UNWELL, UNCONVICTED AND UNCOOPERATIVE: SHOULD FORENSIC PATIENTS BE REQUIRED TO ENGAGE WITH MENTAL HEALTH EXPERTS TO SECURE THEIR RELEASE FROM CUSTODY?

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This article examines whether forensic patients — individuals found not guilty of criminal acts by reason of mental impairment — can be required to engage with mental health experts to secure their release from custodial supervision. Centred on the High Court of Australia's decision in KMD v CEO (Department of Health NT), the paper explores the tension between protecting public safety and the patient's rights to liberty and autonomy. It critiques making non-cooperation with psychiatric assessments a de facto barrier to release, arguing this approach unfairly reverses the onus of proof and undermines the presumption of liberty. The article contends that while a patient's refusal to be assessed is a relevant factor in determining risk, it should not be determinative. It advocates for a rights-based framework where restrictions on liberty must be proven necessary and proportionate, based on a holistic evaluation of all available evidence, rather than making freedom contingent on procedural compliance.

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INTRODUCTION

Across the common law world, legal frameworks allow individuals to be found not guilty of criminal offences where, due to a mental impairment, they lacked certain key capacities at the time of the relevant conduct (such as the capacity to understand the nature or wrongfulness of their actions).[1] Although such individuals are not convicted, they are not fully acquitted either. Instead, they receive what is often termed a 'qualified acquittal', which places them under ongoing court supervision. While this supervision may occur in the community, courts will frequently order that such individuals be detained in a custodial setting, such as a mental health facility or correctional centre, for the public's protection.[2]

In some jurisdictions, these 'custodial supervision orders' ('CSOs') may have no fixed end date: the individual (commonly referred to as a 'forensic patient') will remain detained in a custodial setting until a court or tribunal determines that it is safe for them to be released (usually on a 'non-custodial supervision order' ('NCSO')).[3] In other jurisdictions, legislation will set a maximum end date for detaining forensic patients in custody, but will require a court or tribunal to

[1] This defence was traditionally known as the 'insanity' defence. For a useful overview of the scope and history of this offence, see Nigel Walker, *Crime and Insanity in England* (Edinburgh University Press, 1968). For a survey of different jurisdictional versions of the defence, see Law Commission, *Insanity and Automatism: Supplementary Material to the Scoping Paper* (Report, 18 July 2012) app C.

[2] See, eg, *Criminal Law (Mental Impairment) Act 2023* (WA) s 46; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 26; *Criminal Code Act 1983* (NT) s 43ZA; *Criminal Procedure (Insanity) Act 1964* (UK) s 5(2); *Criminal Code*, RSC 1985, c C-46 (Can) s 672.54.

[3] See, eg, *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 33; *Criminal Code Act 1983* (NT) s 43ZA–ZH; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 24; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 27.

release them earlier if their detention is no longer necessary for the community's protection.[4] These laws reflect the general principle that as forensic patients have not been convicted of a criminal offence, they should be held in conditions that are 'the least restrictive of [their] freedom and personal autonomy as is consistent with the safety of the community'.[5]

While legislative schemes differ, they will generally establish a process for periodically reviewing the need for a forensic patient's continued custodial detention. In determining whether to replace a CSO with an NCSO, the decision-maker is likely to consider factors such as the nature of the individual's mental impairment, whether their mental health has improved while they have been in custody, their medical prognosis, and the supports they would receive if released into the community.[6] To assist them in making this determination, the decision-maker will usually seek and consider reports from expert mental health practitioners, such as forensic psychiatrists and psychologists, who have examined and assessed the forensic patient. In some jurisdictions they will be required to do so.[7] This raises a critical question: what happens if the forensic patient refuses to engage with the relevant experts? Should they be required to remain under custodial supervision until they do? Or should a court or tribunal be permitted to release them into the community regardless of their failure to cooperate?

This was the issue at the heart of the recent High Court of Australia ('High Court') decision in *KMD v CEO (Department of Health NT)* ('*KMD*').[8] The case concerned a forensic patient ('KMD') who sought to be released from a longstanding CSO, but who declined to participate in an interview with a state-appointed forensic psychologist. While the High Court's reasoning turned on the interpretation of the Northern Territory's *Criminal Code Act 1983* ('the Code'), the case raises broader questions about how courts should balance the imperative of community

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[4] See, eg, *Criminal Law (Mental Impairment) Act 2023* (WA) ss 50, 74; *Criminal Law Consolidation Act 1935* (SA) ss 269P–T.

[5] *R v Tzeegankoff* [1998] SASC 6639, quoted in Sentencing Advisory Council (SA), *Mental Impairment and the Law: A Report on the Operation of Part 8A of the Criminal Law Consolidation Act 1935 (SA)* (Report, November 2014) [3.73].

[6] See, eg, *Criminal Code Act 1983* (NT) s 43ZN(1); *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 84; *Criminal Law (Mental Impairment) Act 2003* (WA) s 72; *Mental Health Act 2016* (Qld) s 442; *Criminal Law Consolidation Act 1935* (SA) s 269T(1).

[7] See, eg, *Criminal Code Act 1983* (NT) s 43ZN(2); *Criminal Law Consolidation Act 1935* (SA) s 269T(2); *Crimes Act 1914* (Cth) s 20BK(2); *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 84; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 40(2).

[8] [2025] HCA 4.

protection with the rights of individuals who have acted harmfully but are not criminally responsible for their conduct.

This article addresses these questions in two stages. Part One traces KMD's journey through the criminal justice system, from the events that gave rise to her offending through to the High Court's resolution of her case. This account provides the context needed to fully understand and respond to the normative questions addressed in Part Two: whether it is legitimate to make liberty contingent on cooperation with mental health experts, whether shifting the evidentiary burden onto forensic patients can be justified, and how principles of proportionality, necessity and human rights should shape supervision regimes. While the analysis in this article is situated within the broader common law tradition, its primary focus is on Australian law.

PART ONE: KMD'S JOURNEY THROUGH THE CRIMINAL JUSTICE SYSTEM

A *The Events of 7 May 2013*

KMD is an Indigenous woman who was born and raised in the Northern Territory ('NT').[9] In the early 2000s, KMD married RL, and in 2006 they had a son. Following the breakdown of their relationship in 2007, they became entangled in protracted Family Court proceedings concerning custody and parenting arrangements. During those proceedings, KMD made repeated and serious allegations that RL and others had sexually abused her son. These allegations were investigated by various authorities and found to be unsubstantiated.

Despite these findings, KMD remained convinced that her son was in imminent danger. She attempted to raise her concerns with police, the Family Court, and health professionals, but her claims were consistently dismissed. Over time, she developed the belief that the authorities were unwilling or unable to protect her son, and that she alone was responsible for ensuring his safety. This delusional conviction drove the events of 7 May 2013.

On that day, KMD travelled to RL's home in Virginia, a rural suburb on the outskirts of Darwin, armed with a .44 Magnum Smith & Wesson revolver. She entered the house unlawfully and hid under a bed, waiting for someone to arrive. RL was not home, but his mother, Mrs L, entered the premises later that day. KMD

[9] The facts reported in this section have been obtained from the following judgments: *R v KMD* [2015] NTSC 31; *R v KMD* (No 5) [2022] NTSC 69; *R v KMD (No 6)* [2023] NTSC 51; *Chief Executive Officer Department of Health v KMD* [2024] NTCCA 8; *KMD v CEO (Department of Health NT)* [2025] HCA 4.

confronted her at gunpoint, accused her of involvement in the alleged abuse, and detained her inside the house. KMD then forced Mrs L, at gunpoint, to drive her to her son's school. She wanted to take her son to the police for his protection.

While on the road, they happened to encounter RL driving in the opposite direction. Mrs L flashed the headlights to attract his attention, prompting RL to stop his car. When RL attempted to approach KMD to talk to her, she shot at him, narrowly missing his head. RL sprinted away and KMD tried to follow. To protect RL, Mrs L drove her car between him and KMD. KMD walked around to the passenger side of the car and shot Mrs L in the arm. Mrs L slumped over the steering wheel and pretended to be dead.

KMD then jumped into RL's car (which he had left by the side of the road) and pursued him. RL waved down a passing vehicle driven by Mr I to request assistance. As he was explaining the situation to Mr I, KMD fired at Mr I's car, shattering its rear window. RL then got into the car and Mr I drove off quickly. KMD pursued them, ramming Mr I's vehicle on several occasions. She then pulled next to the passenger side of the vehicle and shot at RL. The bullet hit him in the thumb.

Mr I and RL kept driving, and KMD continued to pursue them for a time, but eventually gave up after she ran out of bullets. She then drove to her son's school, where she collected him contrary to a Family Court order. She drove him to her home, where she asked her partner, JC, to take them to the police station. On the way there they were stopped at a police roadblock and KMD was arrested. She was charged with several offences, including detaining Mrs L against her will, unlawfully attempting to kill RL, and possessing a firearm with an altered serial number.

B *KMD's Special Hearing*

Ordinarily, charges of this nature would be heard in the Supreme Court of the Northern Territory ('Supreme Court'). However, concerns were raised about KMD's fitness to stand trial.[10] Three psychiatrists provided reports to the Supreme Court, in which they each concluded that KMD was experiencing a delusional disorder: she believed (contrary to any evidence) that 'there were threats to her life from a wide range of people' and that 'her son was being

[10] In the NT, a person is deemed unfit to stand trial if they are unable to understand the nature of the charge, plead to the charge, understand the nature of the trial, follow the course of the proceedings, understand the substantial effect of any evidence presented, or provide instructions to their legal counsel: *Criminal Code Act 1983* (NT) s 43J.

sexually assaulted and was in danger of further sexual assault by her former husband and other people'.[11]

Based on this evidence, on 1 May 2014 Riley CJ declared that KMD was unfit to stand trial, and that she was not likely to become fit in the next 12 months. Consequently, the Supreme Court was required to conduct a 'special hearing'.[12] At that hearing, the jury found KMD not guilty of eight offences because of mental impairment.[13]

Where an individual is found not guilty because of mental impairment, the judge must determine whether to release them unconditionally or impose a supervision order.[14] If a supervision order is to be imposed, the judge needs to determine whether to make it custodial or non-custodial. In KMD's case, Riley CJ was of the view that supervision was required, but needed more evidence to determine whether to impose a CSO or an NCSO. His Honour therefore required the provision of additional expert reports. Based on those reports, his Honour imposed a CSO as he was of the opinion that

> if KMD is not in custody, she is likely to be a danger to those people whom she incorrectly believes were a danger to her son and may still be a danger to her son. The level of risk of similar conduct is difficult to assess but the consequences of such conduct are extreme. She has demonstrated the lengths to which she will go because of her deluded beliefs. I am not satisfied that the danger has abated.[15]

In the NT, while CSOs are imposed for an indefinite period,[16] the court must set a 'nominal term' for the order. While the patient does not need to be released at the end of the nominal term, a major review of the order must be conducted three to six months before its expiry, to determine whether the patient should be unconditionally released.[17] The length of the nominal term is to be determined by

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[11] *R v KMD* [2015] NTSC 31, [2].

[12] *Criminal Code Act 1983* (NT) s 43R(3). A 'special hearing' is similar to a trial; however as the accused person cannot defend themselves, they cannot be convicted of an offence. Instead, the possible verdicts are: not guilty; not guilty because of mental impairment (a qualified acquittal); or committed the offence charged (a qualified finding of guilt). The NT special hearing procedures are set out in ss 43V–Y. Similar procedures exist in other Australian jurisdictions.

[13] In the NT, a person is found not guilty because of mental impairment if, at the time they committed the relevant acts, it is found that they had a mental impairment, and as a consequence of that impairment they did not know the nature and quality of the conduct, did not know it was wrong, or were not able to control their actions: ibid s 43C.

[14] Ibid s 43X.

[15] *R v KMD* [2015] NTSC 31, [60].

[16] They may, however, be varied or revoked on application to the court: *Criminal Code Act 1983* (NT) s 43ZD.

[17] Ibid s 43ZG(5).

reference to the term of imprisonment that would have been imposed had the individual been convicted of the relevant offences. In KMD's case Riley CJ set a nominal term of 16 years.

Ordinarily, a CSO would be served in a mental health facility. However, as KMD did not acknowledge that she had a mental illness, and did not agree to receive treatment, she was instead detained at Darwin Correctional Centre.

C *Reviews of KMD's Custodial Supervision Order*

Under the Code, every 12 months after making a supervision order, the 'appropriate person' (currently the Chief Executive Officer (Department of Health NT) ('the CEO')) must submit a report to the Supreme Court on the treatment and management of the forensic patient's mental impairment.[18] After considering this report, the Court may choose to conduct a review to determine whether the supervision order should be varied or revoked.[19] If the Court conducts a review, it must vary a CSO to an NCSO unless satisfied that the safety of the forensic patient or the public will be seriously at risk if they are released on an NCSO.[20]

Section 43ZN(1) of the Code sets out the factors that the court must have regard to in making this determination. These include the nature of the forensic patient's mental impairment, the relationship between that impairment and their offending conduct, whether as a result of that impairment they are likely to endanger themselves or others if released, whether there are adequate resources available for their treatment and support in the community, and whether they are likely to comply with the conditions of the NCSO. Importantly, s 43ZN(2)(a) prevents the Court from releasing a forensic patient from custody unless it has obtained and considered two expert reports.[21]

KMD's CSO was reviewed by Hiley J in 2017 and 2021. In both cases his Honour confirmed the order, finding that KMD's condition had not improved and that she continued to pose a serious risk to public safety.[22] Her CSO was reviewed again in 2022 by Brownhill J, who agreed that KMD posed some level of risk, but held that whether the safety of KMD or the public would be *seriously* at risk if she was released on an NCSO would depend 'significantly upon the terms of any such order and the mechanisms in place to support KMD to live in the community in

[18] Ibid s 43ZK.
[19] Ibid s 43ZH(1).
[20] Ibid s 43ZH(2)(a).
[21] These reports may be prepared by a psychiatrist or 'other expert': ibid s 43ZN(2)(a)(i).
[22] *R v KMD (No 3)* [2017] NTSC 95, [127]–[128]; *R v KMD (No 4)* [2021] NTSC 27, [14]–[15].

compliance with such terms',[23] a matter upon which her Honour had insufficient information. Consequently, in accordance with s 43ZN(2)(a), Brownhill J ordered the production of two expert reports: one to be written by a psychologist, and the other to be written by 'an occupational therapist or social worker or other expert experienced in managing and supporting people with mental health conditions in the community'.[24]

KMD engaged a clinical social worker, Janet Guy, to prepare the latter report. This report was based on approximately 50 hours of sessions with KMD, as well as discussions with KMD's family. Ms Guy reported seeing no signs of active mental illness, noting that KMD's thinking was logical, her judgment intact, and that she had not expressed any threats of harm.[25] While she acknowledged that, as a social worker, she was not qualified to provide a formal forensic risk assessment, Ms Guy drew on her clinical experience with individuals with mental illnesses to assert that KMD's risk could be managed safely in the community.[26] She recommended that KMD be immediately released on an NCSO.

The CEO engaged a forensic psychologist, Professor James Ogloff, to prepare the other report. However, KMD refused to be interviewed by Professor Ogloff, as she did not consider that

> 'co-rumination', that is talking about the same traumatic experience over and over again, will be of any utility for her, and is likely to be detrimental to her mental health. She considered her counselling with Ms Guy, which has a forward looking, rather than a backward looking, approach, to be most helpful to her. She said she would like to have the choice to speak to who she wants, when she wants, on her terms, and there is nothing to be gained from her speaking to forensic mental health personnel about her original offending or what precipitated it because 10 years has passed and she has moved on from that situation. She said that speaking about what she was feeling or thinking 10 years ago will not assist when she does not have those same feelings, experiences or beliefs now.[27]

Consequently, Professor Ogloff's report was largely based on prior assessments that had been conducted by other mental health professionals and other collateral information. Based on this material, Professor Ogloff concluded that KMD 'continues to present a high level of risk for future violence, with little

[23] *R v KMD (No 5)* [2022] NTSC 69, [144].
[24] Ibid [154].
[25] *R v KMD (No 6)* [2023] NTSC 51, [18].
[26] Ibid [20].
[27] Ibid [109].

evidence to suggest that her existing risk factors, which have been contained whilst she has been incarcerated, are being remediated'.[28] He was of the view that she could not be safely managed in the community.[29]

Justice Brownhill considered the information contained in these reports, along with several other reports that were presented to the Court. Her Honour acknowledged that KMD continued to experience a delusional disorder and lacked insight into her condition, but also recognised the absence of violent behaviour during her lengthy period in custody[30] and the substantial protective factors offered by her family and cultural supports.[31] She found that the risk of future violence, while real, could be mitigated to an acceptable level through a well-structured supervision order and supported transition plan. Consequently, her Honour concluded that there was insufficient evidence of serious risk to justify KMD's continued detention. She ordered KMD's CSO be varied to an NCSO,[32] and KMD was released from custody on 12 July 2023.

D *The NT Court of Criminal Appeal Decision*

The CEO appealed Brownhill J's decision to the Northern Territory Court of Criminal Appeal ('NTCCA') on several grounds, including that Brownhill J had placed too much weight on Ms Guy's evidence given her lack of expertise in the area of risk assessment, and that the terms of the NCSO were insufficient to address the forensic risk issues.[33] Most significantly, it contended that Brownhill J had erred in finding that the safety of the public would not be seriously at risk if KMD were released on an NCSO. It argued that this finding was not reasonably open, given the statutory requirement to obtain and consider two expert reports in making this determination,[34] and KMD's failure to engage with one of the report writers.

In a split decision, the NTCCA upheld the appeal.[35] The majority found that the requirement that the court obtain and consider two expert reports is central to the legislative scheme set out in the Code, and that 'this process was effectively

[28] Ibid [92].
[29] Ibid [105].
[30] Ibid [132].
[31] Ibid [166].
[32] Ibid [167].
[33] *Chief Executive Officer Department of Health v KMD* [2024] NTCCA 8, [76].
[34] Ibid; *Criminal Code Act 1983* (NT) s 43ZN(2).
[35] *Chief Executive Officer Department of Health v KMD* [2024] NTCCA 8 (Reeves and Burns JJ; Blokland J dissenting).

rendered nugatory by KMD's refusal to be examined by Professor Ogloff'. It stated that:

> The purpose of obtaining reports was to enable the Court to be informed of KMD's current mental state and to enable the Court to make an assessment of the risk (if any) that KMD currently posed either to herself or the public. KMD's refusal to be examined by Professor Ogloff made it effectively impossible for the primary judge to make a proper assessment of KMD's current mental state and any risk she may present to the public if she were released from custody.[36]

In the majority's view, the review conducted by Brownhill J 'required a balancing of personal and public interests', but 'KMD's refusal to engage with mental health practitioners skewed the focus of the review away from this balance to a focus on KMD's interests, because the effect of her refusal to engage was to ensure that evidence relevant to the public interest was not contemporary and of questionable weight'.[37] Consequently, it concluded that the review had fundamentally miscarried. The NTCCA therefore ordered the CSO be reinstated, and KMD was returned to custody (after having spent over 12 months in the community).

E *The High Court Decision*

KMD appealed this decision to the High Court on four grounds: that the NTCCA had applied the wrong standard of appellate review; that it had denied her procedural fairness; that it had erred in confirming the CSO without receiving evidence of KMD's progress during the period she was released under the NCSO; and that it had erred in finding that Brownhill J's review had miscarried because of her refusal to engage with medical experts.[38]

The High Court unanimously upheld the final ground of appeal, finding that Brownhill J was permitted to vary KMD's CSO to an NCSO despite her refusal to engage with Professor Ogloff. The plurality (Gordon, Steward, Gleeson and Beech-Jones JJ) held that

> KMD was under no statutory obligation to cooperate with the medical experts whose reports were provided pursuant to ss 43ZK and 43ZN(2)(a). While it may be informative for a review of a CSO, and even in the best interests of persons such as KMD to cooperate with experts whose reports inform a review, nothing in those provisions or

[36] Ibid [187] (Reeves and Burns JJ).
[37] Ibid [193].
[38] *KMD v CEO (Department of Health NT)* [2025] HCA 4, [2].

> any other provision of Pt IIA makes such cooperation a prerequisite to the preparation of their reports, much less the conduct of the review under s 43ZH.[39]

The plurality emphasised that the task of the reviewing judge is to assess whether the safety of the person or the public would be 'seriously at risk' on the evidence available. Such an assessment can occur even if the forensic patient does not cooperate, with the patient's non-cooperation being a relevant factor for the judge to consider.[40]

In the plurality's view, as Brownhill J had complied with the statutory requirements, her decision should not have been overturned on this basis. Her Honour had carefully considered all of the available evidence, including expert reports, reports from victims of the original offending, and reports from KMD's next of kin and Aboriginal community.[41] Her Honour had also appropriately taken into account KMD's refusal to engage with the NT or to receive any treatment for her mental health condition.[42]

Justice Jagot, writing separately, also rejected the suggestion that KMD's refusal to engage with forensic experts could be treated as a de facto bar to release. Her Honour noted that under the Code's statutory scheme, upon completing a review a judge *must* vary a CSO to an NCSO unless it is satisfied, on the evidence available, that the safety of the supervised person or the public will be seriously at risk if this occurs. This requirement exists irrespective of the reasons why the judge is not satisfied that such a risk exists. So even if the cause is the forensic patient's failure to engage with the relevant experts, that does not matter; if the court is not satisfied that the safety of the patient or the community would be seriously at risk if they were placed on an NCSO, the judge must release the patient from custody.[43]

The plurality further held that the NTCCA failed to apply the correct statutory framework when exercising its appellate powers under s 43ZB(3). Having purported to identify error in Brownhill J's reasoning, the NTCCA was required to determine the matter in accordance with the statutory requirements in ss 43ZH(2), 43ZM and 43ZN — which included considering what had occurred during the year that KMD had lived in the community under an NCSO. It failed to

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[39] Ibid [25] (Gordon, Steward, Gleeson and Beech-Jones JJ).
[40] Ibid.
[41] Ibid [13].
[42] Ibid.
[43] Ibid [46].

do so, instead reinstating the CSO without engaging with any evidence about that period.[44]

Justice Jagot strongly reinforced this point. Her Honour held that the NTCCA's decision was incompatible with the structure and purpose of the relevant part of the Code (Part IIA), which expressly requires courts to ensure that liberty is only curtailed to the minimum extent necessary for public safety.[45] Her Honour noted that s 43ZH(2)(a) requires a court to vary a CSO to an NCSO unless it is satisfied, on the evidence available, that the supervised person or the public would be seriously at risk if released, and that this inquiry must be grounded in '"the most recent and accurate information" reasonably available to the Court'.[46] In this regard, Jagot J observed that by the time of the NTCCA hearing, KMD had lived in the community for a year under supervision, and had complied with her NCSO conditions. That period of supervised release was highly relevant to assessing current risk. In those circumstances, the NTCCA should have either obtained and considered updated information or remitted the matter to Brownhill J for reconsideration. Instead, it improperly substituted its own judgment and imposed a CSO based on outdated evidence.[47]

In light of these errors, the High Court set aside the NTCCA's orders, restored the NCSO made by Brownhill J (returning KMD to the community), and remitted the matter to a differently constituted bench of the NTCCA for reconsideration in accordance with the Court's reasons. At the time of writing, that matter has not yet been heard.

PART TWO: HOW SHOULD COURTS DEAL WITH FORENSIC PATIENTS WHO REFUSE TO ENGAGE WITH EXPERTS?

While on its face the High Court's decision in *KMD* is an exercise in statutory interpretation, it raises important questions about how we should address the enduring tension between the community's interest in public safety and the rights of forensic patients to liberty, autonomy and dignity. These questions are particularly pressing in cases like KMD's, where the patient has committed serious acts of violence, but has not been held criminally responsible for those acts.

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[44] Ibid [28]–[31].
[45] See *Criminal Code Act 1983* (NT) s 43ZM.
[46] *KMD v CEO (Department of Health NT)* [2025] HCA 4, [42], quoting *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* (1986) 162 CLR 24, 44.
[47] Ibid [43].

This is not a new issue: it is one that common law courts and legislatures have been grappling with since the development of the insanity defence in 1843.[48] What KMD's case exposes, however, is the difficult ethical terrain that must be navigated when a forensic patient refuses to engage with the psychiatric system. At stake is whether courts should condition release from custody on cooperation with mental health experts, or whether doing so would improperly trample on the forensic patient's rights.

A *The Protective Purpose of Custodial Supervision Orders*

In answering these questions, it is useful to start by considering the purpose of a CSO. It is a legal mechanism that authorises the detention of a forensic patient on the basis that they pose a serious risk to the safety of others.[49] Unlike a sentence imposed following conviction, a CSO is not grounded in punishment, retribution or deterrence. Its primary function is protection: to safeguard the community from future harm that may be caused by the forensic patient. While CSOs may also create opportunities for therapeutic intervention, this role is ultimately instrumental, in that any benefits to the individual are justified by the broader goal of community protection.[50]

The need for protection arises not simply because the individual has a mental impairment, but because there is a nexus between that impairment and prior criminal conduct. The person's past actions, though not criminally punishable, nonetheless evidence a risk that may materialise again, unless appropriately managed. In such circumstances, the CSO provides a structure for risk containment where less restrictive forms of supervision are considered inadequate.

This risk-based justification is the dominant organising principle for determining whether a CSO should be imposed; a person should not be made subject to such an order if they are unlikely to threaten the public's safety if they are not detained. The protective function also shapes the nature of the conditions imposed under a CSO. Forensic patients subject to such orders may be confined in secure hospitals or correctional environments, monitored by mental health professionals, and

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[48] *R v M'Naghten* (1843) 10 Cl & Fin 200; 8 ER 718 (HL).

[49] In some jurisdictions, CSOs may also be imposed to prevent harm to the forensic patient themselves: see, eg, *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) ss 32(2), 35(3)(a); *Criminal Code Act 1983* (NT) s 43ZH(2). However, their primary function remains the protection of the public.

[50] See, eg, *Re PL* [1998] VSC 209, [15].

required to comply with intensive restrictions. While these conditions are often experienced as punitive, their legal purpose is not to punish but to mitigate risk.

B *A Just Redistribution of Responsibility?*

Given that the core function of a CSO is to protect the community from serious harm, it may be thought justifiable to continue such an order where a forensic patient refuses to cooperate with a court-ordered forensic mental health assessment. This is especially so where, like KMD, the person has previously engaged in violent conduct that has caused serious harm to the individuals involved (Mrs L, RL, Mr I) as well as endangering the public. In such circumstances, as the individual has already demonstrated a high degree of risk, it may be considered appropriate to shift the evidentiary burden to them — to expect them to demonstrate, with supporting evidence, that they no longer pose an unacceptable risk to the public.

Given the harm the individual has caused, shifting the evidential burden in this way may be seen to constitute a just redistribution of risk. In this regard, the 1981 Committee on Mentally Disordered Offenders (the 'Floud Committee') argued that

> each of us is presumed free of harmful intentions and therefore cannot justifiably be deprived of liberty on the basis that someone thinks we are dangerous; but, as soon as it is proved that we have done a dangerous act, that presumption disappears and it is fair to redistribute the risk of further harm by incarcerating the dangerous person rather than exposing others to the danger.[51]

Such an approach is consistent with the 'precautionary principle', which holds that when the risks of error are high — particularly where public safety is at stake — decision-makers are justified in erring on the side of caution.[52] In the current context, adherence to the precautionary principle suggests that given KMD has demonstrated seriously harmful conduct, and may do so again, the onus should

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[51] Jean Floud and Warren Young, *Dangerousness and Criminal Justice* (London, Heinemann, 1981), cited in Andrew Ashworth, 'Criminal Law, Human Rights and Preventative Justice' in Bernadette McSherry, Alan Norrie and Simon Bronitt (eds), *Regulating Deviance: The Redirection of Criminalisation and the Futures of Criminal Law* (Hart Publishing, 2009) 87–108, 103. The Floud Committee was a working party established by the Howard League for Penal Reform to examine the best approach to take to 'dangerous offenders'. Its report was considered to be 'a document of major importance both academically and in policy terms': AE Bottoms and Roger Brownsword, 'The Dangerousness Debate After the Floud Report' (1982) 22(3) *British Journal of Criminology* 229, 229.

[52] See generally Cass Sunstein, *Laws of Fear: Beyond the Precautionary Principle* (Cambridge University Press, 2005).

lie on her to establish that it is safe for her to return to the community. This arguably includes requiring her to take all reasonable steps to satisfy the court that she no longer poses a risk — including by engaging with court-ordered mental health practitioners. If she fails to do so, then caution dictates that she should remain in detention.

Framed differently, this obligation could be understood as a civic responsibility placed on the forensic patient due to their previously harmful conduct. In this regard, Ramsay has argued in the context of civil preventive orders that a person who has acted harmfully may have a duty to reassure the community that they are no longer a threat.[53] This may be the case even if they were not criminally responsible for their conduct. Given the harm they have caused, it may reasonably be expected that they will engage in procedures that enable others to properly assess risk, such as participating in court-ordered mental health assessments.

It is important to note that advocates of this approach are not suggesting that forensic patients be *forced* to engage with mental health practitioners, or that they should be punished for failing to do so. They remain free to decline to participate in assessments. However, it is suggested that making that choice should carry the consequence of continued detention, as they will not have met the burden of providing sufficient information to demonstrate that they no longer pose a risk to public safety.[54]

Two interrelated claims are implicit in this approach: first, that it is appropriate to place the evidentiary burden on the forensic patient to demonstrate that they no longer pose a serious risk to the community; and second, that this burden can only be discharged through meaningful engagement with mental health experts.[55] These claims are addressed in turn below.

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[53] Peter Ramsay, 'The Theory of Vulnerable Autonomy and the Legitimacy of the Civil Preventative Order' in Bernadette McSherry, Alan Norrie and Simon Bronitt (eds), *Regulating Deviance: The Redirection of Criminalisation and the Futures of Criminal Law* (Hart Publishing, 2009) 109, 116–7.

[54] This point was made by the NTCCA when returning KMD to custody: *Chief Executive Officer Department of Health v KMD* [2024] NTCCA 8, [191].

[55] There is a third claim implicit in this approach: that mental health assessments can accurately predict future risk. This claim is contested. Recent research suggests that even widely used tools have only modest predictive validity: see Maya GT Ogonah et al, 'Violence Risk Assessment Instruments in Forensic Psychiatric Populations: A Systematic Review and Meta-Analysis' (2023) 10(1) *The Lancet Psychiatry* 780, 789. These problems may be compounded where the tools used have not been validated in relation to the relevant population, or where specific training in relation to that population has not been provided (as was the case in *KMD*: see *R v KMD (No 5)* [2022] NTSC 69, [47]). It is beyond the scope of this article to engage with the substantial literature that addresses the limits of risk assessment in forensic psychiatry.

C *Should the Evidentiary Burden be Placed on the Forensic Patient?*

The proposition that a forensic patient should bear the burden of proving their safety rests uneasily with core principles of criminal justice, civil liberties and human rights. While it may seem sensible to require individuals who have previously caused harm to demonstrate that they no longer pose a threat, doing so overlooks the unique legal and moral position of those who have been found not guilty by reason of mental impairment.

In this regard, it is essential to bear in mind that forensic patients, such as KMD, have not been held criminally responsible for their actions. The law has acknowledged that, at the time of the criminal conduct, they lacked the capacity to understand, assess or control their behaviour due to a mental impairment. Placing an evidentiary burden on them to justify their release treats them in a manner analogous to convicted persons, despite the absence of criminal culpability. This approach erodes the normative significance of the mental impairment defence.

Further, requiring a forensic patient to prove that they no longer pose an unacceptable risk to the public in order to secure their release from custody reverses the traditional onus of proof that underpins the criminal law. It transforms what has historically been a presumption in favour of liberty into a presumption of unacceptable risk. This reversal is particularly troubling given the evidentiary difficulty of proving a negative: it is inherently challenging to demonstrate that one will not cause future harm.[56] It is also arguably unnecessary, given that the individual will generally remain under court supervision even after release on an NCSO. Such individuals may be returned to custody at any time if they are deemed non-compliant with the terms of their supervision order, or if their mental health condition deteriorates. This provides the state with scope to address any unacceptable risks that may arise.

Placing the burden of proof on the forensic patient also conflicts with the foundational legal principle that liberty is (and should be) the default condition of the citizen. Since the time of the Magna Carta, it has generally been accepted that in a free society a person should only be deprived of their liberty if the state can justify that deprivation through lawful, necessary and proportionate means.[57]

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[56] Ian Freckelton, 'The Preventive Detention of Insanity Acquittees: A Case Study from Victoria, Australia' in Bernadette McSherry and Patrick Keyzer (eds), *Dangerous People: Policy, Prediction, and Practice* (Routledge, 2011) 83, 90.

[57] Bernadette McSherry and Patrick Keyzer, *Sex Offenders and Preventive Detention: Politics, Policy and Practice* (Federation Press, 2009) 42–3.

In other words, the right to liberty should only be overridden where the cost to society of not taking action would be substantial and sufficient to justify the loss of the right.[58] In the current context, this means that it should not be enough to suggest that a forensic patient's liberty might lead to harm and so they should remain in custody: to continue their detention the state should be required to demonstrate that harm is probable, and that confinement is the least drastic means of prevention.[59]

This principle is reflected in international human rights law. For example, art 9 of the *International Covenant on Civil and Political Rights* ('ICCPR') provides that no one shall be subjected to arbitrary arrest or detention, and requires that any deprivation of liberty be lawful, reasonable and necessary in the circumstances.[60] While protecting the community from serious harm may constitute a legitimate justification for detaining a forensic patient, this is only so where the state can demonstrate that such detention is necessary and proportionate to the risks they pose. Placing the evidentiary burden on the forensic patient to prove they are safe to release undermines this right, as it enables detention not because the individual poses a demonstrable risk, but simply because they are unable to disprove one.

Article 14(1)(b) of the *Convention on the Rights of Persons with Disabilities* ('CRPD') goes further still. It states that 'the existence of a disability shall in no case justify a deprivation of liberty'.[61] While the scope and interpretation of this provision remain contested, the UN Committee on the Rights of Persons with Disabilities has taken a firm stance; it has consistently held that involuntary detention based on psychosocial disability is incompatible with the CRPD, including where it is framed in protective or therapeutic terms.[62] The Committee's Guidelines on art 14 explicitly reject mental health laws that permit detention based on disability-related risk, asserting that such laws discriminate on the basis of disability and violate the right to liberty. Even if one does not adopt this maximalist interpretation, it is clear that any deprivation of liberty under art 14 must be both necessary and proportionate to the actual risk posed by the

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[58] Ashworth (n 51) 107.
[59] Christopher Slobogin, 'Legal Limitations on the Scope of Preventive Detention' in Bernadette McSherry and Patrick Keyzer (eds), *Dangerous People: Policy, Prediction, and Practice* (Routledge, 2011) 37, 41.
[60] *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 9.
[61] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[62] Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities,* 14th Session (September 2015) 2–3.

individual. Where the burden of proof is placed on a forensic patient to establish that they no longer pose a threat, rather than on the state to justify continued detention, it becomes increasingly difficult to maintain that the deprivation of liberty complies with the principles of necessity, proportionality and non-discrimination that underpin art 14.

It is also important to acknowledge that, at a practical level, risk prediction itself remains an inexact science. Despite advances in risk assessment tools, forensic experts still struggle to make consistently accurate assessments of future risk.[63] False positives — where a person is assessed as posing an acceptable risk but in fact does not — are common.[64] When combined with a reversed burden of proof, this practical reality greatly increases the likelihood of erroneous deprivations of liberty.

D *Should Forensic Patients be Required to Engage with Experts to Secure their Release?*

Regardless of where the burden of proof lies, the central issue in any application to vary a CSO to an NCSO is whether the forensic patient can be safely managed in the community. This is a factual question; if the patient is released, will they pose an unacceptable risk to public safety? To avoid the problems of 'sanism' that often accompany 'common sense' judgments of the risks posed by people with mental illnesses,[65] a proper evidentiary foundation is essential to answer that question. Judges must consider, by reference to the patient's past and current circumstances, not only whether harm may occur, but also the probability that it will occur and the magnitude of the potential harm.

Reaching an appropriate evidence-based conclusion will require judges to consider a broad range of factors. They must evaluate not only clinical assessments of the forensic patient's mental state and history of illness, but also patterns of past behaviour, compliance with previous treatment plans, the availability and reliability of community supports, and any relevant insights offered by family members or carers. The forensic patient's insight into their condition, attitude towards risk factors, and willingness to engage with therapeutic supports will also be relevant. Environmental circumstances, such as the stability of the proposed living arrangements and access to ongoing care, may

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[63] See, eg, Ogonah et al (n 55).
[64] See generally Seena Fazel et al, 'Use of Risk Assessment Instruments to Predict Violence and Antisocial Behaviour in 73 Samples Involving 24,827 People: Systematic Review and Meta-Analysis' (2012) 345 *BMJ* e4692.
[65] See generally Michael Perlin, 'Sanism and the Law' (2013) 15(10) *Virtual Mentor* 878.

also bear significantly on risk. Ultimately, the court's task is to synthesise these diverse strands of information into a coherent risk profile, acknowledging both the inherent uncertainty of future predictions and the serious consequences of getting it wrong.

A recent report from a court-appointed expert who has interviewed and assessed the patient will, in most cases, be extremely helpful. Such a report can provide up-to-date information about the patient's current mental state, their level of insight and engagement, and any changes in presentation since their last formal review. However, while this kind of evidence is clearly valuable, it is not essential. The court is still able to make an informed decision based on the other evidence in the case.

In this regard, it is important to note that even in the absence of a recent expert assessment, the court will seldom be without several other sources of evidence (as was demonstrated in KMD's case). Forensic patients are typically subject to extensive monitoring while in custody. Clinical records, behavioural observations, reports from treating teams, compliance with medication, and institutional incident reports can all provide valuable insights. Previous expert evaluations and collateral input from family members or support workers may also assist. This kind of information forms part of the evidentiary matrix on which risk can be assessed and managed, and may well be sufficient to properly assess risk. The court's role is to make the best possible determination on the basis of the material available — it should not be precluded from acting simply because the patient has not participated in a new assessment.

Of course, the fact that a forensic patient has not engaged with an expert will inevitably be a highly relevant consideration. It may suggest a lack of insight, unwillingness to comply with treatment, or an elevated risk of future harm. However, it should not be treated as determinative. The nature of the forensic patient's condition and the reasons for non-engagement must also be carefully considered. In KMD's case, she declined to participate in a forensic assessment because she, perhaps reasonably, believed that discussing the events surrounding her offending would not assist her recovery and could, in fact, be harmful. It is also relevant that KMD's delusional belief appears to have been monosymptomatic, centred exclusively on the alleged risk to her son. By the time of her review hearings, her son was no longer a child, and the immediate circumstances that had sustained the delusion had largely dissipated. Against that backdrop, her refusal to revisit those events with a forensic psychologist may have carried less significance for assessing her current risk than in cases where the delusional content continues to be reinforced by present circumstances.

In other cases, an individual may refuse to cooperate due to adverse past experiences with mental health services, the debilitating side effects of certain medications, or a principled objection to the forensic mental health system itself; or they may be unable to engage due to a cognitive impairment or a psychiatric condition such as catatonia. It would be unjust to impose indefinite detention on a person simply because they are unable, or understandably unwilling, to participate in a court-ordered assessment.

Importantly, the court must avoid treating non-engagement with experts as a proxy for posing an unacceptable risk. Refusal to cooperate is one factor among many and should be weighed accordingly. The court's task is to determine, on *all* of the available evidence, whether the person would pose an unacceptable risk if released from custody — not to punish them for failing to participate in a mental health assessment. This decision should rest on a holistic assessment of risk, not a procedural default.

Requiring engagement with mental health experts as a de facto condition of release also raises serious concerns about the infringement of the patient's autonomy and dignity. Although they may not be formally compelled to participate, the consequences of declining to do so may be so grave as to render the choice illusory. For example, in the NT, where CSOs are indefinite in nature, the 'choice' to not engage would result in lifelong detention. In this context, autonomy is undermined not through direct coercion, but through the structuring of consequences so severe that refusal becomes untenable. This reflects what Szmukler has described as the spectrum of 'treatment pressures', where liberty is undermined not only by formal compulsion but also by subtler forms of coercion, inducement and threat.[66]

At a practical level, it is important to note that situations like KMD's are extremely rare. Most forensic patients are likely to engage with court-appointed experts, given it is likely to be in their best interests to do so.[67] This is due to the fact that judges tend to place considerable weight on matters such as insight, treatment adherence, and willingness to engage with supports: matters that may be best evaluated from a recent assessment.[68] Judges also tend to be cautious in releasing forensic patients from custody, often maintaining supervision orders even when

[66] George Szmukler, *Men in White Coats: Treatment under Coercion* (Oxford University Press, 2018) 153–70.

[67] In this regard, it is worth noting that KMD did engage with experts at her special hearing, as well as during the first two reviews of her CSO.

[68] See generally Ian Freckelton, 'Distractors and Distressors in Involuntary Status Decision-Making' (2005) 12(1) *Psychiatry, Psychology and Law* 88.

expert opinion favours discharge.[69] This judicial tendency toward caution underscores the importance of having clear and fair processes for assessing risk, and ensuring that non-engagement is not misunderstood or unfairly penalised.

CONCLUSION

KMD's case raises important questions about how the justice system should respond to forensic patients who decline to engage with mental health assessments. This article has argued that while cooperation with mental health experts can provide valuable insight into a person's current risk profile, it should not be treated as a prerequisite for liberty. The justification for ongoing detention must rest not on procedural compliance but on clear, evidence-based findings of necessity and proportionality.

This is not to deny the validity of people's desire to adopt a precautionary approach: to detain individuals who have committed harmful acts unless and until it can be affirmatively proven that they are safe to release. However, while such an approach may offer a sense of security, its application in this context sits uneasily with established criminal justice norms. Traditionally, the criminal law requires the state to prove the need for detention, not the individual to prove their entitlement to release. Reversing this logic, even implicitly, risks undermining core protections, particularly for individuals who have not been found criminally responsible. Moreover, it risks transforming the qualified acquittal of 'not guilty by reason of mental impairment' into a kind of indeterminate sentence, contingent on the individual's capacity and willingness to engage with systems they may justifiably mistrust or fear. This creates a fundamental disparity between the protections afforded in ordinary criminal proceedings and those available to forensic patients.

The effects of this disparity are particularly striking when forensic patients are compared with convicted offenders who have committed similar acts but are found criminally responsible. A person who is convicted will ordinarily receive a finite sentence, after which they are entitled to their liberty regardless of ongoing risk. By contrast, forensic patients subject to CSOs may spend significantly longer in custody than convicted offenders sentenced for equivalent conduct. This is because release depends not on the expiry of a fixed term but on periodic assessments of future risk. Such assessments are inherently uncertain and tend to be approached cautiously, with courts inclined to continue detention where doubts remain about community safety. Detaining people on the basis of risk

[69] Freckelton (n 566) 92.

rather than culpability creates a clear potential for disproportionate and discriminatory outcomes.

Part of the problem here lies in how the issue of release from custody is often framed: as a balancing act between protection of the individual and the community. When framed in this way, community protection is highly likely to prevail.[70] That framing was adopted by the NTCCA judgment in *KMD*, which spoke of 'a balancing of personal and public interests' and concluded that KMD's refusal to engage with practitioners had 'skewed the focus' too far in her favour.[71] By reducing the matter to competing interests rather than recognising it as a question of rights, individual liberty was left vulnerable to being eclipsed by community concerns. The better approach, adopted by the High Court, is to begin from a rights-based position, requiring restrictions on liberty to be kept to the minimum consistent with community safety and grounded in the most accurate information reasonably available.[72] This approach better aligns with international human rights instruments such as the ICCPR and the CRPD, which make it clear that liberty may *only* be curtailed where it is lawful, necessary and proportionate. On this view, the liberty of people like KMD should not be treated as a privilege or a reward for cooperation, but as a right that endures regardless of their criminal history, mental health status or willingness to engage with forensic assessments.

The broader significance of *KMD* remains uncertain. While it may ultimately be confined to the peculiarities of Northern Territory legislation, the High Court's insistence that liberty cannot be made contingent on cooperation with experts has the potential to resonate more broadly. The case could inform advocacy for forensic patients in other jurisdictions, and even for civil patients subject to involuntary treatment orders, where non-compliance is often treated as sufficient justification for detention or compulsory treatment. Whether courts will extend *KMD* in this way remains to be seen, but the decision underscores a critical principle: refusal to engage with medical experts should not, in itself, determine a person's right to liberty.

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[70] Bernadette McSherry and Patrick Keyzer, '"Dangerous" People: The Road Ahead for Policy, Prediction, and Practice' in Bernadette McSherry and Patrick Keyzer (eds), *Dangerous People: Policy, Prediction, and Practice* (Routledge, 2011) 251, 253.

[71] *Chief Executive Officer Department of Health v KMD* [2024] NTCCA 8, [193] (Reeves and Burns JJ).

[72] *KMD v CEO (Department of Health NT)* [2025] HCA 4, [25] (Gordon, Steward, Gleeson and Beech-Jones JJ), [46] (Jagot J).