Gemert-Pijnen L. eHealth in Treatment of Offenders in Forensic Mental Health: A Review of the Current State. Front Psychiatry. 2018;9:42

94 Svensson I, Fälth L, Persson B. Reading level and the prevalence of a dyslexic profile among patients in a forensic psychiatric clinic. The Journal of Forensic Psychiatry & Psychology. 2015;26(4):532-50.

95 Fazel S, Wolf A, Fimińska Z, Larsson H. Correction: Mortality, Rehospitalisation and Violent Crime in Forensic Psychiatric Patients Discharged from Hospital: Rates and Risk Factors. PLoS One. 2016;11(7):e0159020.

96 Lund C, Hofvander B, Forsman A, Anckarsäter H, Nilsson T. Violent criminal recidivism in mentally disordered offenders: a follow-up study of 13-20 years through different sanctions. Int J Law Psychiatry. 2013;36(3-4):250-7.

97 Fazel S, Wolf A, Fimińska Z, Larsson H. Correction: Mortality, Rehospitalisation and Violent Crime in Forensic Psychiatric Patients Discharged from Hospital: Rates and Risk Factors. PLoS One. 2016;11(7):e0159020.

98 McDermott BE, Thompson Jr JW. The review panel process: An algorithm for the conditional release of insanity acquittees. International Journal of Law and Psychiatry. 2006;29(2):101-11.

99 Jones v. United States.: U.S.; 1983.

100 Husted JR. Insight in severe mental illness: implications for treatment decisions. Journal of the American Academy of Psychiatry and the Law Online. 1999;27(1):33-49.

understanding of their illness or the motivation underlying their own behaviour.[101,102] Attaining insight includes re-gaining awareness of having an illness, understanding of experiences as symptoms of the illness and acknowledgment of a need for treatment.[101] Moreover, among forensic psychiatric patients, insight includes gaining an appreciation of the factors that contributed to the offending behaviour and must be managed, alongside the individual's mental illness, to reduce the likelihood of reoffending.

Regaining insight is best understood as a progressive process of re-developing clarity in thinking (rather than insight being present or absent), without the distortions of thinking, perception, mood, or cognition that the illness may have created. Not having insight means that the person is not able to screen out irrelevant information, consider relevant information to make decisions or in other words to utilise their cognitions to integrate relevant information and exclude irrelevant information. This interferes with their ability to interpret their experiences with accuracy or make logical, appropriate, and constructive judgements using their past experiences.[103,104,105,106,]

Impaired insight contributes to adverse outcomes, not only because the person may not be fully cognisant of the consequences of their actions but may not understand the need to remain compliant with prescribed treatment or appointments and may even struggle to accomplish simple day-to-day tasks. It may be difficult for them to follow conversations, be systematic and organised in completing tasks and make judgements about what is in their best interest. They misinterpret situations, instructions and interpersonal signals and can engage in illegal or dangerous behaviours without realising it. Because people who lack insight struggle to make a link between their behaviour and consequences, they have difficulty forming abstract concepts about what they should refrain from doing.

In addition to the question of whether the person's mental impairment was treated adequately, appropriately and to such an extent that the mental impairment was no longer the reason for the person to present a risk to themselves or the community, an associated question should be whether the person has gained insight. If the mental impairment cannot be treated fully and completely and there are some residual symptoms, often it is the extent to which the person has gained insight into their psychopathology that determines the protections that must be put in place for the residual symptoms to not be able to increase the risks to the individual or the wider community. If the person has not gained insight it may have to be the reason for necessary restrictions and protections to remain in place to manage any risks.

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101 Amador XF, Flaum M, Andreasen NC, Strauss DH, Yale SA, Clark SC, et al. Awareness of illness in schizophrenia and schizoaffective and mood disorders. Arch Gen Psychiatry. 1994;51(10):826-36.

102 Keefe RSE, Harvey PD. Understanding Schizophrenia. New York: Free Press; 1994.

103 Torrey EF. Surviving Schizophrenia (Ed 3). New York: Harper Perennial; 1995.

104 Gur RC, Saykin AJ, Gur RE, : i. Brain function in schizophrenia: application of neurobiological studies. In: Andreason NC, editor. Schizophrenia: from Mind to Molecule. Washington, DC, American Psychiatric Press; 1994. p. 93-102.

105 Bogerts B. The temporolimbic system theory of positive schizophrenic symptoms. Schizophr Bull. 1997;23(3):423-35.

106 Morice R, Delahunty A. Frontal/executive impairments in schizophrenia. Schizophr Bull. 1996;22(1):125-37.

Decision-making considerations from a clinical perspective

The decision about the release of a person found not guilty because of mental impairment requires consideration of not only ensuring that the person will receive appropriate care, support, treatment, rehabilitation and protection but also ensuring that the person will not present a risk to society by acting in a manner they have done previously because of their mental impairment. If a decision is made that some limitations need to be placed on the person to minimise the risk to others, this needs to be done in a manner that protects the human rights of the person and fulfils the principles outlined in the *Mental Health Act*.

This requires considerations of:

1. active psychopathology
2. effectiveness of prescribed treatment and how critical treatment is to prevent relapse
3. the extent to which the person has gained insight into their mental condition.
4. criminogenic factors and the factors that may be relevant to understand the person's risk profile.

The following decision-making hierarchy is worth considering in determining the location of treatment/residence and restrictions that may be necessary.

Psychopathology

The presence of active psychopathology that was the reason for a not guilty because of mental impairment verdict and other psychopathology that may pose a risk to the person, to others and to the community would suggest that the person must be involuntarily detained in a secure mental health facility.

Remission of psychopathology

If psychopathology is in remission, the next consideration should be whether compliance with prescribed treatment is critical to prevent a relapse. If so, the responsible clinician must consider whether compulsion is necessary for the person to remain in remission.

Whether the person has gained insight

A person who is in remission from symptoms that may be the reason for the person presenting at risk to himself, others or to the community AND has gained insight may be ready for consideration of fewer restrictions.

Consideration of other factors that may be relevant to understand risks the person may pose to themselves, others or to the community

All of the following factors are relevant to understanding the risk the person may present to themselves, to others and to the community even if their psychopathology may be in remission, were compliant with prescribed medication and have gained insight:

- criminogenic factors
- risk of non-compliance

- volatile behaviour
- poor frustration tolerance
- alcohol/substance abuse
- affective instability
- cluster A/B personality traits

Consideration of all of the above factors may determine whether the person should progress from a secure mental health inpatient unit to lesser restrictions, including on leave, to a supported community residential facility, to a community facility with support or to more independent living (see Figure 1).

The proposed process to make decisions that balance the individual's rights and community safety:

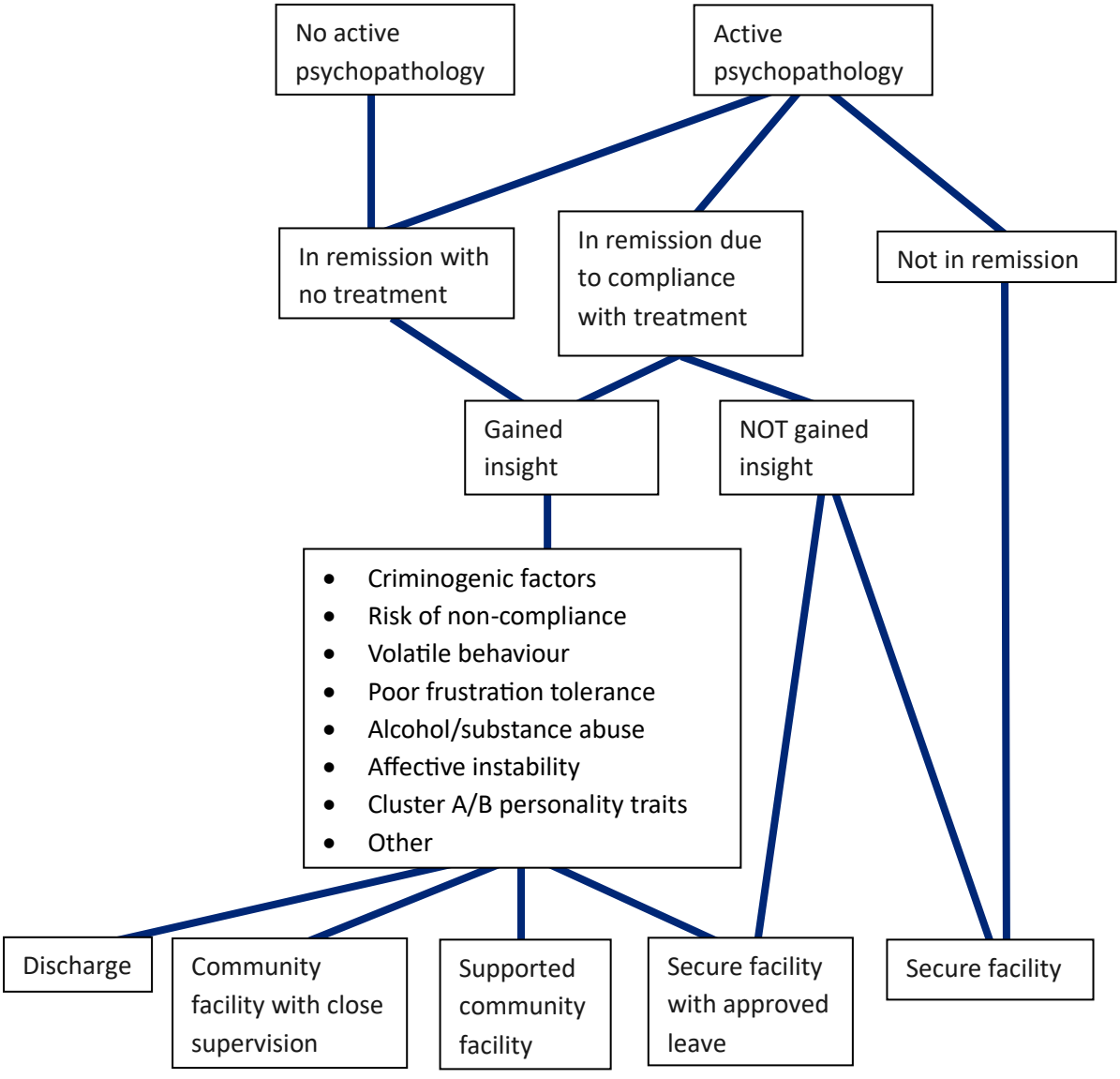

Figure 1: Decision-making considerations from a clinical perspective

Recommendation 24
Decision making in relation to the level of restriction that must be placed on a person deemed NGMI and receiving care from mental health services must consider:

a) **Psychopathology that was relevant for the NGMI determination.**
b) **Other psychopathology that may be the reason for an increase in the risk of the person to themselves, others or the wider community.**
c) **The significance of compliance with prescribed treatment to minimise the risk of relapse.**
d) **The extent to which the person has gained insight.**
e) **Other factors that may be relevant to understanding the risks in relation to the person, including criminogenic factors, (e.g. risk of non-compliance, volatile behaviour, poor frustration tolerance, alcohol/substance abuse, affective instability, cluster A/B personality traits).**

Decision making about granting leave from the facility

A person who is subject to a CRO is often required to abide by conditions in relation to leave approval from the facility where the person is required to reside. As with any other condition, if leave conditions are breached and if the Chief Psychiatrist or delegate of the Chief Psychiatrist becomes aware of the leave conditions having been breached, they must notify ACAT. It will then schedule a hearing. As such a CRO does not give authority for the person to be detained or restrained by any person, including health staff.

It appears that the leave approval requirements have the effect that a person is detained if they are unable to leave a locked mental health facility of their own volition and without the assistance of staff. Even mental health service staff supporting the person seem to have mistakenly formed the view that the CRO authorises their detention through a direction to reside at the unit.

Conditions of leave within the CRO

ACAT is the initial decision maker for conditions related to leave for persons subject to a CRO As the panel understands it, if ACAT requires a person to reside in a secure mental health facility as a condition of an order for release, ACAT typically also includes a condition that the person may have leave from the facility, as approved by the leave panel.

In practice, if the person who is subject to a CRO is admitted to DMHU or GMHU, ACAT will often be provided with a leave application outcome from the leave panel to assist in their decision-making. The leave panel or treating team will also generally provide advice to ACAT about the circumstances under which leave should be approved under (for example, whether the leave should have an escort or should be approved on a recurring basis). ACAT can also make conditions that leave is subject to ongoing approval by the leave panel and should be cancelled if the leave panel revokes their approval.

Verbal information provided to the review panel indicated that applications for leave from persons admitted to a mental health unit under a CRO to ACAT can also be made directly by the person or their legal representative and without previously being reviewed by the leave panel or delegate of the Chief Psychiatrist. This appears to be a relatively rare occurrence, and it appears that if ACAT receives an application without clinical input, they will typically seek information from the treating team, delegate of the Chief Psychiatrist or from the leave panel should the application occur in this manner.

In reality, health staff would only have the authority to prevent the person from leaving the facility if there was an additional order in place that had the effect that detention at a mental health facility was authorised.

Persons subject to a CRO are not necessarily admitted to a mental health unit for the entire duration of their conditional release order. Many people subject to a CRO may also reside in the community and may not have conditions relating to leaving their residence. From verbal information provided to the review panel, it appears that in practice persons subject to a CRO will have a series of gradual lessening of restrictions in consideration of improved symptoms of mental illness and psychosocial functioning, decreased risk of harm (to self and others) and ability to engage productively with support services.

Since the majority of people subject to CRO are admitted to DMHU and GMHU for substantial periods of time, the subsequent leave-related sections will focus on leave processes for these units.

Applying for leave

The process for a person to apply for leave is outlined in the Dhulwa and Gawanggal Leave Management Procedure (2021). This document indicates that an application for leave should be raised by the person with a nurse or during an intensive care plan meeting. The application is then reviewed by the Multi-Disciplinary Team (MDT) who considers the leave application. If indicated, they will review the person's security category and leave entitlement (SCALE) to determine if the leave proposal is appropriate to progress to the leave panel.

The procedure specifies that the MDT must have regard for the following factors when proposing a change of SCALE and in making an application to the leave panel:

- history of successful or unsuccessful leaves
- current clinical presentation, including DASA scores and suicide vulnerability assessment
- the nature and circumstances of known prior violence and offending history
- history of self-harm or suicide
- the safety of any person the person should not associate with
- any potential risks to the person by another person
- scoring on the Dangerousness, Understanding, Recovery and Urgency Manual (DUNDRUM)

- engagement with therapeutic activities.

If the leave is approved through the MDT it is presented to the leave panel for approval. The leave panel considers any pre-existing CRO conditions and the opinion of the treatment team in determining approval. The leave panel must also endorse or revise the SCALE rating as per the factors listed above.

The CHS leave management procedure identifies that leave is therapeutic and serves, among other things, the purpose of maintaining or restoring connection with carers and family members. The procedure states that the subject person is encouraged to engage with carers and family members during periods of leave. Through this engagement carers and family members would have valuable information on how the person reacts to their environment and people whilst engaged in the community with and without escorts. This information could be critical to ACAT and the leave panel in their consideration of changing leave arrangements or restrictions over time, but it is not routinely collected.

Recommendation 25
Include formal procedures relating to supporting Carer involvement and participation in leave-related processes.

Leave panel

The leave panel operates under the policies and procedures of CHS. As outlined previously, there are no people external to CHS that sit on the leave panel.

Recommendations 26 & 27
The leave panel is chaired by a person independent of the treatment team or staffing of the facility in which the person resides. The Chair should have forensic mental health expertise and an understanding of the risks that a person with a mental illness may present to themselves, others and to the wider community.

The leave panel should also include at least one other independent member who is able to provide input about community safety considerations.

Revoking leave

Before a person proceeds on approved leave, the clinical team is required to assess the person's mental state, physical state and any current risks. As part of this process, there are specified forms that are required to be completed called "leave checklist".

The procedure specifies that leave can be suspended or revoked in some circumstances, including when risks are identified as part of the leave checklist process. The procedure specifies that therapeutic leave is at the discretion of the leave panel or "nurse in charge"

(and can therefore be cancelled) although it is not clear under what legal authority leave could be revoked for a person subject to a CRO by health staff.

In practice, it appears that ACAT will at times, include a condition stating that leave can be revoked or suspended by the leave panel.

Recommendation 28
Leave enforcement of a person on a Conditional Release Order from a facility at which they are not involuntarily detained should be reviewed to ensure there is no infringement on the person's liberty

The revision of leave arrangements over time

ACAT is required to review the CRO every 6 months. This includes review of the leave conditions. ACAT can modify conditions based on the information they are provided by way of a report to ACAT, however, there is no information made available from the leave panel to ACAT.

It also appears that whilst the leave panel is sometimes specified in conditional release orders as having an ongoing ability to approve, cancel or revoke leave, there is no formal procedure as to how the leave panel should share relevant information with ACAT.

Recommendation 29
The leave panel must provide a report to ACAT when ACAT is considering revision of leave conditions.

Unauthorised leave

The Dhulwa and Gwanaggal Leave Management Procedure specifies that the Dhulwa Escape and Abscond Procedure should be followed when a person takes unauthorised leave, escapes or absconds. This document could not be located. The CHS Missing Patient Procedure was provided to the review panel. Whilst this document provides a flow chart relating to a person missing from DMHU, clarity is required regarding the extent to which this procedure applies to a person admitted to the GMHU.

Recommendation 30
Canberra Health Services to review the Missing Person Procedure to ensure this reflects inpatients under the care of DMHU and GMHU.

Management of a person on unauthorised leave or has absconded

The delegate of the Chief Psychiatrist must notify ACAT in writing as soon as practicable after becoming aware of the contravention of a conditional release order (including unauthorised leave or if the person is considered to have absconded from the facility).

Following notification, ACAT must then review each condition under section 180 (4) within 72 hours under section 181.

It is not clear whether, in the event that a CRO is cancelled or following a breach, whether ACAT has the authority to issue a warrant to detain the person.

Recommendation 31
Clarify by way of an amendment to the legislation the legal authority for the person on a Conditional Release Order to be apprehended and detained where the person has breached conditions of their conditional release order (including absconding or failure to return from approved leave) and when their approved leave is revoked.

Notification to the police of the person in breach of their CRO, including breach of leave conditions

A person subject to a CRO who is in breach of their leave conditions is reported to the Police. Representatives of the police indicated to the review panel that there is no consistency in the information provided in these reports to the police. Often the police do not get the information they need to assess the risk to the person or the community. Police indicated that having information on people subject to CRO at the time the orders are made and at key transition points or reviews, would better enable them to respond to reports of a person subject to a CRO who has absconded or not returned from leave. Without the information on the level of risk the person presents or appropriate details about the person, limits their ability to respond.

The ambulance service is often called by the police in the process of apprehending a person on a CRO who is absent without leave. The ambulance service indicated that it has no access to information on the person other than that provided to them at the time. They also indicated that the information provided is not consistent and is dependent on the professional providing the information. They also have no system by which to hold information on a person who is not in immediate need so rely on the information provided at the time a response is needed.

Recommendations 32 & 33
A risk rating is developed in consultation with the Police and Ambulance Services to make explicit communication of the level of the risk to the person, others and the community to enable effective triage and response by Police and Ambulance services.

A template is developed and implemented for staff to use when notifying Police/ Ambulance Services where a person has absconded or is absent without permission.

Appealing leave-related decisions

From a review of the procedure, leave applications that are not approved by the MDT do not appear to be presented to the leave panel for further review, irrespective of whether the person wishes to appeal this decision.

If the MDT supports a leave application, but the leave is not approved by the leave panel if the person still wishes to proceed on leave, they must then appeal or make an application to ACAT to request leave. Appeals for decisions regarding leave are made through ACAT under conditions outlined in the *Mental Health Act 2015*.

Recommendation 34
An opportunity for leave decisions to be appealed must be made explicit at every decision point.

Leave as a condition of a CRO

It may be doubted whether leave from a mental health facility is best dealt with by ACAT as a condition of an order for the release of a person. That appears to be current practice, where the person is required, as a condition of a CRO, to reside in a secure mental health facility. On one view, provision for leave is not properly characterised as a condition of release, particularly if it is a body other than ACAT which is primarily responsible for determining leave on an ongoing basis. Even if it may be characterised as such, ACAT does not have the day-to-day contact with persons in the facility to enable it to determine leave on a day-to-day basis.

The review panel also notes that, if ACAT is not empowered to order a person to reside in a secure mental health facility as a condition of release, then it is presumably not empowered to provide that the person may have leave as approved by a third party as a condition of release.

Consideration should be given to including in the Mental Health Act a separate provision for the processes for granting leave and reviewing decisions to grant leave from a secure mental health facility, for persons subject to a conditional release order. It may be that ACAT, or a different body, should be given a distinct power to grant or review the grant of leave from a mental health facility to persons subject to conditional release orders, rather than making leave from a secure mental health facility a condition of release.

Recommendation 35
That consideration be given to including in the Mental Health Act a separate provision setting out the processes for granting and/or reviewing the grant of leave to persons subject to conditional release orders from a secure mental health facility. It is also necessary to clarify who has relevant powers to intervene if there is a significant breach, particularly in the event that urgent intervention is required.

Final comments

It is clear that the purpose of a CRO is to ensure conditions (or restrictions) are put in place and social control is exerted on the individual to minimise the risk of harm to the person, others and the general community. The nature of the conditions of a CRO are such that many people on this are required to remain at a facility and not leave the facility without permission.

The person on a CRO is also often required to reside in the most secure treatment facility in the ACT from where egress is not possible without permission. Conditions imposed on the person to even proceed on leave are stringent and several layers of approvals are necessary for the person who wishes to leave the facility to actually leave. Irrespective of whether the person has consented to stay at such a facility under duress or not, the person is involuntarily detained. Necessary legislative amendments should be made to permit this level of social control considering assessed risks.

The reason why a person who is deemed not guilty because of mental impairment is often required to reside at the most secure mental health facility in the Territory is because the person is considered to have an underlying psychopathology that if left unsupervised or untreated may present risks to the person, others and the general community. This requires a longitudinal and comprehensive assessment of:

- Psychopathology that may have led the person to act in a manner that was socially inappropriate.
- Other psychopathology that may be the reason for the person to be at a risk to themselves, others, or the general community.
- Criminogenic factors that require assessment and management to minimise risk to the person, others, or the general community.
- At least an assessment of the need for treatment and whether compliance with ongoing treatment is essential to prevent relapse of psychopathology that may increase risks to the person, others or the general community.

It is incumbent on mental health providers tasked with this responsibility to undertake assessments and formulate management plans comprehensively and using a structured process of assessment (including risk assessment) to provide a clear and explicit opinion to decision-making bodies about:

- The need for treatment of psychopathology and criminogenic factors that left untreated are likely to present risks to the person, others and the general community, but also
- Whether noncompliance with the management plan in the shorter or longer term is likely to result in relapse and thus increase risks.

Such structured clinical opinion about the person's psychopathology, risks to the person, others and the general community and the need for compliance with treatment are essential to inform the extent to which social control must be exerted on the person found not guilty because of mental impairment and being considered for release from custody and

into the care of mental health services. If the decision is that the person must be required to be detained at a specific facility and accept treatment, until the intervention for psychopathology and criminogenic factors has been completed and the person is considered in remission, legislative amendments to enable involuntary or compulsory treatment are appropriate.

To coerce the person by imposing conditions to reside at a facility from where egress is not possible and take treatment whether they agree or not, as a `condition' to be released from custody, is not appropriate. If detention is considered necessary and the need for detention and treatment to minimise risks to the person, others and the general community is informed by clinical opinion based on comprehensive assessment, the use of involuntary treatment provisions would be in the spirit of the *Mental Health Act*.

Appendix 1: Members of the expanded review panel

Dr Dinesh Arya

Dr Arya is the ACT's Chief Psychiatrist and Chief Medical Officer. He is a Fellow of the Royal Australasian College of Medical Administrators, Australian College of Health Service Management and Royal Australian and New Zealand College of Psychiatrists and a Member of the Royal College of Psychiatrists (UK), has a doctorate in psychopharmacology and a Masters in Business, Executive Masters in Public Administration, Masters in Bioethics and Health Law and Masters in Data Science, Strategy and Leadership. He is a Graduate of the Australian Institute of Company Directors and a Master Black Belt in Lean Six Sigma.

Dr Arya has published significant opinion pieces in peer-reviewed journals on diverse topics including quality improvement, clinical governance, leadership, innovation, mental health facility design, health reform, shared service arrangements and compulsory treatment in mental health. Over the last more than two decades, his senior health executive roles in New Zealand, Australia and the Middle East have included as a Medical Chief Executive, Chief Medical Officer, Executive Director of Mental Health Services, Clinical Lead for Innovation and Reform and Chief Psychiatrist. In the past, he has had academic affiliations as an Adjunct Professor in Health Sciences and Health Management with Flinders University and Charles Darwin University.

Professor James Ogloff

Professor Ogloff is the Dean of the School of Health Sciences and University Distinguished Professor of Forensic Behavioural Science at Swinburne University of Technology. He is a clinical and forensic psychologist and non-practicing lawyer. He is a leading authority in forensic mental health and related areas. Professor Ogloff holds a senior advisory position in forensic mental health at the Victorian Institute of Forensic Mental Health (Forensicare). He has held executive roles in and has led, many reviews of forensic mental health and correctional services. He routinely conducts forensic evaluations in various areas related to his expertise for court proceedings.

Dr Juliet Lucy

Dr Lucy is a barrister and part time senior member of NSW Civil and Administrative Tribunal (NCAT). She has co-authored two editions of NCAT – Practice and Procedure and has also published broadly in the area of administrative law. Dr Lucy's areas of expertise include public law, statutory interpretation, high risk offender matters, human rights and tribunal decision-making.

Dr John Crawshaw

Dr Crawshaw currently serves as the Director of Mental Health and Addiction at the New Zealand Ministry of Health, holding statutory roles as defined by the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017. Dr Crawshaw's professional background primarily lies in forensic psychiatry. He has previously been the Chief Forensic Psychiatrist in Tasmania. Under the provisions of the New Zealand legislation, he holds the statutory responsibility for the management of forensic patients (including the granting of leaves).

Ms Lisa Kelly

Ms Lisa Kelly is the Chief Executive Officer (CEO) of Carers ACT. Ms Kelly holds degrees in Psychology and Community Development and has worked extensively in the community sector. Ms Kelly is passionate about ensuring carers receive high quality support and are recognised for their important role within the community.

Appendix 2: Terms of reference for the expanded review panel

Context/background

On 18 September 2023, an incident occurred when an inpatient residing at the Gawanggal Mental Health Unit, while on approved leave, went to the ANU and allegedly assaulted multiple people. This patient was later charged with two counts of attempted murder, common assault, possession of object to be used to kill or cause grievous bodily harm.

This patient was previously found not guilty due to a mental impairment (NGMI) in relation to 5 counts of attempted murder on 25 August 2017 and subsequently released to the care of mental health services.

Reason

Due to the seriousness of this incident, the ACT Government announced that the Chief Psychiatrist will undertake a review into this incident and the care and treatment provided to this person.

- A Special Purpose Quality Assurance Committee was authorised by the Minister for Health on 30 September 2023, to complete a clinical review of the care and treatment of this person.
- The Chief Psychiatrist is also undertaking an expanded review.

These terms of reference relate to the expanded review.

Purpose of the Chief Psychiatrist's expanded review

To consider best practice in relation to the ongoing mental health treatment, care and management of persons found NGMI released from custody into the care of mental health services, the expanded review will:

a) Consider relevant and comparative policies, legislation and guidelines relating to the best practice in decision making about mental health care (including leave approval).
b) Best practice protocols for information sharing with relevant decision makers and/or stakeholders to enable effective and safe mental health care.

Scope

Consider relevant evidence, expert opinions, research and views and perspectives of relevant stakeholders involved in provision of mental health care and support to people referred to in point above in the ACT. The information from stakeholders around the events of 18 September 2023 may be relevant to consider. Invited stakeholders will include ACT Policing, ACT Ambulance Service, ACT Civil and Administrative Tribunal (ACAT), Public Advocate, Director of Public Prosecutions, Justice and Community Services and other identified persons to ensure consumer and carer perspective (such as Carers ACT, Healthcare Consumers Association and Mental Health Consumers Network).

Any information provided will be managed in accordance with the requirements of:

- *Information Privacy Act 2014*
- *Health Act 1993*
- *Health Records (Privacy and Access) Act 1997*

Review panel

The following experts with expertise in forensic mental health and mental health law will comprise the review panel.

- Dr Dinesh Arya, ACT Chief Psychiatrist
- Distinguished Professor James Ogloff, AM, Clinical and Forensic Psychologist
- Dr John Crawshaw, New Zealand's Director of Mental Health and Forensic Psychiatrist
- Dr Juliet Lucy, Barrister and Senior NSW Civil and Administrative Tribunal Member
- Ms Lisa Kelly, CEO, Carers ACT

Methodology of review

1) Inter-jurisdictional analysis (may include similar overseas jurisdictions) of CROs or equivalent, following NGMI verdict. This may include examination of associated mental health orders, frequency of review, decision-making about ongoing care, provision of required information to facilitate decision making and treatment, as well as leave from the treatment facility.
2) Review of any available data in relation to outcomes for persons subject to a CRO within the ACT for comparative analysis
3) Review of legislation, any available case law, policies, and procedures related to the mental health care of a person found NGMI in the ACT, including those related to leave, risk assessment, decision-making, public safety, and information sharing.
4) Best practice protocols for information sharing between health services and government agencies, including the police, ambulance service and other care providers.
5) Collecting relevant information from stakeholders to examine current processes in the ACT and making associated recommendations (if any) for improvement.

Roles and responsibilities

Chief Psychiatrist will

- Lead the expanded review and support the panel to consider matters identified in the Purpose (above).

Review panel will

- Provide comment on matters before the panel related to their area of expertise, specifically mental health assessment, forensic risk management, decision making processes (including leave from the treatment facility) and information sharing

protocols between agencies for persons found NGMI and released into the custody of mental health services.

Acting Director, Special Project, Office of Chief Psychiatrist will

- To the extent that it is applicable, ensure information will be managed in accordance with the *Health Act 1993* and the *Health Records (Privacy and Access) Act 1997*.
- Oversee internal staff and external consultants engaged in the review, including access and management of information to ensure privacy obligations are understood and met.
- Coordinate commissioning of review reports, participation of external experts and manage secretarial support.
- Assist with review of legislation, evidence, research, stakeholder opinions, analysis and preparation of deliverables.

Timeline

Last week of October 2023

- Review timeline finalised
- External reviewers confirmed
- First review meeting date set
- Meetings scheduled with stakeholders

1st week of November 2023

- Preparatory meeting with the Review panel
- Confirm TOR

2nd week of November 2023

- Reviewing, analysing information and finalising comparative analysis

3rd and 4th week of November 2023

- Clinician/Stakeholder meetings
- Panel members provide input in identified subject matter expert areas.

1st week December 2023

- Draft report prepared

Deliverable

Chief Psychiatrist's report to the Minister for Mental Health on matters that would likely lead to an improvement in the outcomes of people NGMI released into the care of mental health services while balancing community safety. This may include (but is not limited to) recommendations in relation to mental health assessment, care and treatment (including risk assessment), leave management, need for legislative amendments (if any) and information sharing for appropriate and safe care.

Acknowledgment of Country

We acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

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