

SECTION 157:

Review of the operation of the *Forensic Disability Act 2011*

Final report



Contents

1	Executive summary	4
2	Introduction	7
2.1	Statutory requirement to review	7
2.2	Terms of Reference	7
2.3	Methodology	9
2.4	Consultation	10
2.5	Background to the review of the operation of the FDA and the system review	10
2.5.1	The FDA	10
2.5.2	The FDS	10
2.5.3	The Forensic Disability Service System	11
2.6	Related projects and reviews	11
2.6.1	The MHA 2000	11
2.6.2	Carter report	11
2.6.3	Butler report	12
2.6.4	Review of the MHA 2000	12
2.6.5	Senate Community Affairs References Committee inquiry into the matter of indefinite detention of people with cognitive and psychiatric impairment in Australia	12
2.6.6	The introduction of the NDIS in Queensland	13
3	Findings of the review of the operation of the FDA	14
3.1	Strengthening the FDA to promote the care, support and protection of clients in the FDS	14
3.1.1	Principles for the administration of the FDA	14
3.1.2	Statement of rights	15
3.1.3	Client support and planning	16
3.2	Strengthening the FDA to ensure the effective oversight of the FDS by the DFD	19
3.2.1	Oversight mechanisms	19
3.2.2	Powers of the DFD	20
3.2.3	Authorised officers	20
3.2.4	Policies and procedures	21
3.2.5	Clarify the DFD's role in Mental Health Court matters involving people who have an intellectual or cognitive disability	21
3.3	Ensuring the FDA provides a modern, contemporary and legislative framework which is consistent with complementary Queensland legislation	22
3.3.1	Behaviour control	22
3.3.2	Allied persons	24
3.3.3	Offences and penalties under the FDA	25

4	System review of forensic disability services in Queensland	26
4.1	Key Recommendations	26
4.2	The Queensland Government response	26
4.3	Potential areas identified for legislative reform	26
4.4	Governance and legislative design	27
4.5	Expanding and strengthening the role of the DFD	28
4.6	Establishing a consistent restrictive practices framework	28
4.7	Strengthening the legislative framework to support the operation of the FDS	29
4.8	Improving transition of clients through the service system	29
4.9	Ensuring culturally competent services	29
5	Next steps	31
6	Glossary of terms	31
	Footnotes	32
	Attachment	34
	Attachment 1 - <i>Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System</i>	34

Copyright

This publication is protected by the *Copyright Act 1968*.

© State of Queensland (Department of Communities, Disability Services and Seniors) July 2018.

Licence

This work is licensed by the State of Queensland (Department of Communities, Disability Services and Seniors) under a Creative Commons Attribution (CC BY) 4.0 International licence.

To view a copy of this licence, visit: <https://creativecommons.org/licenses/by/4.0/>

Attribution

Content from this report should be attributed as:

The State of Queensland (Department of Communities, Disability Services and Seniors)

SECTION 157: Review of the operation of the *Forensic Disability Act 2011* Final report.

1 | Executive summary

This report provides an overview of the review of the operation of the *Forensic Disability Act 2011* (the FDA review) and identifies key areas of improvement to the *Forensic Disability Act 2011* (FDA).

The FDA is limited in scope to the operation of the Forensic Disability Service (FDS) — a purpose-built, medium secure residential care facility solely for FDS clients with oversight by the Director of Forensic Disability (DFD).

Section 157 of the FDA requires the Minister who administers the FDA to undertake a review of the efficacy and efficiency of the FDA as soon as practicable three years after commencement and table a report about the review's outcome in the Legislative Assembly.

Given the FDA was developed to work alongside the *Mental Health Act 2000* (MHA 2000), this statutory review was commenced in 2016 following the completion of the review of the MHA 2000. It was necessary to wait for the outcomes of the review of the MHA 2000, and the subsequent commencement of the *Mental Health Act 2016* (MHA 2016) given the interrelation of the two pieces of legislation.

The review of the operation of the FDA considered:

- ▶ feedback from key government and non-government partners, including practice information from the DFD
- ▶ data relating to forensic orders (disability) made by the Mental Health Court, and the operation of the FDS
- ▶ the legislative framework in which the FDA operates
- ▶ the operation of forensic disability legislation across other Australian jurisdictions, and
- ▶ submissions to other reviews and inquiries that may have relevance to the forensic disability legislative framework.

The review of the operation of the FDA identified three key areas for improvement:

- 1 | **Strengthening the FDA to promote the care, support and protection of FDS clients:**
 - ▶ Reviewing the principles for the administration of the FDA, in particular to ensure they align with relevant principles in the MHA 2016, the *Guardianship and Administration Act 2000* (GAA), and the United Nations *Convention on the Rights of Persons with Disabilities*.
 - ▶ Clarifying what a statement of rights provided to clients under the FDA must specify, to ensure clients understand all of their rights under the FDA.
 - ▶ Improving the administration of clients' individual development plans, including setting clear minimum timeframes for completion and review of the plans, and requiring consideration of any therapeutic services the client should receive.
 - ▶ Reducing the timeframe for the DFD's review of a client's benefit from care and support.
 - ▶ Requiring the administrator to ensure regular assessment of health care needs.
- 2 | **Strengthening the FDA to ensure the effective oversight of the FDS by the DFD:**
 - ▶ Reviewing and aligning the powers of the DFD with the relevant oversight functions provided under the FDA.
 - ▶ Clarifying the DFD's role in Mental Health Court matters involving people who have an intellectual or cognitive disability.
- 3 | **Ensuring the FDA provides a modern and contemporary legislative framework which is consistent with complementary Queensland legislation:**
 - ▶ Reviewing the behaviour control framework under the FDA to ensure it is consistent with contemporary standards and safeguards for the use of restrictive practices.
 - ▶ Reviewing and clarifying the role of allied persons under the FDA.
 - ▶ Reviewing the penalties under the FDA to ensure alignment with similar penalties under the MHA 2016.

Review of the Forensic Disability Service System (the system review)

During the consultation process undertaken to support the review of the operation of the FDA, stakeholders consistently raised issues about the broader forensic disability service system.

The Queensland forensic disability service system provides services for a small and vulnerable population of people with an intellectual or cognitive disability who are detained in the FDS, or an Authorised Mental Health Service (AMHS) in circumstances where the person is alleged to have committed a serious offence and is found to be of unsound mind at the time of the offence, or unfit for trial as a consequence of their intellectual disability. The broader system is governed under the MHA 2016, the FDA, the *Disability Services Act 2006* (DSA) and the GAA.

As a result of the feedback received from stakeholders during the review of the operation of the FDA, in October 2017, the then Department of Communities, Child Safety and Disability Services (DCCSDS) and Queensland Health commissioned an independent system review of how best to deliver forensic disability services into the future.

The Terms of Reference for the review of the FDA were expanded to include this broader review of the service system. This approach was adopted to ensure that any necessary amendments to the FDA arising from the service system review could be identified, thereby ensuring any proposed changes to the legislation could be considered holistically by the Queensland Government.

The eminent sector representatives commissioned with undertaking the system review were tasked with considering the efficacy, efficiency and cost-effectiveness of the existing framework of services, systems, laws and oversight mechanisms in Queensland which make up the forensic disability service system.

The Terms of Reference also required consideration of the best legislative and administrative arrangements for the Queensland Government portfolio responsibility for the delivery and operation of the system, having regard to the interface with the National Disability Insurance Scheme (NDIS).

The independent system review report: *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System* (the FDSS review report) was provided to the Department of Communities, Disability Services and Seniors (DCDSS) and Queensland Health in March 2018 (Attachment 1).

- 1 | There are four key themes arising from the recommendations of the FDSS review report:**
 - ▶ Implement a new integrated service model for forensic disability services in Queensland under a single administrative arrangement that ring-fences the provision of forensic disability supports and establishes a clear governance framework for the delivery of these services.
 - ▶ Improve the delivery of forensic disability services by ensuring the FDS is embedded within a wider forensic disability system that includes step down facilities and dedicated community resources located in regional 'hubs' to facilitate transition from the FDS and inpatient AMHSs and prevent re-admission.
 - ▶ Improve safeguards and services for forensic disability clients by establishing a consistent restrictive practices framework for the FDS that mirrors the DSA's framework, developing forensic disability expertise across the broader service sector, expanding the role of the DFD to all forensic disability clients and improving cultural capability within the forensic disability service sector.
 - ▶ Address the uncertainties arising from the commencement of the NDIS including considering the support required for forensic disability clients post NDIS full scheme and how these needs will be met in Queensland.

The Queensland Government has welcomed the independently conducted FDSS review report and accepted in principle the need for an improved model for the delivery of forensic disability services in Queensland. However the reform suggested by the report is significant and complex, and deserves detailed and careful consideration. Substantial further work is now required to carefully consider the report's recommendations as part of exploring options for an improved service delivery model that safeguards forensic disability clients and is sustainable into the future.

The FDSS review report considered the following legislative frameworks relevant to administering services for forensic disability clients in Queensland, including:

- ▶ the FDA, which provides safeguards for FDS clients
- ▶ the MHA 2016, which provides safeguards for forensic disability clients who are being managed by an AMHS, and
- ▶ the DSA, which provides safeguards for forensic disability clients receiving services in the community.

2 | Introduction

2.1 Statutory requirement to review

The FDA commenced on 1 July 2011¹ and was designed to complement the then MHA 2000.

Section 157 of the FDA requires the Minister responsible for administering the Act to undertake a review of the efficacy and efficiency of the FDA as soon as practicable three years after commencement (that is, 1 July 2014), in consultation with the Minister responsible for the administration of the MHA (if they are not the same Minister), and table a report about the review's outcome in the Legislative Assembly.

In June 2013, a review of the MHA 2000 commenced. The review included extensive consultation on all matters under the MHA 2000, including the release of specific issues papers on forensic disability services. Given the FDA was developed to work alongside the MHA 2000, the statutory review of the FDA was held over pending the outcomes of the review of the MHA 2000.

In response to the outcomes of the review of the MHA 2000, the Queensland Government developed a new MHA 2016, which commenced on 5 March 2017. The review of the operation of the FDA began as soon as practicable after passage of the Mental Health Bill 2015 in February 2016.

During the consultation process on the review of the operation of the FDA, stakeholders raised issues about the forensic disability service system more broadly, including the way clients are detained to the FDS by the Mental Health Court, lack of transition of forensic disability clients to the community and limited supports available for clients on their return to the community.

A changing environment for disability services (with transition of state disability services to the NDIS to be completed by 1 July 2019) also prompted a need to consider proposals for legislative amendment in a holistic way.

As a result, in October 2017, Government extended the scope of the original FDA review to include the system review.

2.2 Terms of Reference

FDA review

The following is a summary of the Terms of Reference for the review of the operations of the FDA, developed in consultation with the Minister for Health:

Pursuant to section 157 of the *Forensic Disability Act 2011* (FDA), the (then) Department of Communities, Child Safety and Disability Services will review the efficacy and efficiency of the FDA and table a report about the review's outcome in the Legislative Assembly.

The review will be conducted in consultation with the Minister responsible for the *Mental Health Act*², through the Department of Health.

Issues the review will consider

The review will consider whether the FDA is effective and efficient in fulfilling its purpose and will culminate in advice being provided to the Minister.

The purpose of the review is to consider:

- a) whether the FDA, in its current form, is an effective set of laws for meeting the purpose provided in the FDA³, giving effect to the principles of the FDA⁴, and delivering the objectives set out in the explanatory materials (including its explanatory notes and speech)
- b) whether the purpose of the FDA⁵ remains relevant and contemporary
- c) whether the legal framework set out in the FDA, and complementary Acts, such as the *Mental Health Act*⁶, adequately enable the delivery of forensic disability services and provide sufficient and appropriate limitations (for example, to safeguard the rights and freedoms of clients), and
- d) whether any issues or opportunities have arisen from changes since the FDA's commencement (for example, introduction of the *Mental Health Act 2016*).

The system review

The review of the operation of the FDA was expanded to include the following Terms of Reference for an independently conducted service system review. They were developed in consultation with the Minister for Health in 2017:

This component of the review of the *Forensic Disability Act 2011* will:

1. Consider the efficacy, efficiency and cost-effectiveness in delivering intended outcomes for clients of the existing:
 - a) delivery of services, and support, provided to individuals with intellectual disability subject to forensic orders, and how positive outcomes for these individuals are delivered
 - b) interrelationships and connections between the services, systems, laws and oversight mechanisms within the forensic disability service system, and
 - c) policies, laws and service delivery that relate to the making, exercising, review and administration of forensic orders for people with intellectual disability.
2. Consider the best legislative and administrative arrangements for the portfolio responsibility for the delivery and operation of the system, including the results of the work to date on the review of the *Forensic Disability Act 2011*.
3. Consider whether any improvements could be made to:
 - a) better meet the needs of individuals, and ensure individuals are provided with reasonable and necessary care, support and accommodation, and the best promotion of their rehabilitation, habilitation, safe community placement and reintegration into the community
 - b) ensure individuals are able to access services locally, as far as is reasonable to maintain connection to culture, family, language and community, and ensure access to advocates and other support persons of the individual
 - c) existing oversight, monitoring and investigative mechanisms, and
 - d) how the system meets community safety needs and expectations.
4. Have regard to:
 - a) Australia's international human rights obligations, including the principles from the United Nations Convention on the Rights of Persons with Disabilities
 - b) the different and complex needs of the cohort of individuals subject to a forensic order, including their cultural, religious or spiritual beliefs and practices; the needs of persons from culturally and linguistically diverse backgrounds; and in particular, the need for Aboriginal people and Torres Strait Islanders in the system to maintain connection to their culture and community
 - c) the review of the *Mental Health Act 2000*, the Honourable William J Carter's report *Challenging Behaviour and Disability: A Targeted Response*, and His Honour Judge Brendan Butler AM SC's report *Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000*
 - d) the *Mental Health Act 2016*, in particular with regard to changed provisions relating to people with intellectual disability, including those on a forensic order
 - e) the legislation for, and operation of, the National Disability Insurance Scheme (NDIS), and its interface with the system and forensic disability services, and
 - f) the evidence base for best practice delivery of forensic disability services, including contemporary literature, research, and consideration of other forensic disability service system models (either existing or proposed) in other jurisdictions.
5. Identify options that are safe, affordable, deliverable, and provide for effective and efficient outcomes for clients and the community.

Outside scope

The following are outside the scope of this component of the review of the *Forensic Disability Act 2011*:

 - ▶ the mental health system which treats, and cares for people who have mental illnesses, to the extent that it does not relate to individuals with an intellectual or cognitive disability who

are subject to a forensic order (disability) or forensic order (mental health)

- ▶ specific investigation of the individuals currently subject to a forensic order and their particular circumstances, for example why an individual was detained on a forensic order by the Mental Health Court, (this is not intended to limit consideration of the circumstances and needs of the cohort of individuals subject to a forensic order), and
- ▶ the development of options for the policies and procedures providing for the day-to-day operation of services within the system.

2.3 Methodology

FDA review

The then DCCSDS led the review of the operation of the FDA and examined how the FDA can best meet its purpose and give effect to its principles.

The FDA review considered feedback from key government and non-government partners, including Queensland Health, practice information from the DFD; data relating to forensic orders (disability) made by the Mental Health Court, and the operation of the FDS; the legislative framework in which the FDA operates; the operation of forensic disability legislation across other Australian jurisdictions; and submissions to other reviews and inquiries that may have relevance to the forensic disability legislative framework.

Consistent with the original Terms of Reference, the review was strictly confined to matters related to the operation of the FDA and did not consider the broader operation and delivery of all forensic disability services in Queensland.

The system review

In response to stakeholder concerns, Government extended the remit of the FDA review to include a service system review of supports for forensic disability clients.

Government commissioned an independent review of the forensic disability service system to consider the efficacy, efficiency and cost-effectiveness of the Queensland framework of services, systems, laws and oversight mechanisms. In addition, the review of the service system was to consider the best administrative and legislative arrangements

for the Queensland Government portfolio responsibility for the delivery and operation of the forensic disability service system. It was also to have regard to its interface with the NDIS in full scheme.

This approach was adopted to ensure that any necessary legislative amendments to the FDA could be considered from a holistic perspective.

The system review was undertaken from October 2017 by sector respected professionals, Professor James R.P Ogloff AM, Dr. Janet Ruffles, and Dr. Danny Sullivan acting for the Centre for Forensic Behavioural Science, Swinburne University of Technology. The review was conducted independently and supported by the Forensic Disability Service System Review Reference Group, which was co-chaired by the Deputy Directors-General of Queensland Health and DCDSS and included representatives from the following organisations:

- ▶ the Office of the Public Advocate
- ▶ the Anti-Discrimination Commission Queensland
- ▶ the Department of Premier and Cabinet
- ▶ the Department of Justice and Attorney-General
- ▶ Queensland Treasury
- ▶ the Queensland Mental Health Commission
- ▶ Queenslanders with Disability Network, and
- ▶ the Office of the Public Guardian.

The methodological approach to the review process involved:

- ▶ extensive consultations across a broad range of stakeholder groups, including government agencies with functions directly relevant to the review, non-government organisations, advocacy groups and consumers
- ▶ site visits to the FDS, The Park - Centre for Mental Health, Treatment, Research and Education, and various mental health facilities that form part of the Townsville Hospital and Health Service Mental Health Service Group, including the Adult Acute Mental Health Inpatient Unit, the Secure Mental Health Rehabilitation Unit and the Townsville Community Care and Acquired Brain Injury Unit

- ▶ review of legislative, policy and program documents relating to the Queensland forensic disability service system, and
- ▶ ongoing consultation and oversight provided by the Forensic Disability Service System Review Reference Group.

2.4 Consultation

FDA review

To inform the review of the operation of the FDA, targeted consultation was conducted with key stakeholders, including Queensland Health, the DFD, government agencies, the Office of the Public Advocate, the Office of the Public Guardian, the Anti-Discrimination Commission Queensland, and advocacy organisations - Queensland Advocacy Incorporated and Speaking Up For You.

Stakeholder feedback informed potential areas for improvement in the FDA and is referred to throughout this report.

The system review

The FDSS review report outlines the stakeholders consulted during the system review at Appendix B. Key stakeholders included: the DFD, government agencies, the Mental Health Court, the Mental Health Review Tribunal, the Office of the Chief Psychiatrist, the Office of the Public Advocate, the Office of the Public Guardian, and advocacy organisations - Queensland Advocacy Incorporated and Queenslanders with Disability Network.

2.5 Background to the review of the operation of the FDA and the system review

2.5.1 The FDA

The FDA commenced on 1 July 2011, establishing the FDS. The FDA was designed to complement and work alongside the MHA 2000. The FDA provides for the involuntary detention, and the care, support and protection of people subject to a forensic order (disability) and detained to the FDS, while:

- ▶ safeguarding their rights as well as their freedoms
- ▶ balancing their rights and freedoms with the rights and freedoms of other people

- ▶ promoting their individual development and enhancing their opportunities for quality of life, and
- ▶ maximising their opportunities for reintegration into the community.

The FDA also established the DFD as a statutory officer. Section 89 of the FDA clarifies the independence of the DFD by providing that the DFD is not under the control of the Minister. The functions of the DFD include providing independent oversight of the FDA and ensuring protection of the rights of FDS clients. The FDA vests specific powers and functions in the independent DFD and the administrator in relation to the operation of the FDS.

The FDA was developed in response to the findings of the Carter⁷ and Butler⁸ reports which identified that the forensic mental health system is not suitable for people with intellectual and cognitive disability.

The forensic disability population comprises people who are alleged to have committed a serious offence and who are determined by the Mental Health Court to be of unsound mind at the time of the offence, or unfit for trial, as a consequence of their intellectual or cognitive disability.

In such a case, the Mental Health Court may decide to make a forensic order (disability) under the MHA 2016 so that a person is involuntarily detained. The order must state whether the person is to be detained in the FDS or an AMHS.

Prior to the commencement of the FDA, the only option for the Mental Health Court was to make a general forensic order under the MHA 2000 detaining a person to an AMHS (see this report, section 2.6.1 The MHA 2000). The FDA enables the Court to order a person to an appropriate place of detention having considered the person's needs (mental health or disability).

2.5.2 The FDS

The FDS is administered and funded by DCDSS and operates in one location with capacity for up to ten clients. As at 1 July 2018, six clients were detained in the FDS, with five clients residing in the service and one accommodated offsite and adjacent to the FDS pursuant to an order made by the Mental Health Court.

When the FDS commenced operation in 2011, eight of the original ten individuals who became FDS clients were transferred from AMHSs. Two individuals were detained to the FDS by new forensic orders (disability) in 2011 and 2012.

2.5.3 The Forensic Disability Service System

As well as the FDS, a much larger component of people on forensic orders (disability) receive services through AMHSs in the mental health system. This includes people receiving forensic disability services in the community. As at 1 July 2018, 103 individuals were subject to forensic orders (disability) detaining them to an AMHS. Of this group, 12 are detained as inpatients and 91 reside in the community. This number of individuals on forensic orders (disability) has been steadily increasing over the past few years.

When managed by an AMHS, legislative responsibility, clinical governance (risk assessment and advice about supports required and review of risk and care plans) is provided by the relevant AMHS, with oversight provided by the Chief Psychiatrist. Disability support needs are funded by DCDSS, or if eligible the NDIS, and provided by non-government providers.

2.6 Related projects and reviews

2.6.1 The MHA 2000

The MHA 2000 was enacted to provide for the involuntary assessment and treatment, and the protection, of persons (whether adults or minors) who have mental illness while, at the same time, safeguarding their rights. It aimed to meet these objectives by:

- ▶ providing a scheme for the involuntary admission, treatment and protection of people with mental illnesses where this is necessary

- ▶ ensuring that the rights of people with mental illness are protected through independent review of their involuntary status
- ▶ providing for the expert determination of criminal responsibility for people with a mental illness charged with criminal offences, and
- ▶ facilitating the admission and treatment of people with mental illness serving a sentence of imprisonment or charged with criminal offences.

The MHA 2000 replaced the *Mental Health Act 1974* (repealed), which by 2000 no longer reflected the contemporary structure and operation of mental health services and contemporary treatment practices.⁹ The MHA 2000 provided, for the first time, specific legislation for the unique features of mental illness that could not be catered for in other mainstream legislation, particularly the need to provide treatment of mental illness when a person is unable to consent or is unreasonably objecting to treatment.

However, a person could not be involuntarily detained and treated for anything other than mental illness and a person could not be detained for involuntary treatment in a mental health service on the basis of an intellectual disability. The explanatory notes for the Mental Health Bill 2000 note it would be inappropriate and ineffective to provide psychiatric treatment to conditions that are not mental illnesses.¹⁰ An exception to this is if a person is found to be of unsound mind in relation to a criminal offence as a result of their intellectual disability. Such a person could be detained in an AMHS under provisions dealing with people with a mental illness who have committed criminal offences. Importantly, the explanatory notes explain that this was because there was no other suitable scheme.¹¹

2.6.2 Carter report

On 31 July 2006, the Hon William J Carter QC handed down his report *Challenging Behaviour and Disability: A Targeted Response*. The report found that the progressive deinstitutionalisation of the intellectual disability sector in Queensland from the 1970s through to the 1990s resulted in a lack of realistic service options for individuals with a disability who present significant risks to themselves and to those who provide for their care.

The report found ‘there is a small minority of persons who may require secure care because of the nature and extent of the disturbed behaviour and the fact that it can create serious risk of injury or harm not only to the person but also to others, including persons in the community’ and recommended that a purpose-designed 20 place secure care residential facility should provide for these clients.¹² The report also recommended transitional care and accommodation arrangements, community supports and living solutions for forensic disability clients.

The report further found that although the Mental Health Court had jurisdiction to make a forensic order in respect of a person with an intellectual disability who has committed an indictable offence, the power of the Court was limited to order the person to be detained in a mental health service, which ‘objectively and in the mind of the Court is a totally unacceptable outcome.’¹³

2.6.3 Butler report

In December 2006, Brendan Butler AM SC handed down the final report on the *Review of the Queensland Mental Health Act 2000, Promoting Balance in the Forensic Mental Health System*.

The report noted that the primary purpose of the MHA 2000 was to provide for the involuntary assessment and treatment of people with a mental illness (while safeguarding their rights), and that the principles for administration of the MHA 2000 apply to people with a mental illness. However, persons with an intellectual disability could be affected by the provisions of the MHA 2000, because a finding of unsoundness of mind or unfitness for trial could be made on the basis that a person has an intellectual disability (regardless of the presence of a mental illness). Such a person could then be placed on a forensic order by the Mental Health Court and detained in an AMHS for involuntary treatment and care.

The report found:

“The requirement of people on forensic orders to be detained in a mental health service is clearly inappropriate for people with a sole diagnosis of intellectual disability. Mental health services exist to provide treatment for people with mental illness and do not usually have the facilities or expertise to provide appropriate care for people

with an intellectual disability, some of whom may have extremely challenging behaviours and may need long term intensive support and secure care. Detention in high secure facilities for people with mental illnesses can be highly detrimental for people with an intellectual disability, placing the person, other patients and staff at risk.”¹⁴

The report attributed this inappropriate arrangement to the absence of alternative legislation or service arrangements for people with an intellectual disability who require secure care, with no legislation providing analogous provisions to the civil or forensic provisions in the MHA 2000 for the involuntary care and treatment of people with mental illness.

2.6.4 Review of the MHA 2000

The review of the MHA 2000 commenced with the release of Terms of Reference in June 2013 seeking community feedback on possible areas of improvement in the MHA 2000. The review included extensive consultation on all matters under the MHA 2000, including the release of specific issues papers on forensic disability services.¹⁵

As a result of the review, the Mental Health Bill 2015 was introduced on 17 September 2015, passed by the Legislative Assembly on 18 February 2016 and assented to on 4 March 2016. The MHA 2016 commenced on 5 March 2017.

The main objectives of the MHA 2016 are:

- ▶ to improve and maintain the health and wellbeing of persons with a mental illness who do not have the capacity to consent to treatment
- ▶ to enable persons to be diverted from the criminal justice system if found to have been of unsound mind at the time of an alleged offence or to be unfit for trial, and
- ▶ to protect the community if persons diverted from the criminal justice system may be at risk of harming others.

The MHA 2016 largely retains the legislative framework established in the MHA 2000 in relation to Mental Health Court processes, however, it includes amendments to clarify some matters, such as arrangements for persons with a dual diagnosis (intellectual disability and mental illness).

2.6.5 Senate Community Affairs References Committee inquiry into the matter of indefinite detention of people with cognitive and psychiatric impairment in Australia

On 2 December 2015, the Australian Senate referred the matter of the indefinite detention of people with cognitive and psychiatric impairment in Australia to the Senate Community Affairs References Committee for inquiry and report. The inquiry lapsed with the dissolution of the Senate on 9 May 2016. However, before the inquiry lapsed, 71 submissions were made, some of which are relevant to this review. The inquiry recommenced with hearings on 19 September 2016.

A number of submissions to the Senate inquiry opposed the practice of indefinite detention for people with cognitive and psychiatric impairment. The Australian Human Rights Commission, in its submission to the Senate inquiry, provided feedback that the indefinite detention of people with a disability who cannot stand trial is a consequence of systemic failure. The Commission suggested adequate supports are not available to prevent people with disabilities from engaging in offending behaviour.

2.6.6 The introduction of the NDIS in Queensland

Queensland will soon complete its transition to the NDIS and full scheme will commence from 1 July 2019. As a result, DCDSS, which currently administers the FDA and the FDS, is gradually reducing its role in the delivery of disability services in Queensland.

Pursuant to the NDIS applied principles¹⁶ and tables of supports for the justice domain, responsibility for forensic disability services provided while a client is detained will remain with the Queensland Government.

In considering offenders with a disability who are not in custody, the National Disability Insurance Agency (NDIA, 2015) has stated:

The NDIS will continue to fund reasonable and necessary supports required due to the impact of the person's impairment/s on their functional capacity in a person's support package where the person is not serving a custodial sentence or other custodial order imposed by a court or remanded in custody. As such the NDIS would fund supports where the person is on bail or a community based order which places controls on the person to manage risks to the individual or the community (except in the case of secure mental health facilities).

The NDIS will fund specialised supports to assist people with disability to live independently in the community, including supports delivered in custodial settings (including remand) aimed at improving transitions from custodial settings to the community, where these supports are required due to the impact of the person's impairment/s on their functional capacity and are additional to reasonable adjustment.

There remains uncertainty about the intensity of supports the NDIS will fund for the forensic disability client cohort, and at what stage of rehabilitation the client may access NDIS supports.

These interface issues are currently being negotiated between the Queensland and Australian governments.

3 | Findings of the review of the operation of the FDA

A review of the operation of the FDA was originally scoped and undertaken in accordance with the requirement under section 157 of the FDA by the then DCCSDS. The review identified opportunities to:

- ▶ strengthen the legislative framework to promote the care, support and protection of clients in the FDS
- ▶ strengthen the legislative framework to ensure the effective oversight of the FDS by the DFD, and
- ▶ ensure the FDA provides a modern and contemporary legislative framework which is consistent with complementary Queensland legislation.

This section of the report outlines the findings of the review of the operation of the FDA. The findings of this component of the review are limited to proposed areas of change to the FDA itself and were developed in the context of the current operating and service environment.

Any major systemic changes, such as those suggested in the FDSS review report, will prompt a need to examine the opportunity for further improvement or continued applicability in the context of any new or improved service delivery model. However, the findings remain valid and should be considered further in this context.

3.1 Strengthening the FDA to promote the care, support and protection of clients in the FDS

3.1.1 Principles for the administration of the FDA

The principles of the MHA 2016 apply to both persons with a mental illness and persons with an intellectual disability, but only those with an intellectual disability who are detained to an AMHS.¹⁷ The principles for the administration of the FDA in relation to clients of the FDS mirror those in the MHA 2000, with some divergences, to be consistent with the United Nations *Convention on the Rights of Persons with Disabilities*.

The MHA 2016 principles expand upon those contained in the MHA 2000 by including additional considerations, such as:

- ▶ the importance of support persons' involvement in decision-making for people with intellectual and cognitive disability
- ▶ that the unique needs of Aboriginal people and Torres Strait Islanders should be taken into account, the assistance of interpreters should be provided, and decisions should have regard to the person's cultural, religious or spiritual beliefs and practices
- ▶ that the unique needs of persons from culturally and linguistically diverse backgrounds should be taken into account, the assistance of interpreters should be provided, and decisions should have regard to the person's cultural, religious or spiritual beliefs and practices, and
- ▶ a person's right to privacy and confidentiality of information.

During the review of the operation of the FDA, stakeholders provided feedback suggesting that the principles contained in the GAA should be taken into account to inform any changes to the principles in the FDA, as well as the United Nations *Convention on the Rights of Persons with Disabilities*. Feedback was also received that the FDA as a whole could better embed a human rights framework to inform how decisions are made under the FDA.

Finding:

To ensure the FDA, or other relevant legislation into the future, maintains a contemporary human rights approach and to safeguard the rights of FDS clients, the principles for the administration of the FDA could be aligned as far as practicable, applicable and relevant with the expanded principles in the MHA 2016.

The principles of the GAA could also be considered, as well as the United Nations *Convention on the Rights of Persons with Disabilities*. Recognition and application of these principles could also be strengthened and embedded throughout relevant legislation, wherever possible.

3.1.2 Statement of rights

The FDA provides that the DFD must prepare a written statement of rights and the client and their allied person must be given this statement of rights.¹⁸ The administrator of the FDS must ensure a copy of the statement of rights is displayed in a prominent place in the FDS itself.¹⁹ The administrator must also ensure the client is given an oral explanation of the information in the statement as soon as practicable²⁰ and in a way the client understands.²¹

The FDA review was informed that a training program was also developed and is in place for staff and clients at the FDS to assist them in learning about their rights and how they can exercise their rights.

The provisions relating to the statement of rights in the FDA mirrored those in the MHA 2000.²² The review considered the revised provisions relating to a statement of rights contained in the MHA 2016.²³ The statement of rights provisions in the MHA 2016 expanded upon and modernised the provisions in the MHA 2000. For example, the MHA 2016²⁴ provides that the administrator (of an AMHS) must display signs in prominent positions that are easily visible to patients and nominated support persons, and state that a copy of the statement of rights are available on request.

The FDA does not outline the specific rights of FDS clients that should be included in the statement of rights. The MHA 2016, however, explicitly contains the rights of patients of an AMHS;²⁵ for example, the rights of a patient to communicate with others²⁶ and the rights of a patient to be provided with timely and accurate information from a doctor about what treatment and care they are receiving.²⁷

Feedback from stakeholders suggested that advocates and guardians of clients should also be provided with a copy of the statement of rights and that the statement of rights should include rights relating to long-term rehabilitation and goals.

Finding:

To better safeguard the rights of clients in the FDS and to clarify the rights that should be included in their statement of rights, the FDA should reflect the provisions of the MHA 2016, to the extent relevant. Particular consideration could be given to including a prescribed outline of the rights of clients, as is contained in Chapter 9, Part 3 of the MHA 2016. In developing these, the United Nations *Convention on the Rights of Persons with Disabilities* should be closely considered. It should also be considered whether the FDA could be amended to clarify that advocates and guardians, as well as allied persons (or nominated support persons, see section 3.3.2), are provided with a copy of the statement of rights and informed of how clients may exercise these rights.

3.1.3 Client support and planning

Individual development plans

An individual development plan must be prepared for a client in the FDS²⁸ and is considered a vital part of a client's care and support while detained in the FDS.²⁹

Responsibility

The FDA provides that a senior practitioner for the FDS has responsibility to ensure an individual development plan is prepared for a FDS client.³⁰ The plan is required to be prepared by the senior practitioner in consultation with the client, the client's guardian or informal decision-maker and anyone else a senior practitioner considers to be integral to its preparation.³¹ A senior practitioner or an authorised practitioner for the FDS also has the authority to change a client's individual development plan.³²

The DFD provided feedback during the review that it would be more appropriate for the FDS administrator, rather than the senior practitioner, to be responsible for ensuring an individual development plan is prepared for a client and that the appropriate consultation occurs as part of its preparation. This is consistent with the administrator's obligation to ensure a forensic order is given effect, which may, for example, require changing the client's individual development plan.³³

Finding:

Because individual development plans are integral to a client's habilitation and rehabilitation, the FDS administrator's role and responsibility for individual development plans could be clarified in the FDA to ensure timely and thorough planning processes and to provide the administrator with clear authority and oversight responsibilities for the preparation of, and approval of changes to, a client's plan.

Planning for transition back into the community

When the FDA established the FDS, the intention was that clients would be supported to develop skills, independence and positive behaviour to allow them to transition back into the community.

The FDA provides that an individual development plan must outline the plan for the client's transition to participation and inclusion in the community.³⁴ One of the key purposes of the FDA is to maximise FDS clients' opportunities for reintegration into the community.³⁵

The FDA in and of itself does not contain any legislative barriers to a client's reintegration into the community. However, the review found that while the explanatory notes to the Forensic Disability Bill 2011 stated 'transition planning will be an important part of the person's individual development plan',³⁶ this is not explicitly stated in the FDA. The FDA does not emphasise the objective of transitioning FDS clients back into the community, and that therapeutic supports and services must be provided to enable this.

Stakeholders identified that plans need to be individualised around the criminogenic needs of each client and that educational and vocational needs must be addressed to guide a client's reintegration into the community.

Finding:

To better promote and maximise opportunities for FDS clients to reintegrate into the community, the provisions concerning the content and purpose of an individual development plan in the FDA should clarify that a client's transition into the community is a paramount goal. Individual development plans should specify the therapeutic programs or services necessary to ensure transition, and successfully address their criminogenic needs. Consideration could also be given to requiring that educational and vocational needs of FDS clients are included in individual development plans.

Regular review and assessment

The FDA provides that an individual development plan must state intervals for regularly reviewing and, if necessary, changing the individual development plan.³⁷ In practice, plans are reviewed by the FDS every six months; however, no minimum period for review is specified in the FDA. To ensure FDS clients are receiving appropriate and effective services, the DFD has recommended that individual development plans are reviewed every three months and that the FDA should stipulate this.

Other pieces of legislation stipulate minimum periods for the regular review of plans or treatment. Western Australia's *Declared Places (Mentally Impaired Accused) Act 2015*, established the ten-bed Bennett Brook Disability Justice Centre, which operates under a very similar legislative framework to the FDS. The Western Australian legislation provides that a resident's individual development plan must be reviewed before the expiry of six months after it is first prepared and then every twelve months.³⁸

The FDA does not specify that an individual development plan is to be developed within a set timeframe. There is also no defined period that should be included in the individual development plan in terms of the frequency an FDS client should be assessed. The FDA only provides that the administrator must ensure a senior practitioner carries out regular assessments of a client as required under the plan.³⁹

The MHA 2016 provides that a doctor must assess a patient within three months after the date of the patient's previous assessment.⁴⁰

Feedback on the review recommended a plan should be in place within four weeks of a client entering the FDS.

Feedback was also received from stakeholders that the FDA should prescribe that when individual development plans are reviewed, they must be monitored for quality, relevance to the client, and how the plan is contributing to progress towards habilitation and rehabilitation.

Finding:

It is essential that as soon as possible after a client enters the FDS, a plan is in place to ensure their eventual transition back into the community (for example, within four weeks), and that the plan is regularly reviewed to ensure it continues to provide appropriate services. To ensure this happens, the FDA could specify timeframes for the preparation and regular review of an individual development plan and for an FDS client's regular assessment.

To ensure the quality and effectiveness of individual development plans for each FDS client, consideration should be given to including prescriptive requirements in the FDA as to what should be undertaken as part of the regular review of individual development plans. This will help to further ensure a client's individual development plan and the services and programs they require are up to date and appropriate to meet their needs to support their development, independence and inclusion and participation in the community.

Five-year review of a client's benefit from care and support

The FDA requires the DFD to conduct reviews for individuals who have been FDS clients continuously for five years.⁴¹ The administrator must ensure the DFD reviews the benefit to the client of the care and support provided, and considers whether the benefit is likely to continue if a client remains in the service.⁴²

During the review of the operation of the FDA, stakeholders provided feedback that clients had remained in the FDS for long periods of time and that the five-year review period should be shortened. While the intention of this five-year review period was that it would be an oversight and safeguard mechanism in limited cases where a client remained in the FDS for five years, stakeholders expressed there should not be any assumption under the FDA that a person would be detained for five years. This would be contrary to the rehabilitative purpose of both the FDS and the FDA.

Stakeholders considered an appropriate benchmark for a review may be three years. One stakeholder suggested this timeframe on the basis of the amount of time it would typically take for a person with an intellectual disability to successfully complete a rehabilitation program, such as a sex offender treatment program.

Finding:

Consideration could be given to shortening the review period contained in the FDA Chapter 11 from five years to three years.

Ensuring healthcare needs of clients

While the FDS undertakes work to regularly assess and meet the healthcare and other needs of clients while they are detained at the FDS, the FDA does not specifically require that the healthcare needs of clients are attended to while they reside at the FDS.

Stakeholders suggested the FDA could be strengthened to require FDS clients' health to be regularly assessed and their health care needs to be adequately met.

Finding:

The FDA could be strengthened to require the administrator of the FDS to ensure clients are provided with adequate and timely healthcare and their needs are regularly assessed.

3.2 Strengthening the FDA to ensure the effective oversight of the FDS by the DFD

3.2.1 Oversight mechanisms

Role of the DFD

The FDA provides there is to be a DFD.⁴³ The DFD has statutory oversight of the FDS.⁴⁴ The functions of the DFD include:

- ▶ ensuring the rights, involuntary detention, assessment, care and support and protection of FDS clients comply with the FDA
- ▶ facilitating the proper and efficient administration of the FDA
- ▶ monitoring and auditing the FDS's compliance with the FDA
- ▶ promoting community awareness and understanding of the administration of the FDA, and
- ▶ advising and reporting to the responsible Minister at the DFD's own initiative or at the request of the Minister.

Other functions of the DFD, outlined in the FDA, are also consistent with the DFD's statutory oversight and monitoring function in relation to the operation of the FDS.

In practice, the DFD also attends client case conferences, reviews Mental Health Court reports on clients and provides feedback on these, identifies the treatment needs of clients and organises funding once an order is made and determines who best may benefit from the FDS when it has future capacity.

Other oversight

In addition to the role of the DFD, there are a number of oversight mechanisms that are operating effectively. The Office of the Public Guardian operates a community visitors scheme, where community visitors independently monitor disability sites where vulnerable adults live. Community visitors may make inquiries and lodge complaints for, or on behalf of, residents of these 'visitable sites'. Under the *Public Guardian Act 2014*, the FDS is defined as a 'visitable site'.⁴⁵

A community visitor has the authority to access all parts of the FDS, talk to clients, request that staff at the service answer questions and inspect documents, in order to inquire into the adequacy of the service and whether the FDS is upholding the rights of its clients. After a visit, the community visitor must prepare a report on the visit and provide a copy to the Public Guardian, who may then present it to the Public Advocate and the DFD.⁴⁶ Community visitors conduct visits of the FDS every three months.

Oversight is also provided by the Mental Health Review Tribunal, which must review an FDS clients' forensic order (disability) every six months.⁴⁷

Finding:

The review of the operation of the FDA found that these oversight mechanisms are consistent with what is operating across other analogous systems in Queensland and that these mechanisms are sufficient to ensure appropriate oversight of the FDS.

3.2.2 Powers of the DFD

Under the FDA, the DFD has the broad power to do all things necessary or convenient to fulfil their functions⁴⁸ and thereby provide oversight of the FDS.

There is, however, a lack of explicit investigative powers for the DFD under the FDA, which may hinder the DFD's ability to accurately monitor the compliance of the FDS with the FDA to ultimately protect the rights of clients.

The MHA 2016 provides the Chief Psychiatrist with the power to require the administrator of an AMHS to give requested documents or information to the Chief Psychiatrist,⁴⁹ as well as the power to investigate any matter relating to the treatment and care of a patient in an AMHS.⁵⁰ Under the FDA, authorised officers may require the administrator to produce documents or stated information by written notice,⁵¹ but the DFD does not have this power.

Under the current system, it would be appropriate to incorporate powers similar to those of the Chief Psychiatrist into the FDA for the DFD, as this would ensure they have the ability to effectively oversee the operations of the FDS, without having to access information through an authorised officer.

Finding:

Strengthening the investigative powers of the DFD under the FDA could provide the DFD with more effective oversight of the FDS.

3.2.3 Authorised officers

The FDA provides that the chief executive or the DFD may appoint a person, such as a registered health practitioner or lawyer, as an authorised officer⁵² to inspect the FDS and its documents, confer with FDS clients alone, and make inquiries about their detention, care and support.⁵³

Authorised officers have investigative powers under the FDA, to the extent that they may visit the FDS, with or without notice, between 8.00am and 6.00pm,⁵⁴ and may require the production of documents from the Administrator.⁵⁵ It is an offence for the administrator to not comply with a notice from an authorised officer to produce documents, with a penalty of up to 40 penalty units able to be imposed.⁵⁶ An authorised officer's powers also include being able to inspect any part of the service, confer alone with an FDS client and require the administrator or any FDS employee to give the officer reasonable help to exercise their powers.⁵⁷ It is also an offence for a person to refuse to comply with a request by an authorised officer for reasonable help, with a penalty of up to 40 penalty units able to be imposed. The MHA 2016, however, imposes higher penalty units for contravening requests for information and reasonable help from authorised inspectors.⁵⁸

Finding:

To strengthen the oversight mechanisms relating to authorised officers under the FDA, the associated penalty provisions could be increased in line with MHA 2016.

3.2.4 Policies and procedures

Under the FDA, the DFD is required to issue policies and procedures about the detention, care and support and protection of clients in the FDS.⁵⁹ The administrator must then ensure any of these policies and procedures are given effect in the FDS.⁶⁰

As the role of the DFD is to oversee the operation of the FDS to ensure it complies with the FDA, and the administrator is responsible for the administration of the FDS, it is considered more appropriate that the administrator has the responsibility to develop and issue policies and procedures for the FDS, with the DFD maintaining an oversight role. Stakeholder feedback has also supported this finding.

Finding:

Consideration could be given to providing that the responsibility for developing policies and procedures under the FDA rests with the administrator, while the DFD should have the oversight function of approving the policies and procedures before they are implemented in practice by the administrator.

This finding is specific to the FDA and its operation in the current system. No assumption should be made with regard to the finding's applicability to any other component of the forensic disability service system.

3.2.5 Clarify the DFD's role in Mental Health Court matters involving people who have an intellectual or cognitive disability

The review of the operation of the FDA considered the uncertainty surrounding the extent of the DFD's role in appearing in Mental Health Court reference proceedings. This is despite section 114 of the MHA 2016 stating that 'If the person has an intellectual disability... the director of forensic disability may elect to be a party'.⁶¹

In practice, the DFD regularly elects to appear at proceedings. In 2015-16, the DFD elected into 65 matters relating to people with an intellectual disability to make appropriate determinations for a number of these alleged offenders appearing before the Mental Health Court.

However, while the MHA 2016 gives the DFD the right to elect to appear in the Mental Health Court regarding people with an intellectual disability, it does not explain why. The FDA (which establishes the role and functions of the DFD) provides that the DFD has functions relating to the protection of 'forensic disability clients' (defined in the FDA as people detained to the FDS). Because a person with an intellectual disability who is the subject of the reference to the Mental Health Court is not technically an FDS client until the Mental Health Court makes a determination that the person should be detained to the FDS, there is a disconnect between the functions of the DFD under the FDA, and the role the DFD has under section 114 of the MHA 2016.

To address this issue, the FDA needs to make it clear that the DFD not only has functions related to the clients of the FDS, but also has a function regarding persons with cognitive or intellectual disability who are the subject of a reference to the Mental Health Court, for the purpose of advising whether the person would benefit from receiving care and support as a client of the FDS.

This clarification is particularly important to ensure the Mental Health Court has the relevant information before it detains the individuals to the FDS that would benefit from receiving care and support as an FDS client - in turn ensuring that FDS clients are those who have the potential to

transition out of the FDS and reintegrate into the community.

Finding:

Clarify within the FDA that a function of the DFD is a right to elect to appear and make submissions in Mental Health Court proceedings for references involving a person with intellectual or cognitive disability for the purpose of advising whether the person would benefit from receiving care and support as a client of the FDS.

3.3 Ensuring the FDA provides a modern, contemporary and legislative framework which is consistent with complementary Queensland legislation

3.3.1 Behaviour control⁶²

The FDA provides a regulatory framework for behaviour control,⁶³ otherwise known in Queensland as restrictive practices. Under the FDA, practitioners may use restraint, seclusion or behaviour control medication on a client if it is considered necessary to protect the health and safety of clients or to protect others.⁶⁴ Depending upon the type of behaviour control, in most cases it must be authorised by the DFD (for use of restraint),⁶⁵ or a senior practitioner (for use of seclusion).⁶⁶

In 2014, the restrictive practices provisions in the DSA were amended to address the needs of adults with an intellectual or cognitive disability and challenging behaviour, and improve their quality of life, with the aim of ultimately reducing and eliminating the use of restrictive practices.⁶⁷ The MHA 2016 also makes provision for the use of seclusion, mechanical restraint and physical restraint practices for individuals who are involuntary inpatients of AMHSs.⁶⁸

In March 2014, the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* was endorsed by Commonwealth, state and territory ministers. The National Framework focuses on the reduction of the use of restrictive practices in disability services that involve restraint (including physical, mechanical or chemical) or seclusion, in accordance with the United Nations *Convention on the Rights of Persons with Disabilities*.

These changes to the regulatory frameworks concerning restrictive practices are intended to solidify the shift of focus from behaviour control to positive behaviour support for adults with challenging behaviour.

The restrictive practices regime in the FDA is out-of-date and vulnerable people have inconsistent rights with regard to restrictive practices applied across similar legislative schemes. For example, 'behaviour control medication'⁶⁹ should now

be referred to in the FDA as ‘chemical restraint’ for consistency with legislation regulating disability services.⁷⁰ Furthermore, there are no legislative requirements for a senior or authorised practitioner to provide a statement to the client about the use of restrictive practices, or for adults to be involved in the planning and decision-making around restrictive practices, as in the DSA.⁷¹

The FDA also does not provide for a positive behaviour support plan, as provided for in the DSA, which is required to be in place for the client in order to plan for the reduction of the need for restrictive practices to be used on a client.⁷²

Western Australia’s *Declared Places (Mentally Impaired Accused) Act 2015* establishes a centre similar to Queensland’s FDS and provides for a similar legislative framework. The *Declared Places (Mentally Impaired Accused) Act 2015* provides that a resident’s individual development must outline each instance when restrictive practices are used, strategies for reducing their further use and what restrictive practices are appropriate or inappropriate for each individual resident.⁷³ The FDA does not require such details to be included in a client’s individual development plan.

Finding:

To better reflect the contemporary restrictive practices regime in Queensland, and to ensure clients in the FDS are protected, the behaviour control provisions in FDA could be removed and a new framework developed consistent with the restrictive practices provisions in the DSA, the GAA, and the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*.

To further ensure the safety and protection of FDS clients, the FDA could also specify that safeguards regarding the use of restrictive practices must also be included in a client’s individual development plan. The client’s positive behaviour support plan should also be referenced and included in their individual development plan.

3.3.2 Allied persons⁷⁴

The FDA establishes the role and function of ‘allied persons’.⁷⁵ An allied person may be chosen by an FDS client or be declared if the administrator is satisfied an FDS client does not have the capacity to choose an allied person. The function of the allied person is ‘to help the client to represent the client’s views, wishes and interests relating to the client’s assessment, detention, care and support and protection under [the] Act’.⁷⁶

The FDA does not state whether an FDS client must have an allied person; however, the wording it contains (‘the client tells the administrator the client no longer wishes to have an allied person’)⁷⁷ suggests that it is not a requirement.

The role of allied persons is not clear, in particular, whether the allied person merely supports the client to express their views and wishes, or is empowered to advocate on the client’s behalf. The Australian Law Reform Commission has advocated for a continued shift away from substitute decision-making to supported decision-making. It also advocated that by ratifying the United Nations *Convention on the Rights of Persons with Disabilities*, Australia has accepted its obligations to provide persons with disability access to the support they may require to exercise their legal capacity.⁷⁸

The provisions in the FDA about allied persons mirror those of the MHA 2000,⁷⁹ which were replaced by the concept of ‘nominated support persons’ in the MHA 2016.⁸⁰ The MHA 2016 enshrines the place of support persons in its principles, clearly outlines the roles and responsibilities of nominated support persons, includes a framework for officially nominated support persons, and makes reference throughout the MHA 2016 in relation to matters on which support persons may participate.⁸¹

The MHA 2016’s framework for support persons is in line with the contemporary shift towards supported decision-making for people with disability. For example, while the FDA provides that the function of an allied person is to help represent the client’s views, wishes and interests,⁸² a nominated support person under the MHA 2016 may, as part of their role, contact the patient, participate in decision-making and arrange support services for the patient.⁸³

Finding:

Consideration could be given to replacing the concept of allied persons in the FDA with the concept of nominated support persons, as per the MHA 2016. This will provide greater clarity about the role of the allied or support person, and ensure that clients are effectively supported to make decisions.

3.3.3 Offences and penalties under the FDA

The FDA contains a number of offence provisions.⁸⁴ The penalties in the FDA⁸⁵ mirrored those contained in the MHA 2000; however, many penalties for the same offences were increased in the MHA 2016. For example, it is noted that the penalties for offences relating to the ill-treatment of clients in the FDA are lower than those contained in analogous provisions in the MHA 2016. The FDA provides for a maximum of 150 penalty units or 1 year of imprisonment for the ill-treatment of an FDS client.⁸⁶ On the other hand, the MHA 2016 prescribes 200 penalty units or 2 years of imprisonment as the maximum penalty for the ill-treatment of a patient.⁸⁷

Finding:

Offence provisions within the FDA could be updated to align with analogous provisions in the MHA 2016, to reflect contemporary sentencing standards and the seriousness of offences committed under the FDA.

4 | System review of forensic disability services in Queensland

The forensic disability population comprises people who are alleged to have committed an indictable offence and who are determined by the Mental Health Court to be of unsound mind at the time of the offence, or unfit for trial, as a consequence of their intellectual or cognitive disability.

In such a case, the Mental Health Court may decide to make a forensic order (disability) under the MHA 2016 so that a person is involuntarily detained. The order must state whether the person is to be detained in the FDS, which has a ten-bed maximum capacity, or an AMHS.

A large component of forensic disability clients detained to an AMHS are managed in the community accessing non-government organisation provided services with clinical oversight provided by the Chief Psychiatrist.

4.1 Key Recommendations

In October 2017, the then DCCSDS and Queensland Health commissioned the system review.

The FDSS review report contains four key themes:

- ▶ Implement a new integrated service model for forensic disability services in Queensland under a single administrative arrangement that ring-fences the provision of forensic disability supports and establishes a clear governance framework for the delivery of these services.
- ▶ Improve the delivery of forensic disability services by including step down facilities and dedicated community clinical and non-clinical resources located in regional ‘hubs’ to facilitate transition from both the FDS and inpatient AMHSs.
- ▶ Improve safeguards and services for forensic disability clients by establishing a consistent restrictive practices framework for the FDS that mirrors the DSA’s framework, developing forensic disability expertise across the broader service sector, expanding the role of the DFD to all forensic disability clients and improving cultural capability within the forensic disability service sector.
- ▶ Address the uncertainties arising from the commencement of the NDIS including considering the support required for forensic disability clients post NDIS full scheme and how these needs will be met in Queensland.

The findings of the FDSS review report are much broader than those identified through the review of the operation of the FDA, which appropriately focused primarily on improving the legislative framework to support the operation of the FDS in its current operating environment.

4.2 The Queensland Government response

The Queensland Government has welcomed the findings of the FDSS review report and supports in principle the need to develop an improved service delivery model for forensic disability services in Queensland. The Queensland Government has noted that the reform suggested by the FDSS review report is significant and complex and deserves detailed and careful consideration. DCDSS and Queensland Health will work together to explore potential options for an improved service model that safeguards forensic disability clients and is sustainable into the future, along with supporting administrative arrangements.

The opportunities for improvement identified through the review of the operation of the FDA will be considered further in the context of an improved service delivery model.

4.3 Potential areas identified for legislative reform

The findings and recommendations of the review of the operation of the FDA and the FDSS review report raise issues with potential legislative implications. The recommendations of the FDSS review report are still to be considered in detail by the Queensland Government in the context of considering options for a new service delivery model. Opportunities to improve the operation of the FDA through legislative amendment will need to be considered in the same context.

This report cannot pre-empt Government consideration and deliberation about the best service system model for forensic disability services into the future.

The analysis below highlights areas for further consideration once a preferred service delivery model is identified.

4.4 Governance and legislative design

The forensic disability service system currently operates under a legislative framework comprised of the MHA 2016, the FDA, the DSA and the GAA. A significant volume of the provisions which support the system are contained within the MHA 2016, with the FDA providing specifically for the delivery of services to a smaller cohort of clients of the FDS.

The FDSS review report found that the governance structure for the delivery of forensic disability services is fragmented and unclear – a confusion compounded by a legislatively drawn division of client cohorts. A small proportion of the forensic disability cohort of clients detained to the FDS are cared for under the authority of the FDA, while the majority of clients subject to a forensic order (disability) are managed as inpatients or in the community by AMHS as provided under the authority of the MHA 2016. This is largely due to a resourcing issue with the FDS only having a ten-bed capacity.

The FDSS review report noted that the DFD has no current role in relation to the care and support for the majority of people on forensic orders (disability) who instead fall under the oversight of the Chief Psychiatrist. This was observed as inconsistent with the Carter Report which advocated for specialist forensic disability services that de-emphasised a medical model for people with a disability.

The FDSS review report found that separation of the forensic disability cohort means there is “a lack of whole-of-system practice leadership, monitoring, direction and oversight”.⁸⁸ The FDSS review report outlines a suggested, new structure for the forensic disability service system, namely that the administration of the forensic disability service system and the mental health system be undertaken by a single agency (specifying Queensland Health) with a specific division of forensic disability expertise to be retained.

Such a major administrative shift, as proposed in the FDSS review report - and if agreed by the Queensland Government - will require consideration of the legislative framework necessary to support it. At a minimum, consistency and interoperability across the existing forensic

disability service system’s legislative framework will need to be reviewed in conjunction with any system change.

Finding:

The legislative framework required to support a new service delivery model will need to be considered further by the Queensland Government.

In addition, a number of the specific findings in the FDSS review report in relation to strengthening the governance framework may need to be supported by legislative change if they are accepted by the Queensland Government. For example:

- ▶ Establishment of a governance framework including clear clinical reporting lines and decision-making and escalation pathways.
- ▶ Formalising interfaces between the DFD and the Chief Psychiatrist.

4.5 Expanding and strengthening the role of the DFD

The FDSS review report recommends expanding the role of the DFD to all forensic disability clients in Queensland. In particular:

- ▶ Expansion of the role of the Office of the DFD to provide clinical leadership and oversight.
- ▶ The position of the DFD should have authority equivalent to the Chief Psychiatrist and sit independently from the department responsible for the administration of the FDS.
- ▶ It should be clarified that the DFD has the right to appear as a party in all Mental Health Court references connecting people with intellectual or cognitive disability.

A range of potential legislative amendments were also identified as part of the review of the operation of the FDA to strengthen the role of the DFD in relation to enabling effective oversight of the FDS, including:

- ▶ Strengthening the investigative powers of the DFD under the FDA to enable more effective oversight of the FDS.
- ▶ Considering whether the responsibility for developing policies and procedures under the FDA should rest with the administrator so that the DFD could have the oversight function of approving the policies and procedures before they are implemented in practice by the administrator.
- ▶ Clarifying the role of the DFD to appear and make submissions in Mental Health Court proceedings for references involving a person with intellectual or cognitive disability.

Finding:

Both the findings of the review of the operation of the FDA (to strengthen the role of the DFD) and the system review (to expand the DFD role) would require legislative amendment to implement.

Opportunities to improve, strengthen or expand the role of the DFD will need to be considered further in the context of any new service delivery model for forensic disability services in Queensland.

4.6 Establishing a consistent restrictive practices framework

The FDSS review report suggests the establishment of a restrictive practices framework that mirrors that set out in the DSA.

The findings of the review of the operation of the FDA also identified the need to better reflect the contemporary restrictive practices regime for people with a disability in Queensland through the development of a new framework which is consistent with the restrictive practices provisions in the DSA, the GAA, and the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*.

The structural change outlined by the system review i.e. that of bringing together the mental health system and the forensic disability system, is a major policy change. If accepted, the Queensland Government will need to further consider the appropriate legislative mechanism for restrictive practices to be adopted.

At present the MHA 2016, the FDA, the DSA and the GAA all apply different restrictive practices or behaviour support frameworks dependent on where the forensic disability client is placed. While a person is a client in the FDS, the provisions in the FDA apply and the GAA provides for the use of medication for an FDS client's health care but does not include authorisation of behaviour control medication as a form of restrictive practice. The MHA 2016 applies to inpatients of an AMHS. The DSA makes provision for the use of restrictive practices for disability clients, including individuals on forensic order (disability) while they are living within the community.

The legislative framework across inpatient (AMHSs and FDS) and community settings differs due to a recognition that people with disability in the community are not generally subject to a court order, while clients detained in the FDS or an AMHS are subject to a Mental Health Court Order mandating their detention and the provision of care. An order of the Mental Health Court does not authorise the use of restrictive practices outside of inpatient settings and as such, where an individual on a forensic order (disability) resides in the community, the DSA restrictive practices framework is applied.

The DSA is currently under review in preparation for full scheme transition to the NDIS and the concurrent development of a national restrictive practices framework for people with a disability. Any legislative changes with respect to the forensic disability service system will need to coincide with, or follow after, the legislative changes made for the full scheme operation of the NDIS.

Finding:

The restrictive practices framework for the forensic disability service system should be reviewed by Government, taking into account any agreed service model to improve forensic disability services in Queensland and the implications of the NDIS.

4.7 Strengthening the legislative framework to support the operation of the FDS

The findings of the review of the operation of the FDA found there were opportunities to:

- ▶ Strengthen the FDA to promote the care, support and protection of clients in the FDS.
- ▶ Strengthen the FDA to ensure the effective oversight of the FDS by the DFD.
- ▶ Ensure the FDA provides a modern and contemporary legislative framework which is consistent with complementary Queensland legislation.

Finding:

All findings of the review of the operation of the FDA remain valid and the specific identified legislative changes outlined in Chapter 3 should be considered in the context of any new legislative or administrative framework developed to support an improved service delivery model for forensic disability services in Queensland.

4.8 Improving transition of clients through the service system

Both the FDSS review report and the review of the operation of the FDA found there were opportunities to promote better transition of clients through the system.

The review of the operation of the FDA found that transition from the FDS should be better operationalised and identified a range of legislative amendments such as including mandatory transition goals in an individual's development plan and reducing the timeframe for formal review of an FDS client from five to three years following a client's entry into the FDS.

To better support transition, the FDSS review report suggests the introduction of an examination and assessment order prior to detainment, to best ensure a client's suitability to (and likelihood of transition from) the FDS. This would require legislative change.

Less restrictive types of forensic orders are also suggested in the FDSS review report, as is the introduction of a decision-making presumption by the Mental Health Review Tribunal to reduce restrictive supervision automatically unless a need to retain current supervisions levels is demonstrated. Again, these would require legislative change.

Finding:

Any necessary legislative amendments to support improved transition services will need to be considered further in the context of any new service delivery model for forensic disability services in Queensland.

4.9 Ensuring culturally competent services

Both the review of the operation of the FDA and the FDSS review report identified the need for more culturally competent services.

The review of the operation of the FDA found that legislative amendment is needed to reflect the principles of the MHA 2016 which call for services to take into account the unique needs of Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

To better support cultural competent services, the FDSS review report suggests a system-wide review of policies, standards and services, as well as increased Aboriginal and Torres Strait Islander representation on the Mental Health Review Tribunal. This may not require legislative amendment, dependent on the approach agreed by Government.

Finding:

Any necessary legislative amendments to enhance cultural competency of the system will need to be considered further in the context of any new service delivery model for forensic disability services in Queensland.

5 | Next steps

As outlined throughout this report, the Queensland Government supports in principle the need for an improved service model for the delivery of forensic disability services in Queensland.

However, the reform suggested by the FDSS review report is significant and complex and warrants detailed and careful consideration. DCDSS and Queensland Health will work together to explore potential options for an improved service model and the necessary supporting administrative arrangements.

Any necessary legislative changes to support an improved service delivery model will be progressed, taking into account any legislative changes required to complete Queensland's full transition to the NDIS.

6 | Glossary of terms

Throughout this report the following terms are used:

Authorised Mental Health Service (AMHS) refers to a declared health service, or part of a health service providing treatment and care to persons who have a mental illness, including people who have an intellectual disability (defined under the *Mental Health Act 2016*)

Forensic disability client refers to an adult with intellectual or cognitive disability for whom a forensic order (disability) is in force, and who is detained in the FDS, an AMHS or receiving treatment in the community.

Forensic Disability Service (FDS) refers to the service named in section 4 of the Forensic Disability Regulation 2011.

Forensic Disability Service (FDS) client refers to an adult with intellectual or cognitive disability for whom a forensic order (disability) is in force, and who is detained in the FDS.

Forensic disability service system refers to the collection of entities, services and processes that make up the whole system of services and supports for forensic disability clients. This includes the Mental Health Court, the FDS, the DFD, AMHSs and disability support services provided by the Queensland Government or through the NDIS.

Footnotes

- 1 The majority of provisions commenced operation on this date.
- 2 Refers to both the *Mental Health Act 2000*; and the *Mental Health Act 2016*.
- 3 *Forensic Disability Act 2011*, s 3.
- 4 Ibid. ss 7 and 8.
- 5 Ibid. s 3.
- 6 Refers to both the *Mental Health Act 2000*; and the *Mental Health Act 2016*.
- 7 31 July 2006, Hon William J Carter QC *Challenging Behaviour and Disability: A Targeted Response*.
- 8 December 2006, Brendan Butler AM SC the *Review of the Queensland Mental Health Act 2000, Promoting Balance in the Forensic Mental Health System*.
- 9 Mental Health Bill 2000 explanatory notes, p 2.
- 10 Mental Health Bill 2000 explanatory notes, p 5.
- 11 Mental Health Bill 2000 explanatory notes, p 5.
- 12 31 July 2006, Hon William J Carter QC *Challenging Behaviour and Disability: A Targeted Response*, p 13.
- 13 Ibid. p 13.
- 14 December, 2006, Brendan Butler AMSC the *Review of the Queensland Mental Health Act 2000, Promoting Balance in the Forensic Mental Health System*, p 101.
- 15 Two issues papers specifically covering forensic disability matters were released in 2014 and 2015.
- 16 Council of Australian Governments (COAG). Principles to determine the responsibilities of the NDIS and other service systems. November 2015. www.coag.gov.au/sites/default/files/communique/NDIS-Principles-to-Determine-Responsibilities-NDIS-and-Other-Service.pdf
- 17 *Mental Health Act 2016*, ss 5 and 8.
- 18 *Forensic Disability Act 2011*, ss 29 and 30.
- 19 Ibid. s 31.
- 20 Ibid. ss 30 and 146.
- 21 Ibid. s 154.
- 22 *Mental Health Act 2000*, ss 344-346.
- 23 *Mental Health Act 2016*, Chapter 9, Part 2.
- 24 Ibid. s 279.
- 25 Ibid. ss 281-290.
- 26 Ibid. s 284.
- 27 Ibid. s 285.
- 28 *Forensic Disability Act 2011*, s 14.
- 29 *Forensic Disability Act 2011* explanatory notes, p 22.
- 30 *Forensic Disability Act 2011*, s 14(1).
- 31 Ibid. s 14(2).
- 32 Ibid. s 17(1).
- 33 Ibid. s 98.
- 34 Ibid. s 15(1)(b).
- 35 Ibid. s 3(d).
- 36 *Forensic Disability Act 2011* explanatory notes, p 4.
- 37 *Forensic Disability Act 2011*, s 15(1)(c).
- 38 *Declared Places (Mentally Impaired Accused) Act 2015 (WA)*, s 14.
- 39 *Forensic Disability Act 2011*, ss 15(1)(d) and 19.
- 40 *Mental Health Act 2016*, s 205(2).
- 41 *Forensic Disability Act 2011*, s 141. Five years of continuity includes periods where the client was undertaking limited community treatment, absent from the service under a temporary absence approval, detained temporarily in an authorised mental health service, or absent from the authorised mental health service while undertaking limited community treatment under the *Mental Health Act*.
- 42 Ibid. s 141(2).
- 43 Ibid. s 85.
- 44 Ibid. ss 85 and 89.
- 45 *Public Guardian Act 2014*, s 39.
- 46 Ibid. s 47.
- 47 *Mental Health Act 2000*, s 200.
- 48 *Forensic Disability Act 2011*, s 88(2).
- 49 *Mental Health Act 2016*, s 304.
- 50 Ibid. s 308.
- 51 *Forensic Disability Act 2011*, s 125.
- 52 Ibid. s 106.
- 53 Ibid. s 124.
- 54 Ibid.
- 55 Ibid. s 125.
- 56 Ibid. s 125(4).
- 57 Ibid. s 124(2).
- 58 *Mental Health Act 2016*, s 598.
- 59 *Forensic Disability Act 2011*, s 91.
- 60 Ibid. s 99.
- 61 *Mental Health Act 2016*, s 114.
- 62 See Terms of Reference 2, 3 and 4.
- 63 *Forensic Disability Act 2011*, Chapter 6.
- 64 Ibid. s 42.
- 65 Ibid. s 56.
- 66 Ibid. s 61.
- 67 *Disability Services (Restrictive Practices) and Other Legislation Amendment Act 2014*.
- 68 *Mental Health Act 2016*, Chapter 8.
- 69 *Forensic Disability Act 2011*, ss 44, 49 and 50.
- 70 *Disability Services Act 2006*, s 145.
- 71 Ibid. s 191.
- 72 Ibid. s 150.
- 73 *Declared Places (Mentally Impaired Accused) Act 2015 (WA)* s 13.
- 74 See Terms of Reference 2, 3 and 4.
- 75 *Forensic Disability Act 2011*, Chapter 3.
- 76 Ibid. s 24.
- 77 Ibid. s 27(b).
- 78 Australian Law Reform Commission. Equality, Capacity and Disability in Commonwealth Laws. November 2014. www.alrc.gov.au/publications/equality-capacity-disability-report-124.
- 79 *Mental Health Act 2000*, Chapter 9, Part 1.
- 80 *Mental Health Act 2016*, ss 223, 224, 291 and 292.
- 81 Ibid. ss 5(c), 223, 224, 291 and 292.
- 82 *Forensic Disability Act 2011*, s 24.
- 83 *Mental Health Act 2016*, s 291.
- 84 *Forensic Disability Act 2011*, ss 49, 54, 60, 116-120.
- 85 Ibid. s 116.
- 86 Ibid. s 116(2).
- 87 *Mental Health Act 2016*, s 621.
- 88 Ogloff, J.R.P., Ruffles, J., & Sullivan, D. (2018) Addressing needs and strengthening services: Review of the Queensland Disability Service System, Centre for Forensic Behavioural Science, Swinburne University of Technology, p. vi.




Attachment 1

Final Report

Addressing Needs and
Strengthening Services:
Review of the Queensland Forensic
Disability Service System

Prepared for Queensland Department of Health and
Department of Communities, Child Safety and
Disability Services

March 2018



This report was prepared under contract to the Queensland Government acting through Queensland Health and the Department of Communities, Child Safety and Disability Services. The views of the authors do not represent the views of the Queensland Government.

The report was prepared by Professor James R. P. Ogloff AM, Dr. Janet Ruffles, and Dr. Danny Sullivan.

Suggested Citation:

Ogloff, J. R. P., Ruffles, J., & Sullivan, D. (2018). *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System*. Unpublished Report, Centre for Forensic Behavioural Science, Swinburne University of Technology.

Acknowledgements

The Review Team is grateful to Queensland Health and the Department of Communities, Child Safety and Disability Services for their assistance in organising and facilitating this review. In particular, we are grateful to Patrick O'Connor who provided much assistance to us. With his assistance, we obtained much of the information we requested for the review, and were provided with able support throughout. We are also grateful to Professor Karen Nankervis, Executive Director of the Centre of Excellence for Clinical Innovation and Behaviour Support, Associate Professor John Allan, Executive Director of the Mental Health Alcohol and Other Drugs Branch of Queensland Health, Dr John Wakefield and Mr Tony Hayes, who served as the Co-Chairs of the Forensic Disability Service System Review Reference Group, and all of the members of the Reference Group for their leadership, expertise, and advice. Finally, we benefitted greatly from the contributions of the more than 70 people who participated in the consultations undertaken as part of the consultation process, as well as those who provided logistical support and insights into the clinical services at the sites we visited.

Contents

Executive Summary and Recommendations.....	iv
Context and Background.....	1
Purpose of review	1
Scope and limitations.....	1
Methodology/Avenues of Inquiry	1
Literature Review	3
Research literature.....	3
Overview of forensic disability service systems in Australia	9
Human rights framework	9
Forensic disability service systems in Australian jurisdictions	10
<i>Australian Capital Territory</i>	10
<i>New South Wales</i>	11
<i>Northern Territory</i>	12
<i>South Australia</i>	13
<i>Tasmania</i>	14
<i>Victoria</i>	15
<i>Western Australia</i>	16
Description of the Queensland forensic disability service system	18
Legislation	18
Figure 1. Number of Forensic Orders (Disability) imposed by the MHC 2011-2017	20
Service components for the management of Forensic Orders	23
Forensic Disability Service	23
Authorised Mental Health Services	24
Specialist Disability Assessment and Outreach Team	26
Centre of Excellence	26
Key Issues Arising	28
Discussion and Recommendations	34
Governance structure	34
Legislation	40
Role, functions and powers of the Director of Forensic Disability	40
Regulation of restrictive practices	42
A new examination order	43
A new ‘step-down’ order	44
Decision-making presumption	45
Forensic Disability Service	47

Forensic Disability System	54
Indigenous Issues	61
Service Delivery Landscape	63
Disability Services in Broader Justice Context	66
References	70
Appendix A: Reference Group	73
Appendix B: Consultations	74

Executive Summary and Recommendations

In 2011, a new legislative regime for the management of people with intellectual or cognitive disability found unsound of mind or unfit to stand trial was established in Queensland with the enactment of the *Forensic Disability Act 2011* (Qld). The Act was introduced in response to the seminal report by Justice Carter which identified the need to develop a differentiated response to people with an intellectual or cognitive disability who interact with the criminal justice system. Responding to these concerns, the *Forensic Disability Act 2011* (Qld) established the Forensic Disability Service, a purpose-built, medium secure residential facility to provide for the care, support and protection of forensic disability clients, and amended the *Mental Health Act 2000* (Qld) to introduce a new Forensic Order (Disability), providing the Mental Health Court with the ability to differentiate between those with a mental illness and those with an intellectual or cognitive disability.

Since the introduction of *Forensic Disability Act 2011* (Qld), the number of Forensic Orders (Disability) imposed has continued to increase year on year, peaking in 2017 with the making of 32 new Forensic Orders (Disability). This growth contrasts sharply with the rate of revocations; since 2011, only 14 Forensic Orders (Disability) have been revoked, with the result that there are significantly more people entering the forensic disability service system than exiting it. As at 1 December 2017, a total of 97 people were on Forensic Orders (Disability). Six people were detained to the Forensic Disability Service, with the remaining 91 people managed by an Authorised Mental Health Service across all Queensland regions. A further 64 people with a co-occurring mental illness and intellectual disability or cognitive impairment were managed by Authorised Mental Health Services on a Forensic Order (Mental Health). With this increase in the forensic disability population, it is important to ensure that a fair and effective system for the care and support of people with an intellectual or cognitive disability on Forensic Orders, and for the protection of community safety, is in operation.

This independent review was undertaken under contract to the Queensland Government acting through Queensland Health and the Department of Communities, Child Safety and Disability Services (DCCSDS). The purpose of the review is to examine Queensland's forensic disability service system and make recommendations regarding the delivery of services within that system, which will lead to effective and efficient outcomes for clients and the community. The focus of the review is on the current services and support provided to individuals with intellectual disability subject to Forensic Orders made under the *Mental Health Act 2016* (Qld). In examining the current services and support, the review has also considered the interrelationships and connections between the services, systems, laws and oversight mechanisms within the forensic disability service system, as well as the policies, laws and service delivery that relate to the making, exercising, review and administration of forensic orders for people with an intellectual disability.

Additionally, this review has considered the best legislative and administrative arrangements for portfolio responsibility for the delivery and operation of the system, the efficacy of existing oversight and monitoring mechanisms, and whether any improvements could be made which better meet the needs of individuals in the forensic disability system.

Importantly, the review does not examine the mental health system to the extent that it does not relate to individuals with an intellectual disability who are subject to a Forensic Order. Nor does it investigate specific circumstances of individuals currently subject to a Forensic Order or develop options for the policies and procedures providing for the day-to-day operation of services within the system.

The methodological approach to the review process involved:

- Extensive consultations across a broad range of stakeholder groups, including government agencies with functions directly relevant to the review, non-government organisations, advocacy groups, and consumers (see Appendix B).
- Site visits to the Forensic Disability Service, The Park Centre for Mental Health, and various mental health facilities that form part of the Townsville Mental Health Service Group, including the Adult Acute Mental Health Inpatient Unit, the Secure Mental Health Rehabilitation Unit and the Townsville Community Care and Acquired Brain Injury Unit;
- Review of legislative, policy and program documents relating to the Queensland forensic disability service system; and
- Ongoing consultation and oversight provided by a Reference Group (see Appendix A).

The review also examined the research literature regarding forensic disability service models and outcomes. While empirical analysis of the effectiveness, efficiency or outcomes of different service models is limited, the emerging consensus is that a range of integrated complementary services, from secure inpatient settings (offering different levels of security) to specialist community services, provides the best option for securing positive outcomes for both offenders with an intellectual disability and the community. Central to this integrated service model is the development and prioritisation of effective community services which include strong risk assessment and management expertise, multidisciplinary input, provision of a range of targeted interventions, and interagency collaborative relationships with stakeholders. Additionally, researchers have argued that the integration of community-based teams with inpatient services is essential to the provision of good continuity of care. In particular, community forensic disability services, including appropriate step-down facilities, have been identified as playing an essential role in the provision of a clear care pathway for people discharged from secure inpatient facilities. However, academic commentary has acknowledged that inpatient settings remain crucial to the provision of assessment, formulation, care and interventions to people with complex presentations or who present risks above the threshold for safe management in the community. For this group, the literature argues in favour of specialist inpatient services for offenders with an intellectual disability that caters to their unique set of clinical and criminogenic needs rather than being accommodated within general mental health services.

The review also provided an overview of forensic disability service systems in Australian jurisdictions, highlighting that the way in which people with an intellectual disability who offend are managed across jurisdictions is highly variable, with most jurisdictions not having

a separate forensic disability service. What is consistent across the jurisdictions is the challenge that the forensic disability population presents in regard to service provision, resourcing and workforce expertise.

Overall, the review found that there is a high level of recognition across all stakeholders of the complex nature of the forensic disability population and the need for specialist expertise to address their unique clinical and criminogenic needs. However, a consistent theme that emerged during the consultation process across the broad range of different stakeholder groups was that there are significant service gaps in the way in which the forensic disability cohort (including those on a Forensic Order (Mental Health) with a co-occurring intellectual or cognitive disability) are being managed in the current forensic disability service system. Accordingly, a number of areas were identified where improvements could be made, with the following key findings and ensuing recommendations providing opportunities for service improvements.

Governance structure

The governance structure, decision-making pathways, and clinical reporting lines for the delivery of forensic disability services is fragmented and unclear, as is the interface between the multitude of agencies involved in the provision of care to people on Forensic Orders (Disability), including the Director of Forensic Disability, DCCSDS, the Chief Psychiatrist, the Queensland Health, Authorised Mental Health Services, and non- government organisations. The confusion is further compounded by the division that has been legislatively drawn between the small proportion of the forensic disability cohort detained to the FDS (who fall under the responsibility of the Director of Forensic Disability) and the vast majority of Forensic Orders (Disability) that are managed in the community under the responsibility of the Authorised Mental Health Services (which disclaim specialist skills to manage clients with forensic disability) and the Department of Health, with clinical oversight provided by the Chief Psychiatrist. Despite this shared responsibility for the forensic disability cohort, there are no formal mechanisms for communication and coordination across the two legislative offices. Additionally, the separation of the forensic disability cohort into these two groups means that there is a lack of whole-of-system practice leadership, monitoring, direction and oversight. As a result of this division in governance and oversight, significant confusion, inertia and fragmentation has developed amongst the services involved in the provision of support and care to the forensic disability cohort.

Recommendations

- 1 (a) The forensic disability service system and the mental health system should be brought together within a single agency, under the auspices of Queensland Health. A single agency framework would minimise duplication of existing infrastructure and service structures. It also has the ability to facilitate alliances and bridge the current divisions between the forensic disability and mental health sectors which may, in turn, support continuity of care and promote further development of forensic disability expertise.

- (b) Should a single agency framework be adopted in the Department of Health, it must not be subsumed by mental health. Rather, a division of forensic disability should remain to ensure that forensic disability expertise is retained and 'ring-fenced' within the system, and amendments to relevant legislation, including the *Mental Health Act 2016* (Qld), will be required to ensure that legislative safeguards specific to the forensic disability population are put in place.
- (c) As noted elsewhere in this report, the Director of Forensic Disability should be retained to provide specialist oversight to the forensic disability population.
- (d) A single agency system would need to ensure that contemporary best practice principles for the assessment, management and intervention of the forensic disability population are implemented.
- (e) While substantive expertise and a degree of autonomy is required, there are areas where integration between the forensic disability and mental health may be appropriate include (e.g., management of legislative requirements for people on forensic orders (including in relation to court and tribunal processes), data monitoring, reporting and recording of clinical notes, some clinical positions within Authorised Mental Health Services, oversight mechanisms for clinical standards, and staff training and development).
- 2 Establish a clear governance framework for the delivery of forensic disability services, including clear clinical reporting lines and decision-making and escalation pathways, to address the current disconnect between disability and mental health services involved in the care and support of the forensic disability cohort and ensure that services are delivered in an effective, coordinated and accountable way.
 - 3 Expand the role of the Office of the Director of Forensic Disability to provide clinical leadership and oversight of the provision of services to all patients on a Forensic Order (Disability) (not just those detained to the Forensic Disability Service). Mechanisms should also be put in place to formally allow the Office of the Director of Forensic Disability to provide expertise and support to Hospital and Health Services managing patients on a Forensic Order (Mental Health) who have a co-occurring intellectual disability.
 - 4 Formalise relationships across relevant stakeholders. In particular, formal interfaces need to be established between the Director of Forensic Disability and Queensland Health, including the Office of the Chief Psychiatrist.
 - 5 Following transition to the NDIS, ensure that the clinical expertise and governance functions currently undertaken by the Centre of Excellence for Clinical Innovation and Behaviour Support, particularly the provision of support, performance monitoring and operational oversight to services involved in the care and support of people with disabilities, as well as the regulation of restrictive practices in disability services, be retained by a government agency of some form. This could be achieved by either

preserving the operation of the Centre of Excellence or by re-establishing a position akin to the Office of the Senior Practitioner in other Australian jurisdictions.

- 6 Establish information and reporting systems that enable timely access to comprehensive information regarding the forensic disability cohort in order to measure service outcomes and client trajectories, report against key performance indicators, and engage in effective strategic planning and resource allocation. This may include the establishment of a central register of orders which records the number of people on Forensic Orders (Disability) at any one time, the Hospital and Health Services regional location of people on orders, the offending profile of the cohort, and the length of time people have remained on orders. Some of this information is systematically maintained in Consumer Integrated Mental Health Application (CIMHA). As such this recommendation could be satisfied, in part, by enabling the Director of Forensic Disability and the Centre of Excellence (or equivalent Office of the Senior Practitioner) to access CIMHA.

Legislation

The overarching purpose of the legislative framework that underpins Queensland's current forensic disability service system is commendable. However, the review identified some aspects of the *Forensic Disability Act 2011* (Qld) and the *Mental Health Act 2016* (Qld) that may benefit from amendment if that overarching purpose is to be better operationalised.

Under the current legislative arrangements, despite the specialist nature of the office, the Director of Forensic Disability has no role in relation to the care and support of the majority of people on Forensic Orders (Disability) who instead fall under the oversight of the Chief Psychiatrist under the *Mental Health Act 2016* (Qld). This would seem to be inconsistent with the purpose and intention of the Carter Report, which advocated for specialist forensic disability services that deemphasised the medical model. Additionally, while the *Mental Health Act 2016* (Qld) provides that the Director of Forensic Disability may elect into MHC references where the defendant has an intellectual disability or cognitive impairment, the MHC has interpreted this power restrictively as enabling the Director to elect only into references where admission to the FDS is being considered.

Second, a different regulatory regime currently applies to people detained to the FDS (in relation to which the use of restrictive practices is regulated by the *Forensic Disability Act 2011* (Qld)) and those managed by an AMHS receiving disability services (who are subject to the restrictive practices regime under the *Mental Health Act 2016* (Qld) if detained as an inpatient in an AMHS or the restrictive practices framework under the *Disability Services Act 2006* (Qld) if receiving disability services whilst being managed in the community). This has resulted in a disjointed approach to the regulation of restrictive practices for those people detained to the FDS, particularly given that the *Disability Services Act 2006* (Qld) applies to them in other circumstances (such as while undertaking community treatment).

Third, underpinning the *Forensic Disability Act 2011* (Qld) is a strong rehabilitative focus reflecting the vision of a residential treatment facility that caters to clients who could benefit

from interventions and then transition back to the community. This vision has not, however, been translated into practice, with eight of the original intake of clients to the FDS being detained for a continuous period of more than five years. The consistent view amongst stakeholders was that many of the original clients detained to the FDS were inappropriately placed, resulting in these lengthy detention times and the development of a sense of hopelessness amongst both staff and clients. To ensure that the FDS meets its legislative aims, it is essential that those admitted are able to benefit from the interventions delivered by the service. The ability to detain a person, who has been identified as potentially suitable for admission, in the FDS for a short period for the purposes of assessment may assist in determining whether or not a person is likely to benefit from admission.

Fourth, the number of Forensic Orders (Disability) imposed by the MHC has steadily increased year-on-year since their introduction in 2011, with the number of new orders far exceeding the rate of revocations. In response to similar growth in the number of people placed on Forensic Orders (Mental Health), the option of a Treatment Support Order was introduced in the *Mental Health Act 2016* (Qld) which enables the MHC and the MHRT to impose a less restrictive form of order than a Forensic Order in relation to people with a mental illness. Currently, however, the option of a similar 'step-down' order is not available to people with an intellectual disability who come into contact with the criminal justice system.

Finally, it is clear that significant barriers to the revocation of Forensic Orders (Disability) exist, with only 14 Orders revoked since their introduction. An important element in the progression of the forensic disability population is the role of the MHRT, the key decision-making body responsible for the review and revocation of orders. The review was informed that the MHRT has traditionally taken a conservative approach to its assessment of risk and has found it difficult to envisage a transition pathway to revocation for people on Forensic Orders (Disability). This risk-averse approach is facilitated by the operation of a decision-making presumption in favour of maintaining an order to protect community safety. Compounding the legal issues is the stark reality that the accommodation and service options for patients on Forensic Orders (Disability) are very limited and most do not effectively address their disability issues, which can only impact negatively on prospective assessments of community safety by decision-makers.

Recommendations

- 7 Expand the cohort of people for whom the Office of the Director of Forensic Disability is responsible to include all people on Forensic Orders (Disability), including both those detained to the Forensic Disability Service and those managed by Authorised Mental Health Services.
- 8 Continue the Director of Forensic Disability as an independent governor in council appointment. The position should have authority equivalent to the Chief Psychiatrist and should sit independently of the Department responsible for the administration of the FDS. Provide the Director of Forensic Disability with the right to appear as a party in all Mental Health Court references concerning people with an intellectual or cognitive

- disability, rather than only those matters where admission to the Forensic Disability Service is being considered.
- 9 To ensure consistency with complementary legislation and avoid fragmentation, there is a need to establish a restrictive practices framework for people detained in the Forensic Disability Service that mirrors that set out in the *Disability Services Act 2006* (Qld).
 - 10 Consider introducing an examination and assessment order, similar to the Court Examination Order under the *Mental Health Act 2016* (Qld), that enables the Mental Health Court to detain a person to the Forensic Disability Service for a set period of time for the purpose of assessing suitability for admission and capacity to engage. The introduction of such an order could help reduce the likelihood of people being detained in the Forensic Disability Service who are unsuitable and may become held in the facility inappropriately.
 - 11 Consider introducing a less restrictive form of Forensic Order, similar to a Treatment Support Order, to provide equal opportunities for people with an intellectual disability to be managed in the least restrictive way possible and promote transition through the system by providing the MHRT with a 'step-down' option to revocation.
 - 12 Introduce a decision-making presumption, similar to that applying to the Mental Health Review Tribunal when reviewing treatment authorities under the *Mental Health Act 2016* (Qld), that requires the Mental Health Review Tribunal to reduce the level of supervision of a person on a forensic order unless satisfied that a more restrictive level of supervision is required in order to protect the safety of the community, including from the risk of serious harm to people or property. As recommended in Recommendation 5, the introduction of a less restrictive form of Forensic Order, similar to a Treatment Support Order, would allow for people on Forensic Orders (Disability) to be managed at different levels of supervision.

Forensic Disability Service

The principles underpinning the establishment of the FDS are commendable. However, a clear and consistent view across stakeholders was that the FDS has not functioned as envisaged. Numerous issues were identified. First, unacceptably lengthy detention times have been the norm, with the original intake of nine clients all being detained for more than five years. This goes against the purported strong rehabilitative focus of the FDS (as opposed to offering a place of indefinite containment) and its aim of reintegrating clients to the community. The difficulty of transitioning clients from the service has been compounded by the isolation and separation of the FDS from the wider disability and mental health sectors, having been established in the absence of a coherent service strategy and with no clear linkages and exit pathways for clients to the wider service system. Additionally, the carving out of the small group of clients detained to the FDS from the wider service system in which the majority of people on Forensic Orders (Disability) fall under the responsibility of Queensland Health has created significant systemic barriers to transition. The siloed operation of the FDS means that

the transition of a client from the FDS to the community requires the agreement of the Chief Psychiatrist, despite the current lack of a formal interface between the Director of Forensic Disability and the Office of the Chief Psychiatrist.

The isolation of the FDS has also had a significant impact on the workplace culture within the service which was variously described by FDS staff as “toxic”, “dysfunctional”, and “disorganised.” Additionally, intimations of disharmony, bullying and unhappiness were conveyed. Common issues raised by FDS staff included significant division between support and administrative staff, unclear management structure, a lack of role clarity in the staffing profile, inconsistent adherence to policies and procedures, a lack of communication, consultation and practice supervision, and inconsistent delivery of therapeutic programs.

Despite these numerous issues, the FDS also has a number of strengths. The facility itself is well-designed, well-resourced and well-staffed by people with a range of different skills and expertise, many of whom expressed dedication to working with the clientele. It should also be acknowledged that the FDS provides a valuable service in managing the small number of people with an intellectual disability or cognitive impairment who engage in serious challenging behaviours that present a high risk to the safety of themselves and the community. Nevertheless, whilst acknowledging these strengths, it is clear that the FDS is not functioning as intended.

Recommendations

- 13 Retain the Forensic Disability Service as a statewide secure residential treatment service in order to meet the needs of the small number of people with an intellectual disability or cognitive impairment who engage in serious challenging behaviours that present a high risk to the safety of themselves and the community. While it should be retained as a statewide secure residential treatment service, a clear model of service needs to be established that embeds the FDS within the wider service system, including clear linkages and pathways for transition, to ensure patient flow and continuity of care for forensic disability clients returning to the community.
- 14 Establish a clear organisational and governance structure for the operation of the Forensic Disability Service. Depending how the Forensic Disability is established going forward, it would also be critical to articulate clear clinical (disability) governance structures for both FDS clients and the broader forensic disability and dual disability client group.
- 15 Review the staffing profile of the Forensic Disability Service to increase efficiency and ensure that it aligns with the model of care. This would include ensuring that there should be a multidisciplinary team approach in the Forensic Disability Service.
- 16 Re-allocate some existing staff of the Forensic Disability Service to provide statewide assessment and outreach services, and deliver adapted rehabilitative programs targeting criminogenic factors associated with offending behaviour to the whole forensic disability population.

- 17 Ensure that clear organisational policies and procedures for the operation of the Forensic Disability Service are implemented effectively and consistently across the service.
- 18 Consider making orders which detain people to the Forensic Disability Service for a time-limited period of 18-24 months, with the authority for the Mental Health Review Tribunal to renew the order on expiration only if further benefit would be achieved by a person remaining at the service for an additional period of time. Given the limited options in existence to manage people on Forensic Orders (Disability), the AMHS, with the support of the Director of Forensic Disability and the Senior Practitioner/Centre of Excellence, would need to take responsibility for assisting with the management of the person's care.

Forensic Disability System

As noted earlier, many of the issues associated with the FDS stem from the fact that it is not embedded within a wider service system. Additionally, the narrow remit of the Director of Forensic Disability means that the vast majority of people subject to Forensic Orders (Disability) continue to be managed by mental health services without access to specialist forensic disability expertise. This is despite the criticisms of this situation by Justice Carter who observed that "a mental health service has nothing to offer a person who does not have a mental illness". That the current system requires AMHS to accommodate, care for and manage people with an intellectual disability or cognitive impairment, but not a mental illness, is the cause of much consternation. Stakeholders' central concerns related to problems of service delivery, lack of forensic disability expertise and inappropriate infrastructure, with mental health units providing a poor fit for the needs of those with an intellectual disability. Some stakeholders also expressed concern about the required divestment of scarce mental health resources to the management of people with an intellectual disability and the consequential departmental conflict over roles and responsibilities in relation to the forensic disability population.

The lack of clear linkages and transition pathways to more appropriate services in the community also raises the very real danger of extended admissions and resultant institutionalisation. In this sense, while the lengthy periods of detention that have characterised admissions to the FDS is of concern, the lack of appropriate services in the community raises a similar danger for forensic disability clients of indefinite containment in discharge accommodation that has been designed to accommodate the needs of a completely different client group. This occurs on the backdrop of significant inter-departmental challenges created by the need for the FDS to traverse the mental health system in order to transition clients from the service.

In summary, then, many of the concerns identified in the Carter Report continue to pervade the current forensic disability service system which is fragmented, under-resourced and lacking in a clear supervision and management pathway.

Recommendations

- 19 Establish a decentralised ‘hub and spoke’ model for the delivery of forensic disability services by establishing regional forensic disability service ‘hubs’ in the North, Central, South East and South West areas of Queensland to provide outreach services to regional and remote areas within the existing AMHS/HHS framework.
- 20 Given the limited accommodation options for people on Forensic Orders (Disability) and the growing number of people on such orders, Queensland should explore alternative accommodation options over time. Such options might include, for example, supported forensic disability accommodation operated and staffed by NGOs with expertise in the management and support of disabled offenders.
- 21 Establish multidisciplinary teams in the forensic disability service ‘hubs,’ comprising medical, psychiatric, nursing, psychology and allied health professionals possessing a range of skills and competencies across mental health, disability and forensic issues, including the administration of clinical and risk assessment tools relevant to the forensic disability population. These multidisciplinary teams will enhance the capacity of Authorised Mental Health Services to meet the needs of the forensic disability cohort, as well as the needs of other clients of Authorised Mental Health Services who have an intellectual disability or cognitive impairment. Particular priority should be given to addressing the current lack of access to neuropsychological expertise.
- 22 Harness and develop existing forensic disability expertise via workforce development and provision of cross-systems training, education and supervisory opportunities within the mental health and broader service sector. Consideration should be given to engaging the University of Queensland to expand its existing expertise in intellectual disability into forensic disability.
- 23 Enhance staff training, leadership development, professional development, and research opportunities in the area of forensic disability amongst Authorised Mental Health Service staff in order to enhance the expertise and capacity of Authorised Mental Health Services to manage the specialist needs of the forensic disability cohort.
- 24 Address the current lack of expertise and resources in Authorised Mental Health Services to manage the specialist needs of the forensic disability cohort (including those on Forensic Orders (Disability) and those on Forensic Orders (Mental Health) with a co-occurring cognitive disability) by establishing a network of Disability Forensic Liaison Officers. As the service system is developed, consideration will need to be given as to the most appropriate and efficient model for the operation and oversight of the DFLO network across Queensland. Variations on the model may be required to better satisfy the needs of regions with a critical mass of forensic disability clients and those with few such people.
- 25 Address the current absence of a clear supervision and management pathway for people on Forensic Orders (Disability) by establishing step-down facilities in regional ‘hubs’ to facilitate graduated community transition from the Forensic Disability Service

and inpatient units within Authorised Mental Health Services (the latter of which are not designed to meet the care, support, habilitation and rehabilitation needs of the forensic disability cohort).

Indigenous issues

As at December 2017, indigenous clients comprised approximately one-third of the forensic disability population. Of the 97 people on Forensic Orders (Disability), 30% were Aboriginal or Torres Strait Islander, with a similar proportion (29%) of Indigenous clients amongst the 64 people on Forensic Orders (Mental Health) with a co-occurring intellectual disability. Half of the six people detained to the FDS at the time of the review identified as Aboriginal. Such high numbers are unsurprising – but nonetheless greatly disconcerting – given that Aboriginal and Torres Strait Islander people are both over-represented in criminal justice systems across Australia and are more likely to experience cognitive disabilities compared to non-Indigenous people.

It is essential that Indigenous people on Forensic Orders have access to culturally responsive and appropriate interventions and services. This includes access to translation, interpretation and plain language cross-cultural communication services. While this was universally acknowledged throughout the consultation process, stakeholders identified numerous concerns about the ability of the current forensic disability service system to meet this need. Additionally, just as there is a need to embed cultural competency within service delivery models, so too is there a need to provide Indigenous people on Forensic Orders with culturally appropriate assistance and support when navigating the legal system.

Recommendations

- 26 Ensure that culturally competent standards, policies and services be implemented at systemic, organisational and individual levels across the forensic disability service sector to ensure that Aboriginal and Torres Strait Islander people on Forensic Orders (Disability) have access to culturally responsive and appropriate interventions and services, including access to translation, interpretation and plain language cross-cultural communication services.
- 27 Strengthen the cultural competency of the Mental Health Review Tribunal by increasing the number of Indigenous Tribunal Members and assigning those members to hearings involving Aboriginal and Torres Strait Islander people.

Service delivery landscape

One of the challenges of the review concerned the considerable uncertainty amongst stakeholders regarding the impact of the NDIS on the forensic disability service system. Transition to the NDIS is due to be completed by mid-2019, at which time the DCCSDS will cease to offer state-wide disability services and existing disability services regions will be dissolved. What this means for the forensic disability population is unclear. Particular areas of concern raised by stakeholders include uncertainty about who will provide court reports and

assessments to the MHC and MHRT and how they will be funded, the extent to which the NDIS will support the needs of the forensic disability population and how the NDIS will distinguish between disability and criminogenic needs, how people will access support to meet forensic and supervisory needs that the NDIS determines are not specifically related to their disability, and how 'market failure' is to be addressed in relation to people with complex disabilities and difficult behaviours who are unable to engage a willing or suitable service provider through the NDIS. Concern regarding the extent to which specialist skills in forensic disability and opportunities for ongoing staff development, training, mentoring and expert consultancy will be available in the NDIS environment were also raised.

These multiple concerns regarding the potential impact of the NDIS on the forensic disability population urgently need to be considered and resolved.

Recommendations

- 28 As a matter of priority, consider and address the considerable uncertainties surrounding the potential impact of the National Disability Insurance Scheme on the forensic disability services system in Queensland.
- 29 NDIS legislation requires that each state establish arrangements for 'provider of last resort' services to meet service needs where a care provider has withdrawn or cannot be found. The Queensland Government will need to consider whether, at full scheme transition to the NDIS, the National Disability Insurance Agency will provide adequate support and services to people who transition out of the forensic disability service system and into the community. In the event that a person may not be able to access the services required to address their specific criminogenic needs, the Queensland Government should consider how it will address these support and service delivery gaps. It is important to establish and frame the provider of last resort in a contemporary disability service provision model and not default to ongoing detention in mental health facilities.
- 30 Allocate resources for the continued provision of court reports and assessments to the Mental Health Court and the Mental Health Review Tribunal, following transition to the National Disability Insurance Scheme, in matters involving people with an intellectual disability.

Context and Background

Purpose of review

The purpose of the review is to examine Queensland's forensic disability service system and make recommendations regarding the delivery of services within that system, which will lead to effective and efficient outcomes for clients and the community.

Scope and limitations

Under the terms of reference, the focus of the review is on the current services and support provided to individuals with intellectual disability subject to Forensic Orders made under the *Mental Health Act 2016* (Qld). In examining the current services and support, the review also extends to considering the interrelationships and connections between the services, systems, laws and oversight mechanisms within the forensic disability service system, as well as the policies, laws and service delivery that relate to the making, exercising, review and administration of forensic orders for people with an intellectual disability.

Additionally, the review considers the best legislative and administrative arrangements for portfolio responsibility for the delivery and operation of the system, the efficacy of existing oversight and monitoring mechanisms, and whether any improvements could be made which better meet the needs of individuals in the forensic disability system.

The review does not examine the mental health system to the extent that it does not relate to individuals with an intellectual disability who are subject to a Forensic Order.¹ Nor does it investigate specific circumstances of individuals currently subject to a Forensic Order or develop options for the policies and procedures providing for the day-to-day operation of services within the system.

Methodology/Avenues of Inquiry

Each stage of the review process was guided by a reference group comprising individuals with roles and expertise in matters relevant to the reference (see Appendix A).

The review utilised the following methodology:

- Extensive consultations across a broad range of stakeholder groups, including government and non-government organisations, advocacy groups, and consumers (see Appendix B).
- Site visits to the Forensic Disability Service, The Park Centre for Mental Health, and various mental health facilities that form part of the Townsville Mental Health Service Group, including the Adult Acute Mental Health Inpatient Unit, the Secure Mental Health Rehabilitation Unit and the Townsville Community Care and Acquired Brain Injury Unit;

¹ At the time of the review, Queensland Health was also conducting a review of the forensic mental health service, with the aim of exploring options for establishing an integrated statewide forensic mental health service.

- Review of legislative, policy and program documents relating to the Queensland forensic disability service system; and
- Review of research literature, including grey literature, and a consideration of the service models employed in jurisdictions across Australia.

Literature Review

Research literature

In the last three decades, there has been an increase in research attention focused on people with an intellectual disability or cognitive impairment who engage in offending behaviour. This growing interest in forensic disability has, in part, been a product of the deinstitutionalisation and community care movements of the 1980s, which resulted in a reduction in institutional places to which offenders with a disability might have been diverted, and the exposure of greater numbers to the risk of offending behaviour.² The consequent challenges posed by the expanding forensic disability cohort to the judicial system, combined with a political agenda emphasising public protection,³ have led to recognition of the need for evidence-based responses and services that meet the needs of offenders with an intellectual disability. Consequently, in recent years, there have been numerous government reports⁴ and an increased research focus on various aspects of the forensic disability population.

Much of this research has been focused on prevalence studies, life trajectories, support needs, risk assessment and management, and characteristics of people with an intellectual disability who offend.⁵ In regards to the latter, the consistent empirical picture of the forensic

² William Lindsay et al., 'A community forensic intellectual disability service: Twelve year follow up of referrals, analysis of referral patterns and assessment of harm reduction' (2006) 11 *Legal and Criminological Psychology* 113; William Lindsay et al., 'The relationship between assessed risk and security level for offenders with intellectual disabilities' (2010) 21 *Journal of Forensic Psychiatry and Psychology* 537.

³ Carl Benton and Ashok Roy, 'The first three years of a community forensic service for people with a learning disability' (2008) 10 *British Journal of Forensic Practice* 4.

⁴ See, e.g., Australians for Disability Justice, Submission No PP342 to Productivity Commission, *The provision of services under the NDIS for people with disability who are in contact with the criminal justice system*, March 2017; Brendan Butler SC, 'Promoting Balance in the Forensic Mental Health System: Final Report' (Report, Queensland Government, December 2006); Honourable Justice William Carter QC, 'Challenging Behaviour and Disability: A Targeted Response' (Report, Queensland Government, July 2006) ('Carter Report'); New South Wales Law Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: criminal responsibility and consequences*, Report No 138 (2013); Senate Standing Committee on Community Affairs, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* (2016); Jim Simpson, Meredith Martin and Jenny Green, 'The Framework Report: Appropriate community services in NSW for offenders with intellectual disabilities and those at risk of offending' (Report, New South Wales Council for Intellectual Disability, 2001).

⁵ See e.g. Shasta Holland and Peter Persson, 'Intellectual disability in the Victorian prison system: characteristics of prisoners with an intellectual disability released from prison in 2003–2006' (2011) 17 *Psychology, Crime and Law* 25; William Lindsay et al., 'Risk assessment in offenders with intellectual disability' (2008) 52 *International Journal of Offender Therapy and Comparative Criminology* 90; Lindsay et al., 'The relationship between assessed risk and security level for offenders with intellectual disabilities', above n 1.

disability client that has emerged is one of marginality and entrenched disadvantage often involving a history of lengthy institutionalisation, abuse and neglect, stigma, homelessness, unemployment and victimisation.⁶ Yet despite the complexities of the cohort, research in the area of forensic disability service models and outcomes has been comparatively limited, with the majority of research in this area consisting of reports on programs rather than empirical evidence or analysis on the effectiveness, efficiency or outcomes of different service models. Thus, while we have a solid empirical picture of the forensic disability population and their support needs, there remains a lack of empirical clarity as to what optimal support, care, and management entails for the cohort, despite being the focus of much debate and government policy. Nevertheless, it is possible to identify an emerging consensus as to what constitutes 'best practice'.

Following deinstitutionalisation, the question of what was the best form of service provision for people with an intellectual disability who presented challenging behaviour was the subject of debate. As presciently summarised by Mackenzie-Davies and Mansell:

On the one hand, it was argued that special units should be set up to provide backup to community services, to cope with placement breakdown, and to provide specialist assessment and treatment in more-controlled circumstances and with more expert staff than community-based services could provide ... On the other, critics suggested that such units would not help develop the capacity of community services, would fill up with people for whom no suitable long-term placement could be found, would mix residents with very different needs and, thereby, risk perpetuating models of congregate care consistently shown to be of poor quality.⁷

Empirical studies of specialist forensic disability units indicate that some of the latter concerns have indeed been borne out. Thus, while studies suggest that such units are successful in providing short-term assessment and interventions, difficulties are encountered when attempting to transition people to suitable alternative placements in the community, resulting in delayed discharges and 'bed-blocking'.⁸ Additionally, research indicates that positive behaviour change is unlikely to be maintained unless clients have an opportunity to

⁶ Jeffrey Chan, Phillip French, Colin Hudson and Lynne Webber, 'Applying the CRPD to Safeguard the Rights of People with a Disability in Contact with the Criminal Justice System' (2012) 19 *Psychiatry, Psychology and Law* 558; Tony Holland, Isabel Clare and Tanni Mukhopadhyay, 'Prevalence of 'criminal offending' by men and women with intellectual disability and the characteristics of 'offenders': implications for research and service development' (2002) 46 *Journal of Intellectual Disability Research* 6; S. Shepherd, J. R. P. Ogloff, Y. Paradies, & Pfeifer, J. E., 'Aboriginal prisoners with cognitive impairment: Is this the highest risk group?' (2017) 537 *Trends and Issues in Crime and Criminal Justice* 1.

⁷ Naomi Mackenzie-Davies and Jim Mansell, 'Assessment and treatment units for people with intellectual disabilities and challenging behaviour in England: an exploratory survey' (2007) 51 *Journal of Intellectual Disability Research* 802, 802-3.

⁸ Ibid; Benton and Roy, above n 2; Ceri Richings, Rachael Cook and Ashok Roy, 'Service evaluation of an integrated assessment and treatment service for people with intellectual disability with behavioural and mental health problems' (2011) 15 *Journal of Intellectual Disabilities* 7.

progress to the community.⁹ Consequently, the notion that inpatient and community services are an ‘either or’ proposition has been rejected in the research literature, with general agreement that a range of complementary services, from secure inpatient settings (offering different levels of security) to specialist community services, provides the best option for securing positive outcomes for both offenders with an intellectual disability and the community.¹⁰

Central to this integrated service model is the development and prioritisation of effective community services. While limited in number, evaluations of community forensic disability teams have been overwhelmingly positive.¹¹ Benefits noted include reduced reliance on inpatient care, the ability to support people within the least restrictive setting close to home and social networks, increased cost-effectiveness when compared to inpatient care, and the facilitation of a care pathway for those discharged from secure inpatient facilities.¹² Additionally, studies demonstrate reduced offending rates and offending severity following the involvement of community forensic disability teams,¹³ which may be related to the finding that specialist community services were significantly more likely to provide treatment specifically designed to address offending behaviours, compared to mainstream disability and mental health services.¹⁴ This is particularly significant given outcome studies which indicate that the clinical and forensic needs of the forensic disability cohort often remain high after discharge from a secure inpatient setting¹⁵ and that “it is the long-term nature and quality of

⁹ David Sansom and Stuart Cumella, ‘One hundred admissions to a regional secure unit for people with a learning disability’ (1995) 6 *Journal of Forensic Psychiatry* 267.

¹⁰ Regi Alexander et al., “‘Why can’t they be in the community?’ A policy and practice analysis of transforming care for offenders with intellectual disability’ (2015) 9 *Advances in Mental Health and Intellectual Disabilities* 139; Morna Browning, Rosemary Gray and Rose Tomlins, ‘A community forensic team for people with intellectual disabilities’ (2016) 18 *Journal of Forensic Practice* 274; Verity Chester et al., ‘Discharging inpatients with intellectual disability from secure to community services: risk assessment and management considerations’ (2017) 11 *Advances in Mental Health and Intellectual Disabilities* 98.

¹¹ Browning, Gray and Tomlins, above n 9; Benton and Roy, above n 2; Shamim Dinani et al., ‘Providing forensic community services for people with learning disabilities’ (2010) 1 *Journal of Learning Disabilities and Offending Behaviour* 58.

¹² Browning, Gray, Tomlins, above n 9.

¹³ Browning, Gray, Tomlins, above n 9; Benton and Roy, above n 2; Dinani et al., above n 10.

¹⁴ William Lindsay et al., ‘Responsivity to criminogenic need in forensic intellectual disability services’ (2013) 57 *Journal of Intellectual Disability Research* 172.

¹⁵ Regi Alexander et al. ‘Long-term outcome from a medium secure service for people with intellectual disability’ (2006) 50 *Journal of Intellectual Disability Research* 305.

the social care provided that is likely to be particularly critical in minimizing the risk of further difficulties".¹⁶

Thus there is reasonable evidence that much of the forensic disability population, albeit complex, can be managed successfully and safely in the community, provided that appropriate specialist resources are available. Areas of good practice within effective community forensic disability services that have been identified include:

- strong risk assessment and management expertise;
- multidisciplinary input to individualised engagement, assessment, formulation and intervention (including psychiatry, psychology, nursing, speech and language therapy, and occupational therapy);
- the provision of a range of targeted interventions, and;
- the fostering of interagency collaborative relationships with stakeholders, including mental health teams and criminal justice agencies.¹⁷

In regards to programs, the research literature argues that interventions need to be evidence-based and designed, implemented and monitored by specialist staff.¹⁸ Additionally, Hayes argues that:

Collection of appropriate baseline data for every client is vital, and participation in the program needs to continue for as long as is necessary to address the behaviours, rather than being time limited according to waiting lists and cost. Furthermore, the program must be reinforced periodically, on a long-term basis. All of the systems and services which assist the individual must be involved in the program in a consistent and integrated fashion.¹⁹

There is some debate in the research literature as to whether community forensic disability services should operate independently of generic mental health or disability teams as a parallel service, or as an integrated service where specialist forensic clinicians work within general services to provide support to clients with forensic needs.²⁰ While there has been no formal evaluation of parallel vs integrated forensic services within an intellectual disability

¹⁶ Holland, Clare and Mukhopadhyay, above n 5, 16. See also George Gaskell, Julie Dockrell and Hamid Rehman, 'Community care for people with challenging behaviours and learning disability: an evaluation of an assessment and treatment unit' (1995) 34 *British Journal of Clinical Psychology* 383.

¹⁷ Chester et al., above n 9; William Glaser and Daniella Florio, 'Beyond specialist programmes: a study of the needs of offenders with intellectual disability requiring psychiatric attention' (2004) 48 *Journal of Intellectual Disability Research* 591.

¹⁸ Simpson, Martin and Green, above n 3.

¹⁹ Susan Hayes, 'A Review of Non-custodial Interventions with Offenders with Intellectual Disabilities' (2005) 17 *Current Issues in Criminal Justice* 69, 75.

²⁰ Kenneth MacMahon and Ricky McClements, 'Working together: making the case for integrated forensic services for people with intellectual disabilities' (2015) 6 *Journal of Intellectual Disabilities and Offending Behaviour* 204.

setting, MacMahon and Clements have argued that the advantages of an integrated model include “availability of multi-disciplinary clinicians, development of forensic skills across wider groups of clinicians, reduction in stigma and avoidance of delay in transfer of care between services”.²¹ The avoidance of potential isolation of forensic services from other community services was also noted, as was the fact that, in areas with smaller populations, parallel services may not be feasible due to low case numbers.

Regardless of the service model, there is consensus in the research literature that it is essential that community-based teams are integrated with inpatient services in order to provide good continuity of care. In particular, community forensic disability services, including appropriate step-down facilities, have been characterised as playing an essential role in the provision of a clear care pathway for people discharged from secure inpatient facilities. Positive outcomes of an integrated care pathway between inpatient and community services include the provision of timely assessments, interventions, continuity of care and reduced lengths of stay, reducing the need to divert people to inpatient psychiatric facilities.²²

However, the research literature acknowledges that “even with the best trained community teams, it would be a mistake to assume that one can manage without any inpatient beds whatsoever”.²³ Thus, inpatient settings remain crucial to the provision of assessment, formulation, care and interventions to people with complex presentations or who present risks above the threshold for safe management in the community.²⁴ For this group, academic commentary has argued in favour of specialist inpatient services for offenders with an intellectual disability that caters to their unique set of clinical and criminogenic needs rather than being accommodated within general mental health services. Issues associated with the management of forensic disability clients within mental health units that have been identified include the lack of relevant disability and forensic expertise amongst staff, lack of access to appropriate interventions and targeted programs, the pace of ward life and the vulnerability of people with an intellectual disability to exploitation.²⁵ In regards to people with an intellectual disability and co-occurring mental health issues, a lack of research comparing outcomes of specialist inpatient services compared to mainstream psychiatric services makes

²¹ Ibid 204.

²² John Devapriam et al., ‘Impact of care pathway-based approach on outcomes in a specialist intellectual disability inpatient unit’ (2014) 18 *Journal of Intellectual Disabilities* 211; Alexander et al., above n 9.

²³ Alexander et al., above n 9.

²⁴ Alexander et al., above n 14; Devapriam et al., above n 21; Kiran Purandare and Anusha Wijeratne, ‘Reflections on the use of a specialist acute assessment and treatment unit for adults with intellectual disability’ (2015) 9 *Advances in Mental Health and Intellectual Disabilities* 132.

²⁵ Stuart Cumella, ‘Mental health services for people with a learning disability’ (2009) 3 *Advances in Mental Health and Learning Disabilities* 8; John Devapriam and Regi Alexander, ‘Tiered model of learning disability forensic service provision’ (2012) 3 *Journal of Learning Disabilities and Offending Behaviour* 175.

it difficult to draw any robust conclusions as to which is to be preferred.²⁶ Nevertheless, the indications are that “in services where mainstream psychiatric services are the only alternative, extra help and staff training appear to be necessary.”²⁷

Finally, research has noted the need for services to employ robust risk assessment and management processes in order to ensure that, in accordance with the principle of least restriction, people posing the highest level of risk managed in higher levels of security and with the highest level of expertise. This also has significant implications for the cost-effectiveness of services. While research is limited, a study by Lindsay et al. found a weak relationship across secure and community forensic disability services between risk and level of security.²⁸ Reasons postulated for the finding include a lack of confidence and a reluctance to accept and manage any individuals but those considered low risk by community teams, resulting in increased referrals to secure services in preference to maintaining that person in the community. This emphasises the need for comprehensive training and development of staff expertise in order to ensure that community services feel comfortable with the assessment, care and management of forensic disability clients.

²⁶ Robert Chaplin, ‘General psychiatric services for adults with intellectual disability and mental illness. 48 *Journal of Intellectual Disability Research* 1; Robert Chaplin, ‘New research into general psychiatric services for adults with intellectual disability and mental illness’ (2007) 53 *Journal of Intellectual Disability Research* 189.

²⁷ Chaplin, ‘New research into general psychiatric services’, above n 25, 197.

²⁸ Lindsay et al., ‘The relationship between assessed risk and security level for offenders with intellectual disabilities’, above n 1.

Overview of forensic disability service systems in Australia

Human rights framework

The delivery of forensic disability services in Australia is guided by ethical and human rights frameworks.

While the general human rights protections set out in the *International Covenant on Civil and Political Rights* and the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* are clearly applicable to the forensic disability cohort, the most significant statement by the international community on the human rights of people with a disability is set out in the *Convention on the Rights of Persons with Disabilities* (CRPD), which Australia ratified on 17 July 2008. Parties to the Convention are required to promote, protect, and ensure the full enjoyment of human rights by people with disabilities and ensure that they enjoy full equality under the law.

The guiding principles underpinning the CRPD include respect for inherent dignity, individual autonomy and independence, equality of opportunity and non-discrimination, and full and effective participation and inclusion in society. Articles of particular relevance to the way in which people with a disability are managed within the justice system include the following:

- Article 12 requires that people with a disability are given equal recognition before the law and that appropriate support measures are made available to enable them to exercise their legal capacity.
- Article 13 affirms equal access to justice for people with a disability.
- Article 14 requires that people with a disability enjoy the right to liberty and security, and are not deprived of their liberty unlawfully or arbitrarily. The Article further provides that “the existence of a disability shall in no case justify a deprivation of liberty”. It is unclear if this phrase should be interpreted to condemn any laws enabling the involuntary detention of individuals with a disability or if it applies more narrowly to disallow deprivation of liberty that is *solely* based on disability, as opposed to circumstances where other criteria such as the need for treatment or dangerousness co-exist with a disability. Regardless, Article 14(2) makes it clear that, where a person with a disability is deprived of their liberty through any process, they should be treated in compliance with the CRPD, including by provision of reasonable accommodation.
- Reflecting the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Article 15 provides that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment, while Article 16 prohibits exploitation, violence and abuse against people with a disability.
- Article 19 recognises the equal right of people with a disability to live, participate and be included in the community, with equal opportunity to choose their place of residence and living arrangements. The Article goes on to provide that people with a disability should have access to a range of in-home, residential and community support services to support community living and prevent isolation or segregation.

- Article 19 is supported by Article 26, which affirms the right to engage in comprehensive habilitation and rehabilitation services for the purpose of enabling people with a disability to attain and maintain maximum independence, and to support full inclusion and participation in all aspects of life.
- Article 22 affirms respect for privacy.
- Article 25 establishes the right to health and the non-discriminatory provision of services.
- Article 28 requires that people with a disability are provided with access to an adequate standard of living and social protection.

Forensic disability service systems in Australian jurisdictions

The way in which people with an intellectual disability who offend are managed across Australian jurisdictions is highly variable. Generally, specialised forensic disability services are not well developed, with most jurisdictions not having a separate forensic disability service. Accordingly, management and supervision of the forensic disability population tends to fall within the responsibility of forensic mental health services or correctional services, with general disability needs met under co-care arrangements with disability services (if at all). Additionally, most jurisdictions do not have a specialised inpatient service, resulting in many people with an intellectual disability on custodial orders being detained in prison or secure psychiatric facilities. Those who are managed in the community generally receive support from disability services, with oversight by forensic mental health services in some jurisdictions.

It should be noted that the forensic disability population has presented a challenge to all jurisdictions in regard to service provision, resourcing and workforce expertise. Uncertainties regarding the impact of the National Disability Insurance Scheme (NDIS) on the management of the cohort has also been identified as a significant concern across the jurisdictions.²⁹

Australian Capital Territory

The Australian Capital Territory (ACT) does not have a separate forensic disability service. Nor does it have a specialist inpatient facility for forensic disability clients. Following a finding of mental impairment or unfitness to plead, the *Mental Health Act 2015* (ACT) requires the court to refer the matter to the ACT Civil and Administrative Tribunal (ACAT) which is responsible for the making of a forensic mental health order. In relation to people with an intellectual disability or cognitive impairment, ACAT may make a Forensic Psychiatric Treatment Order (where a person has a co-occurring mental illness) or a Forensic Community Care Order. The

²⁹ See various submissions to the Joint Standing Committee on the National Disability Insurance Committee, The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition (2017).

latter order sets out the types of treatment, care or support a person is to receive and where the person is to live or be detained which may include an approved community care facility. While the Chief Psychiatrist is responsible for people placed on a Forensic Psychiatric Treatment Order, a Care Coordinator (a statutory appointment made by the Minister for Health) is responsible for coordinating the provision of treatment, care or support for a person to whom a Forensic Community Care Order applies. Management and supervision of people on a Forensic Community Care Order is undertaken by disability services; the ACT's Forensic Mental Health Service has no role in relation to offenders with an intellectual disability or cognitive impairment, unless they have a co-occurring mental illness.

Where there is no practicable alternative, forensic disability clients may be detained in a correctional facility (*Crimes Act 1900* (ACT) s 308(d)). There is no specific unit for detainees with an intellectual disability at the sole prison in the ACT, the Alexander Maconochie Centre.

New South Wales

While New South Wales (NSW) does not have a specialist inpatient unit for forensic disability clients, it does have a statewide community forensic disability service, known as Statewide Disability Services (SDS).

SDS comprises a multidisciplinary team that provides advice, programs and assessment of people with disabilities, including people found not guilty by reason of mental impairment or unfit to stand trial under the *Mental Health (Forensic Provisions) Act 1990* (NSW).

Following a finding of unfitness by a court, a person is referred to the Forensic Division of the Mental Health Review Tribunal (MHRT) for review of whether a person has a mental illness or a mental condition for which treatment is available in a mental health facility. The matter then returns to court, whereupon the court may make an order that the person be detained in a mental health facility or some other place, generally a correctional centre. Where a person is found not guilty by reason of mental impairment, there is no requirement for the court to obtain a determination from the MHRT regarding the person's mental illness or mental condition; the court may unconditionally release the person or make an order for conditional release or detention. Ongoing review and management of forensic clients is undertaken by the MHRT, which may make orders regarding a person's continued detention, care or treatment, and their release either unconditionally or subject to conditions. Reviews are conducted at least every six months.

The disability support needs of offenders, whether in custody or in the community, are addressed by the SDS. The SDS provides reports to the MHRT and links offenders with cognitive impairment to community agencies. The lack of a separate secure facility appropriate for offenders with an intellectual disability means that those forensic disability clients in NSW who cannot be managed in the community tend to be detained in correctional

centres.³⁰ In this regard, the SDS oversees the running of three Additional Support Units (ASUs) within Long Bay Correctional Centre which accommodate prisoners with cognitive impairments who require placement outside the general prison population. The ASUs comprise an assessment unit, a therapeutic programs unit and a pre-release unit that includes employment programs and post-release support programs.

Following the revocation of a forensic order, a person may be supported by the Community Justice Program (CJP). The CJP, operated by the Office of the Senior Practitioner, works with a range of non-government organisations to provide case management, behaviour intervention and accommodation services to people with an intellectual disability exiting the criminal justice system, and who are considered beyond the capacity of general disability services. It comprises five teams: Intake Team, Service Liaison Team (which provides advice and support to service providers), Assessment Team (including neuropsychological, risk and adaptive functioning assessments), Forensic Consultancy Team (which provides training and behaviour intervention services to service providers), and NDIS and Clinical Practice Standards Team (which monitors clinical practices, provides advice on policy matters and provides leadership in the transition to the NDIS).

The NSW forensic mental health service – Justice and Forensic Mental Health Network – has no role in relation to offenders with an intellectual disability or cognitive impairment, unless they have a co-occurring mental illness. Nor are forensic disability clients accommodated within the NSW Forensic Hospital.

Northern Territory

The Northern Territory does not have a separate forensic disability service. Similar to Victoria's scheme, following a finding of not guilty by reason of mental impairment or unfitness to stand trial under Part IIA of the *Criminal Code Act 1983* (NT), a person may be unconditionally released or declared liable to supervision and placed on a custodial or a non-custodial supervision order. Subsequent reviews of supervision orders and the decision to revoke an order is undertaken by the Supreme Court.

While the Criminal Code provides that people on a custodial supervision order are only to be detained in a correctional centre when there is no practicable alternative, the lack of a dedicated secure forensic disability facility means that people subject to custodial orders, including those with an intellectual disability, tend to be held in the Complex Behaviour Unit (within the walls of the Darwin Correctional Precinct), the John Bens Unit (a repurposed part of the maximum security wing of the Alice Springs Correctional Centre designed to cater for people on custodial supervision orders) or in the mainstream prison population. The Complex Behaviour Unit and the John Bens Unit accommodate both people with mental health disorders and those with cognitive impairments. Both are operated by the Northern Territory Department of Corrections with support from the Department of Health (Office of Disability).

³⁰ New South Wales Law Reform Commission, above n 3.

Complementing these services are two specialist forensic disability support facilities – Step-Down Cottages on the perimeter of the Darwin Correctional Precinct and an eight bed Secure Care Facility next to the Alice Spring Correctional Centre. These facilities are managed by the Office of Disability.

Whether on a custodial or non-custodial supervision order, those with an intellectual disability are managed and supported by the Specialist Support and Forensic Disability Unit of the Department of Health. The program includes disability support workers and Forensic Disability Officers who provide intensive and ongoing management, consultation, liaison and training services to correctional services, provision of court reports, and pre- and post-release support programs.

It is noted that the Northern Territory Government has recently announced a major review of forensic services across disability, mental health and justice.³¹

South Australia

South Australia does not have a separate forensic disability service. A person found mentally incompetent or unfit to stand trial under Part 8A of the *Criminal Law Consolidation Act 1935* (SA), whether by reason of a mental illness or intellectual disability, and found liable to supervision, is managed and supervised by South Australia's Forensic Mental Health Services which comprises inpatient, community, prison mental health, court liaison and victim support services. Forensic Mental Health Services are also responsible for providing court reports regarding forensic disability clients. All people found liable to supervision are deemed to be in custody of the Minister for Health, Mental Health and Substance Abuse for the purposes of care and supervision regardless of the cause of their mental incompetence or unfitness. There is no legislative requirement for oversight by the Minister for Disabilities.

Dispositional options in relation to a person with an intellectual disability found liable to supervision include unconditional release or a supervision order that either commits the person to detention or releases the person to the community on a licence within conditions determined by the Court. Those released on licence to the community are managed by the Community Forensic Mental Health Service, with case management and general disability needs being met by Disability Services SA. Supervisory responsibilities for those released on licence are divided between the Minister for Health (treatment of monitoring of the mental condition) and the Parole Board (all other supervision). People placed on a detention order are detained in the High Security Inpatient Services of South Australia which comprises James Nash House, a secure forensic mental health facility, and the Kenneth O'Brien Rehabilitation Unit, a high secure unit that provides a rehabilitation model of care. There is also provision to

³¹ Matt Cunningham, 'NT Government reviewing how it manages people deemed mentally unfit to plead to serious crimes', *NT News* (online), 22 January 2018 <<http://www.ntnews.com.au/news/nt-government-reviewing-how-it-manages-people-deemed-mentally-unfit-to-plead-to-serious-crimes/news-story/d65c4559d95170384b6a687fe65f5677>>.

detain a person in prison if there no practicable alternative available for the person's detention.

While there is no separate specialist inpatient facility for forensic disability clients – James Nash House and the Kenneth O'Brien Rehabilitation Unit accommodate both those with a mental illness and those with an intellectual or cognitive disability – James Nash House does include a specialist forensic disability unit ('Birdwood Unit'). Forensic Mental Health Services also operates a 10 bed 'step-down' residential rehabilitation unit – Ashton House – which provides a care pathway for people with either a mental illness of an intellectual disability transitioning from High Security Inpatient Services following the authorisation of community leave by way of a licence under the supervision order.

As at 25 June 2015, 22.5% of the 285 forensic patients in South Australia had a primary diagnosis of intellectual disability.³²

Tasmania

Tasmania does not have a separate forensic disability service. A person found unfit to plead under the *Criminal Justice (Mental Impairment) Act 1999* (Tas) (CJMI Act), whether by reason of a mental illness or intellectual disability, is managed and supervised by Tasmania's Forensic Mental Health Service, with the Chief Forensic Psychiatrist holding ultimate responsibility for orders made under the CJMI Act.

On being found unfit to plead, a person may be managed in the community under a Supervision Order or detained in a secure facility under a Restriction Order. Both of these orders are indefinite. Forensic clients with an intellectual disability on a Supervision Order are managed by the Community Forensic Mental Health Team, whilst those on a Restriction Order are detained in the Wilfred Lopes Centre, Tasmania's secure mental health facility, which accommodates both those with a mental illness and those with an intellectual or cognitive disability. There is no specialist inpatient facility for forensic disability clients, nor is there a separate unit for forensic disability clients within the Wilfred Lopes Centre. Non-government organisations may provide support to clients with a cognitive impairment detained in the Wilfred Lopes Centre if such support is organised and requested by the inpatient treatment team. The CJMI Act expressly prohibits the detention of those placed on a Restriction Order in correctional centres.

Supervision and Restriction Orders are reviewed annually by the Tasmanian Forensic Tribunal but revocation of the order can only be made on application by the client to the Supreme Court of Tasmania. The relevant test for release is whether the person is "likely to endanger" another person or other people generally. The CJMI Act does not specify any presumption in favour of release or detention. Rather, the decision-maker may make any order it considers appropriate.

³² Ed Heffernan, Bobbie Clugston and Steve Patchett, 'Review of the South Australian Forensic Mental Health Service' (Report, South Australian Government, July 2015) 42.

Victoria

While Victoria has a specialist forensic disability service, it does not have a specialised inpatient facility solely for people found unfit to stand trial or not guilty by reason of mental impairment by reason of intellectual disability or cognitive impairment under the *Crimes (Mental Impairment and Unfitness to be Tried Act 1997* (Vic). Following a finding of unfitness or mental impairment, the court has the option to either unconditionally discharge the person or declare them liable to supervision under either a custodial supervision order or a non-custodial supervision order. Those placed on a custodial supervision order may be detained in custody in a residential treatment facility or a residential institution, whilst those on a non-custodial supervision reside in the community subject to conditions, which may include conditions to receive services in an appropriate place or from a disability services provider. Where there is no practicable alternative, a person on a custodial supervision order may be detained in prison. Responsibility and management of people on supervision orders with an intellectual disability falls to the Secretary of the Department of Health and Human Services (DHHS).

For people with an intellectual disability on a custodial supervision order, there are two specialist forensic disability facilities in Victoria – the Intensive Residential Treatment Program (IRTP) and the Long Term Rehabilitation Program (LRTP). The IRTP is a 14 bed secure residential facility provided by the Disability Forensic Assessment and treatment Services (DFATS) which includes treatment, support and accommodation for people who display high-risk anti-social behaviour and are involved, or at risk of being involved in the criminal justice system. In addition to those on custodial supervision orders, the facility accommodates those on compulsory treatment orders under the *Disability Act 2006* (Vic), extended supervision orders under the *Serious Sex Offenders (Detention and Supervision) Act 2009* (Vic) and Community Corrections Orders under the *Sentencing Act 1991* requiring secure disability accommodation. The IRTP facility is funded by Disability Services within DHHS. It comprises three ‘houses – Waratah, Blackwood and Yarra – and the physical layout of the facility is designed to replicate, as far as possible, a normal domestic residential environment. Each client has their own bedroom and shares the communal facilities of the house with other clients. In addition to operating the IRTP, DFATS also provides community programs and a consultancy service.

The LRTP is a residential step-down institution which is gazetted as a secure facility under the *Disability Act 2006* (Vic). Managed by DHHS, the LRTP accommodates up to five people transitioning to community living. The facility is located on the grounds of Plenty Residential Services which comprises approximately 20 houses on 20 hectares for people who require intensive 24 hour support in a semi-secure environment.

Under the provisions of the *Disability Act 2006* (Vic), DFATS and the LRTP are subject to clinical oversight by both the Office of the Senior Practitioner and the Victorian Civil and Administrative Tribunal to ensure that the rights of individuals who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards are

maintained. Accordingly, DFATS and the LRTP must ensure its compliance with a range of legislative requirements and provide a framework of policies and procedures to support this compliance. In order to be accommodated within either the IRTP or the LRTP, clients must meet the relevant criteria for admission under the *Disability Act 2006* (Vic); where a person does not meet the admission criteria, the only other option is prison.

People with an intellectual disability on a non-custodial supervision order are managed in the community by Disability Services within DHHS. Where they require secure supervision, they may be accommodated within the LRTP provided they meet the admission criteria.

For people with an intellectual disability who are detained in prison, oversight is provided by Disability Pathways, a business unit of Corrections Victoria, which determines placement and provides support and interventions for prisoners with an intellectual disability. Corrections Victoria has units at two prison locations that accommodate male prisoners registered as having an intellectual disability. The Marlborough Unit at Port Phillip Prison (a maximum security prison) is a specialised unit for prisoners with a cognitive impairment, comprising 35 beds, while limited disability support is also available at Loddon Prison (a medium secure facility), which has two specialist clinical staff and a mentoring program to support up to 25 prisoners with an intellectual disability. Female prisoners with an intellectual disability are located at the Dame Phyllis Frost Centre, a multi-security level prison, however given the small number of women identified with intellectual disability, there is no unit dedicated to managing these prisoners. Rather, female prisoners with an intellectual disability are located in units according to a range of considerations, including offence type and functioning level. Prisoners with a registered intellectual disability may be seen by Disability Services while in prison, although registration is voluntary.

Finally, it should be noted that the Victorian Institute of Forensic Mental Health (Forensicare), Victoria's public forensic mental health provider, conducts some work in the forensic disability space. Forensicare psychologists conduct fitness to stand trial and mental impairment assessments under contract to the Office of Public Prosecutions. Furthermore, under contract to DHHS, Forensicare provides one consultant psychiatric session and one psychiatric registrar session per week to DFATS clients. The clinic is currently staffed by a UK-trained psychiatrist with specialisation in learning disability, a psychiatry trainee, and a coordinator (generally with a psychology or social work background).

Western Australia

Under section 24 of the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA), there are two pathways for a person found unfit to plead – unconditional release or a custody order; there is no provision for supervision and management of a person in the community. People found unfit to plead on the basis of an intellectual disability or cognitive impairment and placed on a custody order can be detained in either a prison or a declared place. Under the *Declared Places (Mentally Impaired Accused) Act 2015* (WA), the only declared place in Western Australia is the Bennett Brook Disability Justice Centre (DJC) which opened in 2015

and has capacity for 10 forensic disability clients. Prior to the opening of the DJC, there was no other option but to detain a forensic disability client on a custody order in prison.

The DJC is operated by the Disability Services Commission within the portfolio of the Minister for Disability Services. Following the imposition of a custody order by the court, the matter is referred to the Mentally Impaired Accused Review Board which makes a recommendation, taking into account an assessment undertaken by the Disability Services Commission, as to whether to detain someone in prison or in the DJC. However, the final decision as to the place of custody lies with the Minister for Disability Services. Similarly, while the Board is the key reviewing body for those on custody orders, its recommendations regarding leaves of absence (leave from place of custody for up to 14 days), conditional release (release from place of custody subject to conditions) and unconditional release all require approval from the Governor, based on recommendations of the Attorney-General.

Despite its 10 bed capacity, the 2016-17 Annual Report of the Mentally Impaired Accused Review Board reports that, since the opening of the DJC, only three people have been accommodated at the Centre, with one having been successfully transitioned to the community. Accordingly, it can be surmised that a significant number of forensic disability clients remain detained in prison. For this group, as well as those on conditional release, a prison in-reach/out-reach service is provided by the Disability Services Commission's Disability Justice Service.

Western Australia's State Forensic Mental Health Service has no role in relation to offenders with an intellectual disability or cognitive impairment, unless they have a co-occurring mental illness.

Description of the Queensland forensic disability service system

Legislation

Prior to 2011, the primary piece of legislation governing both the forensic disability and forensic mental health service systems was the *Mental Health Act 2000* (Qld). The Act (since replaced by the *Mental Health Act 2016* (Qld)) provided for a person charged with an indictable offence but determined to be of unsound mind at the time of the offence or unfit for trial to be diverted from the criminal justice system to the Mental Health Court (MHC) which could impose a forensic order. However, the MHC's jurisdiction to make Forensic Orders was limited under the Act to ordering detention in an "authorised mental health service for involuntary treatment or care" (s 288). This raised obvious problems regarding those people found unsound of mind or unfit for trial by reason of an intellectual or cognitive disability for whom placement in a mental health service was inappropriate.

The impetus for legislative change was driven by the 2006 reports of Justice Carter³³ and Brendan Butler³⁴ which addressed issues raised by the conflation of mental illness and intellectual disability in the Act, and the need for more appropriate and specialised services to cater for people with an intellectual or cognitive disability who interact with the criminal justice system. Thus, in 2011, the *Forensic Disability Act 2011* (Qld) was enacted which established a legislative regime for the detention of people with intellectual or cognitive disability who have been found unsound of mind or unfit to stand trial. In particular, the *Forensic Disability Act 2011* (Qld) establishes and regulates the Forensic Disability Service (FDS) – a purpose-built, medium secure residential facility – and provides for the care, support and protection of people who are forensic disability clients. Under section 10 of the Act, a forensic disability client is defined as a person with an intellectual or cognitive disability who is subject to the Forensic Order (Disability) and has been ordered by the MHC to be detained for treatment or care in the FDS. Aims of the *Forensic Disability Act 2011* (Qld) include: safeguarding rights and freedoms while balancing those rights and freedoms with the rights and freedoms of other people; promoting individual development and enhancing opportunities for quality of life; and maximising opportunities for transition and reintegration into the community.

Complementing the establishment of a specialised service for forensic disability clients, the *Forensic Disability Act 2011* (Qld) amended the *Mental Health Act 2000* (Qld) to introduce a new Forensic Order (Disability) which provides the MHC with the ability to differentiate between those with a mental illness and those with an intellectual or cognitive disability. Accordingly, under the current legislative regime set out in the *Mental Health Act 2016* (Qld), the MHC has the option to impose one of two types of Forensic Orders in relation to people with an intellectual or cognitive disability who are found unsound of mind or unfit for trial. Those with an intellectual disability or cognitive impairment, but no mental illness, are placed

³³ Carter Report, above n 3.

³⁴ Butler, above n 3.

on a Forensic Order (Disability), with involuntary care (but not treatment) to be provided by either an Authorised Mental Health Service (AMHS) or the FDS. The category of order may be either 'inpatient' (which, for those detained to the FDS, may be described as 'residential') or 'community', as stipulated by the MHC. Where a person is managed as an inpatient (either in the FDS or an AMHS), the MHC may authorise Limited Community Treatment which may include 'on-ground' leave, escorted or unescorted leave to the community and overnight leave for periods of not more than seven days. Where a person has an intellectual or cognitive disability *and* a co-existing mental illness, a Forensic Order (Mental Health) is imposed, with involuntary treatment and care provided by an AMHS as an inpatient or in the community. Those placed on a Forensic Order (Mental Health) cannot be detained to the FDS. In making a forensic order, the MHC must determine that the forensic order is necessary in order to protect the safety of the community, including from the risk of serious harm to other persons or property (s 134). Similarly, in deciding to impose a 'community' category of order, the MHC must determine that "there is not an unacceptable risk to the safety of the community" (s 138(2)).

Since the introduction of the Forensic Order (Disability) in 2011, the number of such orders imposed each year has increased. As shown in Figure 1, these increases have been particularly significant in the past three years, peaking in 2017 with the making of 32 new Forensic Orders (Disability). This growth contrasts sharply with the rate of revocations; since 2011, only 14 Forensic Orders (Disability) have been revoked by the MHRT,³⁵ with the result that there are significantly more people entering the forensic disability service system than exiting it. As at 1 December 2017, a total of 97 people were on Forensic Orders (Disability), 83 (86%) of whom were male and 14 (14%) female. Six people were detained to the FDS (one accommodated offsite on 24/7 Limited Community Treatment), with the remaining 91 people managed by an AMHS across all Qld regions. A further 64 people with a co-occurring mental illness and intellectual disability or cognitive impairment were managed by Authorised Mental Health Services on a Forensic Order (Mental Health), 56 (88%) of which were male and 8 (13%) female.

³⁵ Data drawn from Mental Health Review Tribunal Annual Reports 2011-2017.

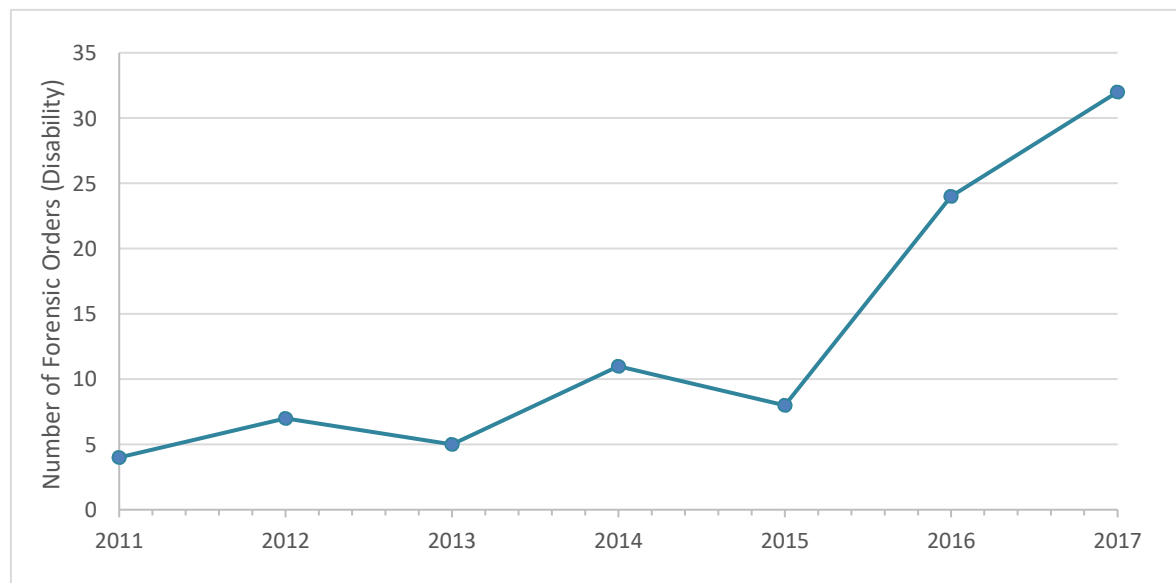


Figure 1. Number of Forensic Orders (Disability) imposed by the MHC 2011-2017³⁶

Furthering the aim of the *Forensic Disability Act 2011* (Qld) to establish a specialised regime for forensic disability clients, the *Forensic Disability Act 2011* (Qld) also establishes the role of the Director of Forensic Disability, an independent statutory office appointed by the Governor in Council.

As outlined under section 87 of the *Forensic Disability Act 2011* (Qld), the Director has the following functions—

- ensuring the protection of the rights of forensic disability clients under the Act
- ensuring the involuntary detention, assessment, care and support and protection of forensic disability clients comply with the Act
- facilitating the proper and efficient administration of the Act
- monitoring and auditing compliance with the Act
- promoting community awareness and understanding of the administration of the Act
- advising and reporting to the Minister on any matter relating to the administration of the Act -
 - on the director's own initiative; or
 - at the request of the Minister if the matter is in the public interest.

The role is an active one, with section 128 of the *Forensic Disability Act 2011* (Qld) giving the Director (and others, including the Chief Psychiatrist), protection from liability for acts done honestly and without negligence under the Act. The Director is also responsible for the issuing of policies and procedures, and is required to advise and report to the Minister for Disability

³⁶ As at 1 December 2017. Data provided by the Queensland Office of the Chief Psychiatrist, December 2017.

Services on any matter relating to the administration of the *Forensic Disability Act 2011* (Qld). The Director of Forensic Disability is supported by four staff members: a Principal Legal Officer, a Principal Legal Policy Officer and two Principal Clinical Advisors. The projected total budget of the Office for the 2017-18 financial year is \$860,072.

As part of the role in providing legislative oversight of forensic disability clients, the *Forensic Disability Act 2011* (Qld) requires the Director to conduct a review of any person detained to the FDS for a continuous period of five years. The purpose of this review is to determine if the individual has received benefit from the care and support provided by the service and whether the benefit is likely to continue (s 141(2)). The aim is to ensure that individuals are not detained to the service indefinitely. In accordance with the Act, reviews were recently undertaken for eight clients, the findings of which were that all eight clients were ready to transition from the FDS, having received maximum benefit from their time at the service. Consequently, four clients have been successfully transitioned to the community and transition processes have been initiated in relation to the remaining six clients detained to the FDS. The review was informed that, over the course of the FDS' six and a half years of operation, a total of four clients have been transitioned from the service: one client transferred to a secure unit at Townsville Hospital; one client moved to Toowoomba to live with family; one client transferred to Baillie Henderson Hospital in Toowoomba with the expectation that they would quickly transition to supported accommodation in the community with NDIA support; and one client transferred to Townsville Community Care Unit with access to leave to allow them to spend five days living with family. One client has passed away whilst detained to the FDS.

Ultimately, however, the decision to make any changes to a Forensic Order, including whether to confirm or revoke an order, change the category from inpatient to community, and authorise Limited Community Treatment, lies with the MHRT, which is required to review Forensic Orders every six months. Under section 432, when reviewing a forensic order, the MHRT must have regard to the circumstances of the person, the nature of their offence and the length of time since its commission, any victim impact statement regarding the offence, and the person's willingness to participate in any intervention program recommended by the MHC. Section 442(1) goes on to set out a decision-making presumption that the MHRT must confirm the order if it is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to people or property.

While the *Forensic Disability Act 2011* (Qld) and the *Mental Health Act 2016* (Qld) are the primary pieces of legislation governing the regime for the detention of people with an intellectual disability who have been found unsound of mind or unfit to stand trial, the *Disability Services Act 2006* (Qld) and the *Guardianship and Administration Act 2000* (Qld) are also relevant, principally in regards to the regulation of the use of restrictive practices on persons with an intellectual or cognitive impairment on a Forensic Order (Disability). The *Disability Services Act 2006* (Qld) regulates the use of restrictive practices (such as seclusion and containment) in relation to people receiving services from government funded disability service providers. Accordingly, it applies only to people on Forensic Orders (Disability) who are not detained in the FDS but are receiving services under the *Disability Services Act 2006*

(Qld) whilst being managed by an AMHS in the community or where a forensic disability client is undertaking community treatment. In regard to people detained as an inpatient in an AMHS, the restrictive practices regime in the *Mental Health Act 2016* (QLD) applies, whilst those detained in the FDS are subject to the restrictive practices framework set out in Chapter 6 of the *Forensic Disability Act 2011* (Qld) unless undertaking community treatment in which case the framework in the *Disability Services Act 2006* (Qld) applies. The *Guardianship and Administration Act 2000* (Qld) enables decision-making on behalf of individuals who have impaired decision-making capacity with respect to legal, treatment and/or behaviour support matters. This Act applies to both forensic disability clients detained to the FDS and those managed by an AMHS.

Service components for the management of Forensic Orders

Forensic Disability Service

The central element of the current forensic disability service system in Queensland is the Forensic Disability Service (FDS). Opening in 18 July 2011, the FDS is a purpose-built, medium secure residential treatment and rehabilitation facility in Wacol, Brisbane. At the time of the report, the service is operated by the South West region of DCCSDS (rather than under a statewide portfolio) and is funded to support up to ten forensic disability clients. While, as a statewide service, the FDS provides some outreach services, such as delivery of criminogenic programs, it is not resourced to provide community support staffing models to people residing in the community under a 'community' category of Forensic Order (Disability). It has an annual budget of almost \$7 million.

The aim of the FDS is to provide a specialised model of care for people with intellectual or cognitive impairment who are found unfit for trial by the MHC, which includes opportunities for habilitation and rehabilitation whilst supporting and protecting individual rights. The minimum requirements for admission to the FDS are that a person must:

- be between 18 and 65 years of age;
- have an intellectual disability or cognitive impairment;
- not require involuntary treatment and care for a mental illness; and
- be on a Forensic Order (Disability).

Additionally, consideration must be directed to the person's:

- need for the level of restriction and security provided by a medium secure environment in order to manage current risk to the community;
- ability to engage and respond to rehabilitative treatment; and
- likely benefit from the support and care provided by the FDS.

The FDS is set in parkland at the end of a long, winding road through government land in Wacol. The road passes numbers of vacant and decommissioned buildings, some of which appear to be residential units for people with disability which have been heavily modified and have trappings of security. It is comprised of an administration block (which includes a staffed secure gatehouse and a seclusion area) and three 'houses' set around a large central recreation area.

The houses are well-appointed, light and spacious, and include kitchens, bedrooms and communal areas. While the current layout of the FDS allows for nine beds (one house has been individually modified to accommodate the needs of one client), there are currently five people accommodated in the FDS: one resident in each of two houses and three in another house. An additional client is detained to the FDS but is accommodated offsite on 24/7 Limited Community Treatment.

The staffing profile for each house in the FDS includes a house team leader, clinician and forensic officer staff. A centralised team of clinicians provides assessment and treatment interventions, including the delivery of skills-based and offence-specific programs to both those detained to the FDS and to a limited number of people on Forensic Orders (Disability) managed in the community (in 2016-17, the FDS delivered offence-specific programs to three community clients).

The day-to-day operations of the FDS are overseen by an Administrator, a statutory role appointed by the Director under the *Forensic Disability Act 2011* (Qld). Under the Act, a forensic disability client is in the legal custody of the Administrator. The Administrator is also responsible for appointing a Senior Practitioner and an Authorised Practitioner. The main functions and powers of the Senior Practitioner include the preparation of Individual Development Plans, authorisation of Limited Community Treatment, and the implementation of the use of regulated behaviour controls; while the Authorised Practitioner is responsible for changing Individual Development Plans where authorised by the Senior Practitioner, and implementing, reporting and documenting the use of regulated behaviour controls.

Authorised Mental Health Services

While the FDS is a central component of the current forensic disability service system, the vast majority of people on Forensic Orders (Disability) never have any involvement with the service. Thus, people on a Forensic Order (Disability) who are not detained to the FDS are managed and supervised by an AMHS under the responsibility of Queensland Health, as are those on Forensic Orders (Mental Health) who have an intellectual disability and a co-occurring mental illness. Depending on the category of order imposed by the MHC, this group may be detained as an inpatient in an AMHS or may reside in the community.

As at 30 June 2017, 81 individuals were managed by an AMHS under a Forensic Order (Disability).³⁷ Of these, 14 (17%) were detained in an inpatient setting, 21 (26%) were residing in the community under a community category of Forensic Order (Disability), and 46 (57%) were accessing Limited Community Treatment as authorised by the MHC or MHRT, allowing them to reside in the community under the supervision of an authorised psychiatrist.

The distribution of people on Forensic Orders (Disability) across the Authorised Mental Health Services as at 1 December 2017 is set out in Table 1 on the following page.

³⁷ The number of people on Forensic Orders (Disability) managed by Authorised Mental Health Services has since increased to 91 people (as at 1 December 2017).

Table 1. Distribution of Forensic Orders (Disability) across Authorised Mental Health Services as at 1 December 2017³⁸

Authorised Mental Health Service	Number of people on Forensic Orders (Disability)
Bayside	1
Cairns Network	6
Central Queensland Network	5
Children's Health Queensland	1
Darling Downs Network	10
Forensic Disability Service	6
Gold Coast	4
Logan Beaudesert	7
Mackay	4
Princess Alexandra Hospital	5
Redcliffe Caboolture	1
Royal Brisbane and Women's Hospital	6
Sunshine Coast Network	3
The Prince Charles Hospital	4
Townsville Network	11
West Moreton Network	14
Wide Bay	9
Total	97

While falling under the responsibility of Queensland Health, DCCSDS and mainstream service providers may be engaged in providing disability support to this group, including delivering accommodation support, community access support, or skill development and education programs. However, given the narrow remit of the *Forensic Disability Act 2011* (Qld), people on Forensic Orders who are not detained to the FDS are unlikely to have access to specialist forensic disability advice and services. Additionally, the Director of Forensic Disability is not involved in ensuring the care, protection, support and human rights of the individual, with this responsibility falling to the Chief Psychiatrist under the *Mental Health Act 2016* (Qld). Accordingly, the cohort of people on Forensic Orders (Disability) who are managed by

³⁸ Data provided by the Office of the Chief Psychiatrist as at 1 December 2017.

Authorised Mental Health Services are subject to policies and guidelines set by the Chief Psychiatrist. The Chief Psychiatrist also chairs the 'Complex Case Panel', a multi-agency senior clinical panel that has responsibility for monitoring and reviewing complex cases involving patients on Forensic Orders (Disability).

Specialist Disability Services Assessment and Outreach Team

The Specialist Disability Services Assessment and Outreach Team (SDSAOT) is a statewide multidisciplinary service staffed by senior consultant psychiatrists, psychiatrists in training, and psychiatric nurses. It has an unclear scope to provide assessment and consultation to people with an intellectual or cognitive disability across Queensland, where there appears to be a co-occurring mental disorder.

The review was informed that the SDSAOT has had some involvement with the forensic disability population over the years, including forensic disability clients detained to the FDS. SDSAOT's provision of service to the FDS has significantly reduced over time, as the direction of the FDS moved towards clients accessing community medical support and services and due to an amendment to the Mental Health Act where and the New Charges Psychiatrist Reports previously provided by SDSAOT were abolished and replaced with reports by the Senior Practitioner of the FDS appointed under the *Forensic Disability Act 2011*. However, many stakeholders expressed uncertainty about the role and functions of the SDSAOT. DCCDS advises that SDSAOT is a statewide service with a primary role to assisting and supporting clinicians in managing clients with intellectual or cognitive disability and severely challenging behavior by conducting mental health assessments and facilitating access to mental health services and supports.

The review understands that SDSAOT was funded by Disability Services but has been 'cashed out' to the NDIS. There has been some discussion of narrowing the focus of the SDSAOT to the area of child safety and the delivery of services to children with an intellectual disability in state care. However, its future role remains unclear and, under the 2017 machinery-of-government changes, is a question that falls to the Department of Child Safety, Youth and Women to consider. Regardless, it appears likely that the SDSAOT will no longer have involvement with the forensic disability population.

Centre of Excellence

The Centre of Excellence for Clinical Innovation and Behaviour Support was established in 2008 in response to the Carter Report. Headed by a joint Professorial Chair between the DCCSDS and the University of Queensland, the Centre's function is to "engage in practice leadership and disability research in clinical innovation and governance, forensic disability, high and complex needs and positive behaviour supports."³⁹

The Centre works alongside stakeholders in the disability sector to support best practice in positive behaviour support and the reduction in the use of restrictive practices in relation to people with disabilities who have high and complex needs which may include the forensic disability cohort. In this way, it is linked to Queensland's Quality and Safeguard Framework and fulfils the functions assumed by the office of the Senior Practitioner in other jurisdictions. The Centre also provides training and staff development courses to professionals working in the disability sector, and has a role in building sector capacity in the provision of sustainable, effective supports and supporting the transition to the NDIS.

³⁹ Centre of Excellence for Clinical Innovation & Behaviour Support, DCCSDS, Queensland Government (21/6/2017) <<https://www.communities.qld.gov.au/disability/centre-excellence/about>>.

Key Issues Arising

The review and recommendations were informed by an extensive consultation process across a broad range of different stakeholder groups. While a wide range of views and perspectives were provided, consistent themes emerged concerning service gaps in the way in which the forensic disability cohort (including those on a Forensic Order (Mental Health) with a co-occurring intellectual disability) are being managed in the current forensic disability service system. Specific issues are summarised as follows:

- The FDS operates in isolation and is not embedded within a wider service system. There is an absence of clear relationships, formal agreements or operating frameworks with other service components in the disability and mental health sectors. This lack of integration within the wider service system has contributed to lengthy periods of detention, due to the lack of a clear referral and discharge pathway, and the development of a negative organisational culture within the FDS - variously described as “toxic”, “dysfunctional” and “disorganised” - and characterised by a sense of hopelessness on the part of both staff and clients. This contrasts starkly with the purported strong rehabilitative focus of the FDS (as opposed to offering a place of indefinite containment) and its aim of reintegrating clients to the community, having benefitted from the focused interventions offered by the service.
- The isolation of the FDS is symptomatic of a broader disconnect between disability and mental health services in the community which negatively impacts on the way in which forensic disability clients who are not under the care of the FDS are supervised and managed. While there exist a number of valuable service components and pockets of expertise in assessing and managing the needs of forensic disability clients, these components are not working together, which leads to a confusing and fragmented management approach, and the lack of a clear trajectory to revocation of the order.
- The absence of a clear supervision and management pathway for people on Forensic Orders (Disability) has impeded the progression of clients. While the *Mental Health Act 2016* (Qld) requires that Forensic Orders be reviewed at least every six months by the MHRT, only 14 Forensic Orders (Disability) have been revoked in the six and a half years since the commencement of the *Forensic Disability Act 2011* (Qld).⁴⁰ This raises the question of whether the current system allows or acknowledges individuals’ progress, reduction in risk or the capacity for risk to be managed adequately in the community.
- A particular service gap impeding the trajectory of those on Forensic Orders (Disability) identified by many stakeholders is the lack of step-down facilities to which those detained in the FDS or as inpatients in an AMHS can transition. In the absence of such facilities, the options for community transition are limited, leading to many being detained for lengthy periods of time in restrictive and inappropriate settings, such as high-dependency units within mental health services, which are not designed to meet

⁴⁰ Data drawn from Mental Health Review Tribunal Annual Reports 2011-2017.

forensic and disability needs. Research supports that a graduated transition is the safest process to reintegrate individuals back to the community.⁴¹

- The clinical governance for the delivery of forensic disability services is unclear. There was much uncertainty amongst stakeholders about the governance structure, decision-making pathways and clinical reporting lines, highlighting the need for a clear governance framework.
- Associated with the absence of a clear governance framework for the delivery of forensic disability services is a lack of clinical and legislative oversight of the total cohort of those on Forensic Orders (Disability). Under the *Forensic Disability Act 2011* (Qld), the role of the Director of Forensic Disability is restricted to the care, support and protection of forensic disability clients detained to the FDS (which, at the time of the review, numbered six people). The remaining forensic disability population (numbering 91 people as at 1 December 2017) falls under the responsibility of Queensland Health. This means that, for the vast majority of people subject to a Forensic Order (Disability), clinical oversight is provided by the Chief Psychiatrist under the *Mental Health Act 2016* (Qld) whose primary role is in providing clinical leadership to the provision of mental health, not disability, services.
- The lack of central oversight of the majority of people on Forensic Orders (Disability) has contributed to a general lack of knowledge and information about the cohort. While information regarding people on Forensic Orders (Disability) who are managed by Authorised Mental Health Services is recorded in the Consumer Integrated Mental Health Application (CIMHA), this system is not accessible by the Director of Forensic Disability or the Centre of Excellence.
- The complex and unique nature of the forensic disability cohort was acknowledged by all stakeholders, but this acknowledgment was accompanied by significant concern regarding the capacity and expertise of service providers to appropriately meet the forensic and disability needs of people on Forensic Orders (Disability). This was particularly the case in regard to those people not detained to the FDS who are not subject to specialist oversight by the Director of Forensic Disability but rather fall under the responsibility of Queensland Health. A consistent view across multiple stakeholders in the mental health sector was that the complexity of the forensic disability cohort presented a significant challenge given the lack of expertise and capacity of mental health services to manage the specialist needs of the cohort.
- One aspect of this concern related to the inappropriateness of detaining people with an intellectual disability in facilities designed to manage people with acute mental illness, such as acute inpatient and high-dependency units. Such facilities are typically austere and stimulus-free environments designed for short stays, with small bedrooms and limited communal space. Clients are often subject to wrap-around control and observation, with limited opportunity to exercise independent living skills. Co-patients

⁴¹ Holland, Clare and Mukhopadhyay, above n 5.

may be highly medicated, or alternatively behaviourally disturbed and unpredictable. While other mental health facilities, such as Secure Mental Health Rehabilitation Units and Continuing Care Units, may be a better fit for the care, support, habilitation and rehabilitation needs of the forensic disability cohort, the fact remains that they have been designed to accommodate the clinical needs of people with a mental illness rather than those with an intellectual disability.

- The inappropriateness of the physical environment of mental health facilities to accommodate people on Forensic Orders (Disability) is accompanied by a general lack of disability expertise amongst mental health staff. This is noted throughout Australia and has historical basis in the separation of mental illness and intellectual disability services which has occurred over the last fifty years. By their own admission, staff most often lack expertise in working with people with intellectual disabilities. Numerous stakeholders conveyed a sense of ‘being at a loss’ as to how to appropriately manage the needs of the forensic disability cohort and acknowledged that, for some people on such orders, the lack of forensic and disability expertise means that the service system is providing not much more than containment. During the consultations, senior clinical and administrative mental health staff plainly asked the question of whether they ‘can say no’ about having responsibility for patients on Forensic Orders (Disability), given their lack of expertise and perceived lack of options and resources to work effectively with this patient group. Moreover, similar concern was expressed regarding patients on Forensic Orders (Mental Health) who have a co-occurring disability.
- This view of the system as ineffectual for the forensic disability cohort is unsurprising, given that the primary focus and skillset of those who work in mental health is in working with individuals with a mental illness, not a disability. Accordingly, there is limited knowledge regarding best practice principles for the assessment, management and intervention of the forensic disability population.
- In addition to a general lack of disability expertise is a lack of a multidisciplinary team care approach to the management of people on Forensic Orders (Disability). There is general consensus in the literature that care and support of the forensic disability cohort should be provided by multidisciplinary teams, comprising medical, psychiatric, psychological, nursing, and allied health professionals (including speech pathologists and occupational therapists) appropriately skilled in rehabilitation and habilitation interventions to maximise quality of life and target offending behaviours.⁴² This team approach is currently lacking in Queensland’s forensic disability service system. Of particular note is the lack of access to neuropsychologists who have specific expertise in the assessment of how cognitive impairment impacts on behaviour and strategies and rehabilitation approaches for those with low cognitive functioning.
- There is also a lack of rigorous systems for the assessment of people on Forensic Orders (Disability). The process for the admission of the original intake of clients to the FDS

⁴² MacMahon and McClements, above n 19.

appears to have been *ad hoc*, with no clear eligibility criteria (or a failure to adhere to set criteria) and no formal comprehensive clinical assessments of clients' rehabilitation and habilitation needs, or static or dynamic risk factors, conducted on entry to the FDS. This contributed to a view amongst stakeholders that the initial cohort of clients detained at the FDS were inappropriately placed and "should never have come here", being comprised of clients identified by AMHS as being "difficult" and "in the too hard basket" but not necessarily those who were able to benefit from the interventions offered by the FDS. The result has been lengthy periods of detention and a view that the "FDS was set up to fail". The absence of baseline assessment data has also meant that there is no information against which to assess and analyse benefit over time. That being said, it is apparent that a systematic and structured risk assessment and management process has not been implemented in the FDS which has contributed to slow community transition.

- Stakeholders also expressed concern about the limited expertise in the broader disability and mental health sectors in regards to the administration of standardised evidence-based clinical and risk assessment tools relevant to the forensic disability population. This impacts on the quality of court assessments and reports, as well as the ongoing assessment and management of risk of those not detained in the FDS, which is a key component to informing treatment and care planning in accordance with risk, need and responsivity factors.
- In addition to a lack of clear assessment processes and expertise, some stakeholders expressed concern about the limited availability, both within the FDS and in the community, of evidence-based intervention and management programs specifically targeted to the forensic disability population. Thus, while there is some good practice around the delivery of general skill-based and habilitative programs, the number and reach of programs that seek to address criminogenic needs are lacking. While the FDS delivers some rehabilitative programs that target criminogenic factors associated with offending behaviour (including problematic sexualised behaviour, anger management and arson), there is a need for these programs to be more accessible to the whole statewide forensic disability population, and to be delivered on a more consistent basis. Within the FDS, there is a clear disconnection between clinical and direct support staff which means that key information and messages from individual and group treatment sessions are often not reinforced in the clients' day-to-day environment, thereby impeding skills generalisation. It was also noted that, currently, there is only one adapted program (addressing sexual offending) facilitated by Queensland Corrective Services for prisoners with an intellectual disability.
- It was clear that there is a need for forensic disability expertise to be enhanced through workforce development and training. A reoccurring theme was that a number of service delivery areas, including Authorised Mental Health Services, are operating without forensic disability expertise. Accordingly, there is a need to develop staff training (including training in risk assessment and management), leadership and professional development programs and research opportunities involving partnerships with

academic institutions. Such workforce development would not only assist in ensuring that the rehabilitation, habilitation and criminogenic needs of the forensic disability cohort are more appropriately addressed, but it would also provide a larger pool of expertise from which court reports may be sourced.

- Compounding the considerable service gaps and lack of clarity regarding the oversight and governance of the forensic disability cohort is a great deal of uncertainty across all stakeholders regarding the transition to the NDIS and its impact on the forensic disability cohort. The uncertainties are multiple and increasingly pressing, given that transition will be completed in 18 months' time.
- In the absence of statewide disability services, it is unclear who will conduct assessment and provide reports to the MHC regarding a person's level of risk and appropriate supports. It is also unclear how the NDIS will distinguish between forensic and disability needs. Where the NDIS does not provide adequate support to address a person's risk, it is uncertain how forensic needs will be met. It is noted that the criminal justice system does not currently provide support to the cohort and the Director of Forensic Disability is not funded to either advise on or provide ongoing treatment and support. These issues have been noted in other jurisdictions in Australia, and are associated with both uncertainty in non-government sector organisations, and devolution of previous services provided and/or funded by state government departments
- The key decision-making bodies – the MHC and the MHRT – echoed the observation by service providers that the forensic disability cohort present very different challenges to those posed by people on Forensic Orders (Mental Health). The latter cohort makes up the vast majority of matters involving Forensic Orders heard by the MHC and the MHRT, resulting in a much higher level of understanding amongst judges and sitting members of mental health issues, the treatment and management trajectory of people with a mental illness, and consequently, the treatment pathway to be navigated by those on Forensic Orders (Mental Health) towards revocation of the Order.
- In contrast, concern was expressed regarding the limited expertise amongst judges and sitting members in intellectual disability, a lack of strong legal representation of people on Forensic Orders (Disability) in tribunal hearings, the lack of appropriate forensic disability services in the community, and limited provision of rigorous assessments and information regarding transition planning by service providers in tribunal reviews of Forensic Orders (Disability). These concerns, combined with the difficulty of fitting the forensic disability cohort into a system that is primarily designed around the concepts of treatment and gradual recovery, have contributed to the development of a risk-averse approach to the consideration of forensic disability matters and a lack of understanding on the part of legal decision-makers regarding care and support pathways for those on Forensic Orders (Disability) and how offending behaviour may be remediated to the point that legal decision-makers may be confident revoking an Order.

- Last but by no means least, a number of stakeholders commented on the importance of delivering culturally appropriate services to the high proportion of people on Forensic Orders (Disability) who are Aboriginal and/or Torres Strait Islander. As at December 2017, the proportion of people on Forensic Orders (Disability) who are Aboriginal or Torres Strait Islander was 30%, with a similar proportion (29%) of those on Forensic Orders (Mental Health) with a co-occurring intellectual disability being Indigenous. These numbers are significantly greater than the approximately 4% of Queenslanders who are Aboriginal or Torres Strait Islanders. This over-representation presents particular challenges for the service system in preventing isolation of Indigenous clients from communities of origin and culture, and maintaining their connection to country and language. Poor indigenous representation within MHRT panels was also noted.

Discussion and Recommendations

Governance structure

During the course of the consultation process, it quickly became clear that there is significant uncertainty across stakeholders about the governance structure (clinical and operational), decision-making pathways and clinical reporting lines for the delivery of forensic disability services. Much of the confusion arises because of the multitude of agencies involved in the provision of care to people on Forensic Orders (Disability), including the Director of Forensic Disability, DCCSDS, the Chief Psychiatrist, Queensland Health, Authorised Mental Health Services, and non-government organisations. The interface between these agencies is fragmented and unclear.

The confusion is further compounded by the division that has been legislatively drawn between forensic disability clients detained in the FDS (who fall under the responsibility of the Director of Forensic Disability) and those on Forensic Orders (Disability) who are managed in the community under the responsibility of the Authorised Mental Health Services and the Department of Health. The separation of the forensic disability cohort into these two groups means that there is a lack of whole-of-system practice leadership, monitoring, direction and oversight. Thus, while under the *Forensic Disability Act 2011* (Qld), the Director of Forensic Disability has clear responsibility for and oversight of the very small proportion of the forensic disability cohort detained to the FDS, the vast majority of Forensic Orders (Disability) are managed in the community by an AMHS.

Clinical oversight of the delivery of services to the majority of people on Forensic Orders (Disability) falls to the Chief Psychiatrist whose primary role is in providing clinical leadership to the provision of mental health, not disability, services. Authorised Mental Health Services disclaim specialist skills to manage clients with forensic disability, yet are responsible for most of the people in this population. Despite this shared responsibility for the forensic disability cohort, there are no formal mechanisms for communication and coordination across the two legislative offices. As a result of this division in governance and oversight, significant confusion, inertia and fragmentation has developed amongst the services involved in the provision of support and care to the forensic disability cohort. While many stakeholders commented that the alignment between government agencies is currently the strongest it has ever been, the view is that this alignment relies on the individuals involved, goodwill and a commitment by those in the positions to forge strong working relationships, rather than being underpinned by a formal clinical governance structure.

It is crucial that a clear clinical governance framework for the delivery of forensic disability services be established in order to ensure that services are delivered in an effective, coordinated and accountable way. Given the transition to the NDIS, the review learned that the state is essentially divesting itself of disability services to the NDIS. Oversight of people on Forensic Orders (Disability) will need to be retained. The question is where such services should be accommodated in government. There are essentially two possible governance options. The first is to establish, in some form, a forensic disability service that parallels the mental health and forensic mental health services. The second is to incorporate the forensic

disability service into the Department of Health alongside the mental health and forensic mental health services.

A forensic disability service that paralleled the mental health system may provide a more specialised forensic disability service with dedicated resources and no risk of those resources being subsumed by other agencies. However, such a model would require the considerable investment of resources (particularly given the dismantling of Disability Services under the NDIS) both centrally for governance and oversight and at the local level to provide service delivery. Moreover, a parallel system would do nothing to overcome the divide that exists between disability services and mental health services, nor would it facilitate the expansion of skills among mental health services in dealing with people with disabilities in a contemporary evidence-based manner. Given the direction the Department of Communities, Disability Services and Seniors is heading, with the divestment of services and a diminution of the disability services division, creating a parallel disability forensic service would not be efficient or practically viable. Also, if a parallel system was established, the concerns regarding the lack of communication and service delivery between disability and mental health would need to be addressed.

Alternatively, the forensic disability service system and the mental health system could be brought within a single agency, under the auspices of Queensland Health.⁴³ If this option was adopted, steps would need to be taken to overcome the risks of a return to the pre-Carter service landscape, with the care and support needs of the forensic disability population being conflated with those of people with a mental illness, and the subsequent diminution of appropriate and specialist forensic disability expertise. However, the advantage of a single agency framework is that it avoids duplication of existing infrastructure and service structures. It also has the ability to facilitate alliances and bridge the current divisions between the forensic disability and mental health sectors which may, in turn, support continuity of care and promote further development of forensic disability expertise.

However, to achieve the positive impacts of a single agency framework, it is critical that forensic disability expertise is retained and 'ring-fenced' within the system to ensure that resources are not subsumed by mental health and that contemporary best practice principles for the assessment, management and intervention of the forensic disability population are implemented. This could be accomplished, for example, by having a forensic disability division within the Department of Health, thereby creating a hybrid service model in which some parallel care is provided, but with areas of integration and opportunities for joint working between forensic disability and mental health. Areas where integration may be appropriate include, for example, the management of legislative requirements for people on forensic orders (including in relation to court and tribunal processes), data monitoring, reporting and

⁴³ As noted, a concurrent review is being undertaken to identify options to establish an integrated statewide forensic mental health service for Queensland. Once both reviews are completed, there would be value in considering synergies and linkages between the forensic mental health and forensic disability governance and service systems. While the expertise is partly distinguishable (i.e., disability versus mental illness), there are similarities in the forensic expertise and issues. Indeed, in most Australian States, forensic disability and forensic mental health services are managed together.

recording of clinical notes, some clinical positions within Authorised Mental Health Services, oversight mechanisms for clinical standards, and staff training and development.

It is noted that, in the course of the review, multiple stakeholders in the mental health sector commented that the complexity of the forensic disability cohort currently presents a significant challenge given the lack of expertise and capacity of mental health services to manage the specialist needs of the cohort. This emphasises the unique challenges and needs presented by the forensic disability population when compared to mental health and the subsequent importance of equipping services that have responsibility for the forensic disability cohort (as well as other clients with a co-occurring intellectual disability or cognitive impairment) with relevant expertise.

Recommendations

- 1 (a) The forensic disability service system and the mental health system should be brought together within a single agency, under the auspices of Queensland Health. A single agency framework would minimise duplication of existing infrastructure and service structures. It also has the ability to facilitate alliances and bridge the current divisions between the forensic disability and mental health sectors which may, in turn, support continuity of care and promote further development of forensic disability expertise.
- (b) Should a single agency framework be adopted in the Department of Health, it must not be subsumed by mental health. Rather, a division of forensic disability should remain to ensure that forensic disability expertise is retained and 'ring-fenced' within the system, and amendments to relevant legislation, including the Mental Health Act 2016 (Qld), will be required to ensure that legislative safeguards specific to the forensic disability population are put in place.
- (c) As noted elsewhere in this report, the Director of Forensic Disability should be retained to provide specialist oversight to the forensic disability population.
- (d) A single agency system would need to ensure that contemporary best practice principles for the assessment, management and intervention of the forensic disability population are implemented.
- (e) While substantive expertise and a degree of autonomy is required, there are areas where integration between the forensic disability and mental health may be appropriate include (e.g., management of legislative requirements for people on forensic orders (including in relation to court and tribunal processes), data monitoring, reporting and recording of clinical notes, some clinical positions within Authorised Mental Health Services, oversight mechanisms for clinical standards, and staff training and development).

- 2 Establish a clear governance framework for the delivery of forensic disability services, including clear clinical reporting lines and decision-making and escalation pathways, to address the current disconnect between disability and mental health services involved in the care and support of the forensic disability cohort and ensure that services are delivered in an effective, coordinated and accountable way.

Given the complex and distinct needs of the forensic disability population, clinical leadership and oversight of the provision of services to the forensic disability cohort should be provided by the Director of Forensic Disability, as Queensland's only overseeing body for forensic issues specifically pertaining to individuals with intellectual disability. Specialist oversight would also help ensure that specialist forensic disability expertise is not subsumed within mental health in a single agency framework. The position should have authority equivalent to the Chief Psychiatrist (which must necessarily retain responsibility for the oversight of people on Forensic Orders (Disability) who are managed by Authorised Mental Health Service) and should involve the provision of independent specialist input and advice regarding the care, support and protection of the forensic disability cohort. This should include the provision of assistance and input into the development by the Chief Psychiatrist of clinical guidelines and policies and procedures.

Recommendation

- 3 Expand the role of the Office of the Director of Forensic Disability to provide clinical leadership and oversight of the provision of services to all patients on a Forensic Order (Disability) (not just those detained to the Forensic Disability Service). Mechanisms should also be put in place to formally allow the Office of the Director of Forensic Disability to provide expertise and support to Hospital and Health Services managing patients on a Forensic Order (Mental Health) who have a co-occurring intellectual disability.

Regardless of the governance structure that is established, clarity is required in regard to clinical reporting lines and escalation pathways, and the roles and responsibilities of the various government and non-government agencies involved in the delivery of services to the forensic disability population need to be clearly defined. Additionally, relationships across relevant stakeholders need to be formalised. In particular, at the state level, formal interfaces need to be established between the Director of Forensic Disability and Queensland Health, including the Office of the Chief Psychiatrist, the Executive Director of Mental Health, and AMHS Clinical Directors in the various Queensland regions. At a local level, formal communication lines should be established between AMHS Clinical Directors, HHS Mental Health Co-ordinators, relevant non-government organisations, and those responsible for the case management of forensic disability clients (such as Disability Forensic Liaison Officers (see section entitled 'Forensic Disability System')).

Recommendation

- 4 Formalise relationships across relevant stakeholders. In particular, formal interfaces need to be established between the Director of Forensic Disability and Queensland Health, including the Office of the Chief Psychiatrist.

It is noted that Queensland is one of three jurisdictions in Australia that does not have an Office of the Senior Practitioner (the other jurisdictions being Western Australia and the Northern Territory). While there is some variation between jurisdictions, the Senior Practitioner is generally responsible for evaluating and monitoring the use of restrictive interventions in disability services, developing guidelines and standards, providing education and information to disability service providers, and developing links to professional and academic institutions to facilitate knowledge and training in clinical practice. It is understood that, at the time of the establishment of the Office of the Director of Forensic Disability, an Office of the Chief Practitioner Disability was also created, with both roles being held by the same person, Dr Jeffrey Chan. Since Dr Chan's departure, the role of the Chief Practitioner Disability has fallen away, with the functions of a Senior Practitioner falling within the purview of the Centre of Excellence for Clinical Innovation and Behaviour Support. With the transition to the NDIS, the future of the Centre of Excellence is unclear. It is, however, essential that the clinical governance functions currently undertaken by the Centre, including the provision of support, performance monitoring and operational oversight to services involved in the care and support of people with disabilities, as well as the regulation of restrictive practices in disability services, be retained by a government agency of some form following transition to the NDIS. This could be achieved by either preserving the operation of the Centre of Excellence or by re-establishing a position akin to the Office of the Senior Practitioner in other Australian jurisdictions.

Recommendation

- 5 Following transition to the NDIS, ensure that the clinical expertise and governance functions currently undertaken by the Centre of Excellence for Clinical Innovation and Behaviour Support, particularly the provision of support, performance monitoring and operational oversight to services involved in the care and support of people with disabilities, as well as the regulation of restrictive practices in disability services, be retained by a government agency of some form. This could be achieved by either preserving the operation of the Centre of Excellence or by re-establishing a position akin to the Office of the Senior Practitioner in other Australian jurisdictions.

Finally, the availability of comprehensive data is an important factor in the ability to measure service outcomes, track client trajectories and progress, report against key performance indicators, and engage in effective strategic planning and resource allocation. Accordingly, it

is important that the governance structure incorporates an efficient and effective data and information system that allows for timely access to information regarding the forensic disability cohort. The review was informed that data regarding people on Forensic Orders (Disability) who are managed by Authorised Mental Health Services is recorded and managed in CIMHA, the statewide clinical information system that delivers functions required to meet the statutory obligations under the *Mental Health Act 2016* (Qld) and is monitored and reported on by the Office of the Chief Psychiatrist. However, this system is not accessible by the Director of Forensic Disability or Centre of Excellence. In order to ensure that the management of the whole forensic disability population is supported and informed by comprehensive data, the existing CIMHA system should be utilised to record information regarding all people on a Forensic Order (Disability), with arrangements put in place to enable the Director of Forensic Disability and the Centre of Excellence (or equivalent Office of the Senior Practitioner) to easily access the data.

Recommendation

6 Establish information and reporting systems that enable timely access to comprehensive information regarding the forensic disability cohort in order to measure service outcomes and client trajectories, report against key performance indicators, and engage in effective strategic planning and resource allocation. This may include the establishment of a central register of orders which records the number of people on Forensic Orders (Disability) at any one time, the Hospital and Health Services regional location of people on orders, the offending profile of the cohort, and the length of time people have remained on orders. Some of this information is systematically maintained in Consumer Integrated Mental Health Application (CIMHA). As such this recommendation could be satisfied, in part, by enabling the Director of Forensic Disability and the Centre of Excellence (or equivalent Office of the Senior Practitioner) to access CIMHA.

Observation

Although outside the scope of the terms of reference, significant limitations were identified in the provision of disability services in the broader mental health service. This includes, patients on Forensic Orders (Mental Health) with a co-occurring cognitive disability as well as other mental health patients with such co-occurring disorders. Queensland Health should recognise the importance of developing capacity within mental health services across the spectrum of intellectual disability, not solely forensic disability. A range of strategies would be required to help achieve a greater degree of disability expertise to enhance the services of people with mental illnesses and co-occurring disability.

Legislation

The overarching purpose of the legislative framework that underpins Queensland's current forensic disability service system is commendable. However, the review identified some aspects of the *Forensic Disability Act 2011* (Qld) and the *Mental Health Act 2016* (Qld) that may benefit from amendment if that overarching purpose is to be better operationalised.

Role, functions and powers of the Director of Forensic Disability

In relation to the *Forensic Disability Act 2011* (Qld), the lack of clinical and legislative oversight, by a person with expertise in both disability and forensic services, of the total cohort of people on Forensic Orders (Disability) should be rectified by clarifying and expanding the role of the Director of Forensic Disability. As noted earlier, under Chapter 8 of the *Forensic Disability Act 2011* (Qld), the role of the Director is restricted to the care, support and protection of 'forensic disability clients' who are defined in section 10 as those on a Forensic Order (Disability) who fall under the responsibility of the FDS. The FDS is funded to support up to ten forensic disability clients as inpatients at any given time. While, as a statewide service, it can provide outreach to people on Forensic Orders (Disability) who are managed in the community, it is not resourced to provide community support staffing models to those on a 'community' category of order. At the time of the review, the number of people detained to the FDS was six (with one client accommodated offsite on 24/7 Limited Community Treatment).

At the time of the Review, there were 91 people on Forensic Orders (Disability) outside the FDS, who were managed in the community under the responsibility of Queensland Health, with an additional 64 people on Forensic Orders (Mental Health) with a co-occurring intellectual or cognitive disability. As shown in Figure 1, these numbers are expected to grow steadily over time, with the number of people placed on orders far exceeding those whose orders are revoked. Yet despite the specialist nature of the office and the skills of its staff, under the current legislative arrangements, the Director of Forensic Disability has no role in relation to the care and support of this sizeable group, with oversight instead provided by the Chief Psychiatrist under the *Mental Health Act 2016* (Qld). Nevertheless, the review was informed that the Director is regularly contacted by other agencies, such as AMHS, Corrective Services, DCCSDS and non-government organisations for advice, input and direction regarding people on Forensic Orders who have an intellectual or cognitive disability, despite this not being a legislated function of the Director in the *Forensic Disability Act 2011* (Qld).

Additionally, while the *Mental Health Act 2016* (Qld) provides that the Director of Forensic Disability may elect into MHC references where the defendant has an intellectual disability or cognitive impairment, the MHC has interpreted this power restrictively as enabling the Director, who it described as having "extremely limited statutory functions" (at [15]), to elect only into references where admission to the FDS is being considered (*In the matter of Sukkur Abdus* [2016] QMHC 10). As a result of this narrow scope, the review was advised that the Director rarely elects into MHC hearings, even where forensic disability expertise may be beneficial. As observed by Dalton J in *Abdus*,

in the vast majority of cases before the Mental Health Court involving someone with an intellectual disability (I would estimate in the region of 98 to 99 per cent), the Director of Forensic Disability has no powers, functions, responsibilities or obligations in relation to the person the subject of the reference.

Conversely, the *Mental Health Act 2016* (Qld) designates the Chief Psychiatrist as a party in all MHC references concerning people with an intellectual disability or cognitive impairment. While section 114(2) of the *Mental Health Act 2016* (Qld) provides that the Chief Psychiatrist may elect not to be a party if the Director has opted in, the review was advised that the Chief Psychiatrist has never exercised this power to not be a party, even in matters where an individual has an intellectual disability but no co-occurring mental illness.

It is difficult to envisage that the intention of the *Forensic Disability Act 2011* (Qld) was to create a legislative office with responsibility for such a small, albeit complex, group of people, whilst leaving more than 90% of the forensic disability population, who are managed by Authorised Mental Health Services under the oversight of the Chief Psychiatrist, without specialist forensic disability oversight. This would seem to be inconsistent with the purpose and intention of the Carter Report, which advocated for specialist forensic disability services that deemphasised the medical model. This is also in contrast to those on Forensic Orders (Mental Health) in relation to whom the Chief Psychiatrist ensures the rights of patients are protected, as well as providing clinical leadership and expert clinical advice to AMHS, and monitoring and auditing compliance with the *Mental Health Act 2016* (Qld).

Similar specialist oversight of the forensic disability population is required which could be achieved by expanding the role, functions and powers of the Director of Forensic Disability to cover all people with an intellectual or cognitive disability who are placed on Forensic Orders (Disability), not just those detained to the FDS. The role of the Director should include the right to appear as a party in all MHC references concerning people with an intellectual or cognitive disability, rather than only those matters where admission to the Forensic Disability Service is being considered. Additionally, while the Chief Psychiatrist must necessarily retain responsibility for overseeing people on Forensic Orders (Disability) who are managed by Authorised Mental Health Services, the Director of Forensic Disability should work alongside the Chief Psychiatrist and have a role in providing specialist input and advice regarding the care, support and protection of the forensic disability cohort. This would include the provision of assistance and input into the development of Chief Psychiatrist's policies and guidelines to ensure that, as appropriate, they take into account the special needs of both patients on Forensic Orders (Disability) and those on Forensic Orders (Mental Health) who have a co-occurring cognitive disability.

Recommendation

- 7 Expand the cohort of people for whom the Office of the Director of Forensic Disability is responsible to include all people on Forensic Orders (Disability), including both those detained to the Forensic Disability Service and those managed by Authorised Mental Health Services.

Consideration should be given to the most appropriate reporting structure for the Director of Forensic Disability in order to ensure the role's independence. During the consultation process, it was suggested that the role of the Director could be subsumed within mental health, perhaps with the role assumed by the Chief Psychiatrist. However, this risks a return to the pre-Carter service landscape, with the care and support needs of the forensic disability population being conflated with those of people with a mental illness.

Rather, the position should have authority equivalent to the Chief Psychiatrist and should sit independently of the Department responsible for the administration of the FDS (just as the Chief Psychiatrist is independent of Authorised Mental Health Services), thereby avoiding any conflict and ensuring that the role has the ability to provide effective oversight of the forensic disability cohort. The Director of Forensic Disability has an independent statutory oversight role to ensure the protection of the rights of forensic disability clients, and that the detention, assessment, care and support, and protection of the clients comply with the *Forensic Disability Act 2011*.

Recommendation

- 8 Continue the Director of Forensic Disability as an independent governor in council appointment. The position should have authority equivalent to the Chief Psychiatrist and should sit independently of the Department responsible for the administration of the FDS. Provide the Director of Forensic Disability with the right to appear as a party in all Mental Health Court references concerning people with an intellectual or cognitive disability, rather than only those matters where admission to the Forensic Disability Service is being considered.

Regulation of restrictive practices

A person subject to a Forensic Order (Disability) may have their rights limited in a number of ways. Restrictions on a person's liberty can result from being detained in the FDS or as an inpatient in an AMHS, and through the imposition of restrictive interventions, including containment, seclusion, physical, chemical and/or mechanical restraint.

Despite the availability of similar restrictive practices to both people detained in the FDS and those managed by an AMHS receiving disability services, a different regulatory regime applies to each group. In regards to forensic disability clients detained to the FDS, the use of restrictive practices is regulated by Chapter 6 of the *Forensic Disability Act 2011* (Qld), while those managed by an AMHS are either subject to the restrictive practices regime under the *Mental Health Act 2016* (Qld) if detained as an inpatient in an AMHS or the restrictive practices framework under the *Disability Services Act 2006* (Qld) if receiving disability services whilst being managed in the community. The review was informed that this distinction

reflects an intention that the *Forensic Disability Act 2011* (Qld) mirror, as far as possible, mental health legislation with relevant changes for the forensic disability cohort. It has, however, resulted in a disjointed approach to the regulation of restrictive practices for those people detained to the FDS, particularly given that the *Disability Services Act 2006* (Qld) applies to them in other circumstances (such as while undertaking community treatment). In order to ensure consistency with complementary legislation and avoid fragmentation, the restrictive practices framework applying to people detained to the FDS should mirror that set out in the *Disability Services Act 2006* (Qld). It is noted that the current review of the *Forensic Disability Act 2011* (Qld) proposes a similar amendment to the Act in order to ensure a modern, contemporary and consistent approach to the regulation of restrictive practices in the FDS.

In regards to those people on Forensic Orders (Disability) or Forensic Orders (Mental Health) with a co-occurring disability who are detained as inpatients in an AMHS, it is reasonable that the restrictive practices framework set out in the *Mental Health Act 2016* (Qld) continue to apply. Indeed, it would be unwieldy and operationally difficult to implement two different regimes within a single facility for different groups of clients.

Recommendation

- 9 To ensure consistency with complementary legislation and avoid fragmentation, there is a need to establish a restrictive practices framework for people detained in the Forensic Disability Service that mirrors that set out in the *Disability Services Act 2006* (Qld).

A new examination order

Underpinning the *Forensic Disability Act 2011* (Qld) is a strong rehabilitative focus. Thus, the purpose of the Act, articulated in section 3, includes the promotion of the individual development of forensic disability clients and their opportunities for quality of life, and the maximisation of opportunities for community reintegration. Stakeholders confirmed that the vision for the FDS was not to provide a place of indefinite containment, but rather a residential treatment facility which would cater to clients who could benefit from interventions delivered by the FDS and could eventually transition to full community reintegration.

This vision has not, however, been translated into practice, with eight of the original intake of clients to the FDS being detained for a continuous period of more than five years. The Director's Five Year Reviews of these clients (as required by s 141(3) of the *Forensic Disability Act 2011* (Qld)) found that all had received maximum benefit from their time at the FDS, and no further benefit would be achieved by them remaining at the service. In two cases, clients were deemed to have gained very little benefit from their time at the FDS and "a more

appropriate service model was required to meet their ongoing complex needs”.⁴⁴ This finding reflected the consistent view amongst stakeholders that many of the original clients detained to the FDS were inappropriately placed, resulting in lengthy detention times and the development of a sense of hopelessness amongst both staff and clients. In some cases there was explicit reference to limited willingness to engage or capacity to benefit from rehabilitative interventions; and in others concern was raised that community safety concerns had trumped rehabilitative potential of the placement.

To ensure that the FDS meets its legislative aims, it is essential that those admitted are able to benefit from the interventions delivered by the service. While the establishment and application of well-defined admission criteria, based on clinical assessments of risk and treatment needs, are critical in identifying appropriate clients, it is acknowledged that it is sometimes difficult to determine a person’s suitability prior to admission. The ability to detain a person, who has been identified as potentially suitable for admission, in the FDS for a short period for the purposes of assessment may assist in determining whether or not a person is likely to benefit from admission. It is noted that the *Mental Health Act 2016* (Qld) provides power to the MHC to make a Court Examination Order which requires a defendant to submit to an examination by a court-nominated psychiatrist or health practitioner. The Order may authorise a person to be detained in an AMHS (but not the FDS) for the purposes of the examination for a set period of time. A similar type of examination and assessment order that gives the MHC the option to detain a person to the FDS for the purpose of assessing suitability and capacity to engage would be an effective way to reduce the likelihood of inappropriate placements.

Recommendation

- 10 Consider introducing an examination and assessment order, similar to the Court Examination Order under the *Mental Health Act 2016* (Qld), that enables the Mental Health Court to detain a person to the Forensic Disability Service for a set period of time for the purpose of assessing suitability for admission and capacity to engage. The introduction of such an order could help reduce the likelihood of people being detained in the Forensic Disability Service who are unsuitable and may become held in the facility inappropriately.

A new ‘step-down’ order

As shown in Figure 1, the number of Forensic Orders (Disability) imposed by the MHC has steadily increased year-on-year since their introduction in 2011, with the number of new orders far exceeding the rate of revocations. While this increase highlights the need to investigate prevention and early intervention strategies which could potentially reduce the number of people with an intellectual disability coming into contact with the criminal justice

⁴⁴ Director of Forensic Disability, *Annual Report 2016-17* (2017) 31.

system, consideration should also be given to the options available to the judiciary when dealing with the cohort. In particular, the introduction of a step-down order similar to the Treatment Support Order, which was introduced in the *Mental Health Act 2016* (Qld) in response to similar growth in the number of people placed on Forensic Orders (Mental Health), should be considered.

Treatment Support Orders enable the MHC and the MHRT to impose a less restrictive form of order than a Forensic Order in relation to people with a mental illness. The orders may be imposed by the MHC where a person is found to be of unsound mind or unfit for trial but they do not require the level of supervision under a Forensic Order in order to protect the safety of the community. Additionally, the MHRT may make a Treatment Support Order on the revocation of a Forensic Order. In this instance, the Treatment Support Order forms an important component of a patient's recovery by enabling the MHRT to 'step-down' a person from a Forensic Order. The legislative presumption is that people on such orders are managed in the community, unless it is necessary for the person to be managed as an inpatient, having regard to treatment and care needs, and the safety of the person and the community. This contrasts with the default position under a Forensic Order which is detention unless the MHC is satisfied that there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of serious harm to other persons or property.

Currently, the option of a less restrictive form of forensic order is not available to people with an intellectual disability who come into contact with the criminal justice system. Consideration should be given to introducing a similar type of order for people on Forensic Orders (Disability) in order to align the legislation regarding forensic orders regardless of the type of order (Disability or Mental Health) and provide equal opportunities for people with an intellectual disability to be managed in the least restrictive way possible. In turn, the availability of such an order may assist in reducing the number of people being placed on Forensic Orders (Disability) at initial disposition by the MHC, as well as promote transition through the system by providing the MHRT with a 'step-down' option to revocation.

Recommendation

- 11 Consider introducing a less restrictive form of Forensic Order, similar to a Treatment Support Order, to provide equal opportunities for people with an intellectual disability to be managed in the least restrictive way possible and promote transition through the system by providing the MHRT with a 'step-down' option to revocation.

Decision-making presumption

As noted earlier, it is clear that significant barriers to the revocation of Forensic Orders (Disability) exist, with only 14 Orders revoked since their introduction.⁴⁵ While there are a multitude of factors that impede the progression of the forensic disability population, an important element is the role of the MHRT, the key decision-making body responsible for the

⁴⁵ Data drawn from Mental Health Review Tribunal Annual Reports 2011-2017.

review and revocation of orders. In deciding whether or not to continue or revoke an order, section 432 of the *Mental Health Act 2016* (Qld) requires the MHRT to have regard to the circumstances of the person, the nature of the index offence and the period of time since its commission, any victim impact statement relating to the index offence and the person's willingness to participate in any intervention program offered to the person on the MHC's recommendation. Section 442(1) goes on to set out a decision-making presumption that the MHRT must confirm the order if it is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to people or property.

The review was informed that the MHRT has traditionally taken a conservative approach to its assessment of risk and has found it difficult to envisage a transition pathway to revocation for people on Forensic Orders (Disability). This risk-averse approach is facilitated by the operation of a decision-making presumption in favour of maintaining an order to protect community safety. It is harder for a person on an Order to prove the complete absence of risk to the community than for the state to provide evidence in support of the presence of any level of risk to the community. Accordingly, the presumption contributes to the slowing of the progression of a person through the system in a way that is inconsistent with the aim of providing care and support in the least restrictive way consistent with the safety of the community.

Compounding the legal issues is the stark reality that the accommodation and service options for patients on Forensic Orders (Disability) are very limited and most do not effectively address their disability issues, which can only impact negatively on prospective assessments of community safety by decision-makers.

It is noted that the decision-making presumption imposed on the MHRT when reviewing Forensic Orders is in contrast to that imposed when reviewing treatment authorities; section 421(1) of the *Mental Health Act 2016* (Qld) provides that the MHRT must revoke the authority if the treatment criteria no longer apply or there is a less restrictive way for the person to receive treatment and care for the person's mental illness.

In combination with the introduction of a 'step-down' order similar to a Treatment Support Order (discussed above), the introduction of a similar decision-making presumption more favourable to the transfer of people on Forensic Orders to a less restrictive option, will better promote the progress of people through the system, by requiring the MHRT to provide clear justification if an Order is to be continued. Such a presumption will also impose an impetus on service providers (which bear most risk) to consider and prepare for the possibility of revocation at each review hearing. As it stands, the current model promotes inertia, partly due to decision-making presumptions that operate in favour of preserving the status quo.

Recommendation

- 12 Introduce a decision-making presumption, similar to that applying to the Mental Health Review Tribunal when reviewing treatment authorities under the *Mental Health Act 2016* (Qld), that requires the Mental Health Review Tribunal to reduce the level of supervision of a person on a forensic order unless satisfied that a more restrictive level of supervision is required in order to protect the safety of the community, including from the risk of serious harm to people or property. As recommended in Recommendation 5, the introduction of a less restrictive form of Forensic Order, similar to a Treatment Support Order, would allow for people on Forensic Orders (Disability) to be managed at different levels of supervision.

Forensic Disability Service

The principles underpinning the establishment of the FDS are commendable. Meeting a key recommendation of the Carter Report, the FDS was intended to provide people on Forensic Orders (Disability) with a favourable alternative to detention in a mental health facility. As recognised by Justice Carter, “It is beyond argument that a person with intellectual disability who has not been diagnosed with a mental illness will be inappropriately housed or accommodated in a mental health service whose core function is the treatment of mental illness”.⁴⁶ As a purpose-built, medium secure facility, the FDS was established to provide people on Forensic Orders (Disability) with a residential treatment and rehabilitation program that could safely and appropriately meet the unique needs of cohort. However, a clear and consistent view across stakeholders was that the FDS has not functioned as envisaged. Numerous issues were identified.

First, unacceptably lengthy detention times have been the norm, with the original intake of nine clients all being detained for more than five years, including one client who died whilst a client of the service in January 2016. This goes against the purported strong rehabilitative focus of the FDS (as opposed to offering a place of indefinite containment) and its aim of reintegrating clients to the community, having benefitted from the focused interventions offered by the service. As discussed earlier, one of the main reasons for the extended detention times was a failure to apply strict admission criteria based on a robust assessment of risk and treatment need. Instead, numerous stakeholders advised that the original intake to the FDS comprised those clients identified by AMHS as being “difficult” and “in the too hard basket” but not necessarily those who were able to benefit from the interventions offered by the FDS. Numerous members of current FDS staff commented, in regards to current clients of the FDS, that “they should never have come here”.

The isolation and separation of the FDS from the wider disability and mental health sectors has further compounded the difficulty of transitioning clients from the service. While, at the time of its opening, the facility was touted as “a bricks and mortar example of the State

⁴⁶ Carter Report, above n 3, 162.

Government's commitment to deliver more appropriate services for people with an intellectual disability and complex, challenging behaviours",⁴⁷ it was established in the absence of a coherent service strategy. As a result, the FDS has, in the words of one stakeholder, operated as "an orphan" with no community team, and no clear linkages and exit pathways for clients to the wider service system. Numerous stakeholders identified the lack of step-down facilities in regional areas as a major hurdle to transition, noting that the lack of capacity and forensic disability expertise in regional areas has contributed to a strong degree of reticence on the part of AMHS about the return of FDS clients to their region. In this regard, the following observation by Justice Carter in 2006 remains valid: "Not surprisingly the need for a mental health service to have to accommodate, care for and manage in a mental health service a person with intellectual disability but not a mental illness has been the cause of significant inter-departmental dialogue and tension".⁴⁸ It also leaves mental health services feeling powerless due to the limited availability of resources and expertise to meet the needs of the forensic disability cohort. Clients' lengthy periods of detention in the FDS has also contributed to a disconnection from regional services.

The carving out of the small group of clients detained to the FDS from the wider service system in which the majority of people on Forensic Orders (Disability) fall under the responsibility of Queensland Health has further isolated the FDS and created significant systemic barriers to transition. Indeed, it is telling that, while a Memorandum of Understanding between DCCSDS and Queensland Health "outlining corporate and service level arrangements in relation to forensic disability matters" was entered at the time of the establishment of the FDS, it expired in March 2015 and has not been renewed. The siloed operation of the FDS means that the transition of a client from the FDS to the community requires the agreement of the Chief Psychiatrist, despite the current lack of a formal interface between the Director of Forensic Disability and the Office of the Chief Psychiatrist. The challenges associated with client transition are neatly articulated in the Director of Forensic Disability's Annual Report 2016-17: "geographical distance, intricacies of inter-government relationships, and the various stakeholders required to agree and support [a] client's return to the community [have to be] carefully navigated".⁴⁹ In short, a functional system requires more than a 'bricks and mortar' solution, whereby the FDS needs to be integrated into a wider service system, with clear linkages and pathways for transition to ensure patient flow and continuity of care for forensic disability clients returning to the community.

The isolation of the FDS from the broader health and disability systems has had a significant impact on the culture within the service. In the course of the review, a large number of FDS staff across clinical, administrative and management positions were consulted. All expressed significant concern about the workplace culture of the FDS which was variously described as "toxic", "dysfunctional", and "disorganised." Additionally, intimations of disharmony, bullying

⁴⁷ Honourable Curtis Pitt, Minister for Disability Services, Mental Health and Aboriginal and Torres Strait Islander Partnerships, 'Wacol facility a Queensland first' (Media Release, 13 July 2011).

⁴⁸ Carter Report, above n 3, 163.

⁴⁹ Director of Forensic Disability, *Annual Report 2016-17* (2017) 35.

and unhappiness were conveyed. Common issues raised by FDS staff included:

- There is a significant division between direct support staff and those working in the Administrative Building. Many clinical staff expressed a sense of not being supported by management, whilst management described clinical staff as being mistrustful.
- The organisational structure of the FDS is unclear. Staff expressed considerable confusion regarding the roles and responsibilities of the various positions in the staffing profile, resulting in tension, conflict and disengagement. It is noted that, in some areas, the FDS appears to be over-staffed, resulting in a duplication and deskilling of roles. In this regard, a number of staff articulated frustration that the current staffing model does not provide opportunities for staff to apply their skills and expertise to effectively meet client needs, with the speciality of positions getting lost over time. For example, the review was informed that, while clinicians initially provided a much greater level of clinical input, a large part of their role has now been reduced to the management of seclusion, with limited input into transition and management planning. It is noted that there are three clinicians on shift during the day, with one clinician allocated to each house (one of which accommodates only one client).
- In addition to a lack of role clarity, there has, until recently, been a lack of clear organisational policies and procedures to govern practice (or inconsistent adherence to existing policies), such as admission and discharge processes (including eligibility criteria), risk assessment and management, and critical incident debriefing. In regards to the latter, staff reported that, generally, they are not provided with the opportunity to debrief following an incident, contributing to the view that staff are not supported and missing the opportunity to share lessons learned and improve practice.
- Similarly, while relevant policies and procedures have recently been reviewed and reissued, staff identified some continued concerns regarding practices around clinical documentation. In particular, in regards to Limited Community Treatment, staff stated that client leave entitlements are often not documented accurately and the organisation of the necessary paperwork is often chaotic which can cause leave to be delayed.
- There is a general lack of communication and consultation across all aspects of the service. While there are regular team meetings within the three 'houses' that make up the FDS, staff reported limited opportunities to communicate with other staff across the service in regards to, for example, transition planning or IDPs. This

contributes to the sense of isolation and disconnection experienced by FDS staff, and a lack of cohesiveness across the service.

- There is a lack of regular practice supervision provided to staff, and limited opportunities for staff training and professional development. There is also a tokenistic approach to performance management, with limited feedback or performance reviews provided to staff.
- There has been a considerable turnover of senior staff since the establishment of the FDS. The review was informed that there have been two Directors of Forensic Disability and four Regional Directors in five years, and multiple changes in Senior Practitioners and Administrators. Currently, the whole management team, bar one position, is acting and many members of staff are drawn from a pool of casuals. The frequent changes in senior management have been accompanied by some inconsistency in approach to the FDS' model of care over the years, resulting in confusion and conflict amongst staff, whilst the lack of permanency in positions has resulted in staff disengagement and a lack of continuity of care.
- The delivery of therapeutic programs, including offence-specific and rehabilitative programs, over the years has been limited, and lacking in co-ordination and consistency. Staff also described a disconnection between direct support staff and members of CHART, the team responsible for the development and delivery of programs. This lack of co-ordination and communication between the two teams makes it difficult for direct support staff to reinforce key learnings and treatment themes in clients' day to day environment which is essential if skills generalisation is to occur. The lack of movement of clients through the service has also contributed to a lack of motivation regarding the delivery of programmatic interventions over the years.

Despite these numerous issues, the FDS also has a number of strengths. The facility itself is well-designed, well-built and well-tended, and the houses are light, spacious and individually modified. The facility is well-staffed by people with a range of different skills and expertise, many of whom expressed dedication to working with the clientele, as well as being very well-resourced. It should also be acknowledged that, while there was a perception amongst some stakeholders that the FDS has achieved no outcomes over its six years of operation, it provides a valuable service in managing the small number of people with an intellectual disability or cognitive impairment who engage in serious challenging behaviours that present a high risk to the safety of themselves and the community. For this group, it is important that the state retains an ongoing capacity to provide secure care in a purpose-built residential treatment facility, such as the FDS, benefitting both the person and the community in terms of managing

risk. Finally, following years of inertia, there have been significant efforts in the past 18 months to transition clients from the service, with two clients discharged in the past year.⁵⁰

Nevertheless, whilst acknowledging these strengths, it is clear that the FDS is not functioning as intended. While it should be retained as a statewide secure residential treatment service, a clear model of service needs to be established that embeds the FDS within the wider service system, including clear linkages and pathways for transition, to ensure patient flow and continuity of care for forensic disability clients returning to the community.

Recommendation

13 Retain the Forensic Disability Service as a statewide secure residential treatment service in order to meet the needs of the small number of people with an intellectual disability or cognitive impairment who engage in serious challenging behaviours that present a high risk to the safety of themselves and the community. While it should be retained as a statewide secure residential treatment service, a clear model of service needs to be established that embeds the FDS within the wider service system, including clear linkages and pathways for transition, to ensure patient flow and continuity of care for forensic disability clients returning to the community.

There is a need to repurpose some of the FDS' significant resources in order to increase efficiency and better meet its purported focus on the rehabilitation and community reintegration of clients. In particular, a clear organisational and clinical governance structure for the operation of the FDS needs to be established that clearly defines the roles and responsibilities of the various positions in the staffing profile, as well as establishing clear reporting lines and escalation pathways. The current staffing model should also be reviewed to ensure that the distribution of staff aligns with a model of care that prioritises clinical and recovery needs, and supports a multidisciplinary team care approach to client engagement, assessment, formulation and intervention. In particular, the staffing profile should address the current shortage of allied health expertise and input (particularly in the areas of psychology, speech pathology and occupational therapy) into the care, support and assessment of clients. This shortage may, in part, be addressed by harnessing and repurposing those existing staff with allied health qualifications.

⁵⁰ As noted earlier, the review was informed that four clients have been transitioned from the FDS over its six and a half years of operation: one client transferred to a secure unit at Townsville Hospital; one client moved to Toowoomba to live with family; one client transferred to Baillie Henderson Hospital in Toowoomba with the expectation that they would quickly transition to supported accommodation in the community with NDIA support; and one client transferred to Townsville Community Care Unit with access to leave to allow them to spend five days living with family. One client has passed away whilst detained to the FDS.

Recommendations

- 14 Establish a clear organisational and governance structure for the operation of the Forensic Disability Service. Depending how the Forensic Disability is established going forward, it would also be critical to articulate clear clinical (disability) governance structures for both FDS clients and the broader forensic disability and dual disability client group.
- 15 Review the staffing profile of the Forensic Disability Service to increase efficiency and ensure that it aligns with the model of care. This would include ensuring that there should be a multidisciplinary team approach in the Forensic Disability Service.

These staff also have the potential to play a critical role in the delivery of therapeutic programs and interventions (including offence-specific and rehabilitative programs) which should be evidence-based and adapted to address the needs of the cohort. Programs should be delivered on a consistent basis and need to be embedded within individualised management plans. This will assist in bridging the current disconnection between clinical and direct support staff in reinforcing key learnings and treatment themes, and help facilitate skills generalisation in the clients' day-to-day environment. Additionally, the expertise of the FDS in delivering programs targeted to the forensic disability population should be harnessed and made more accessible to the whole cohort of people on Forensic Orders with an intellectual disability or cognitive impairment. This could be achieved by either delivering programmatic interventions onsite at the FDS to external clients, or on an outreach basis in various regions depending on the level of need and demand for a particular program. Additionally, the FDS could provide training to staff in the disability and mental health sectors in the delivery of specialist forensic disability programs, thereby assisting in workforce development. It would also be desirable for the FDS to provide a consultation/liaison service to AMHS and non-governmental agencies managing people on Forensic Orders (Disability) and perhaps those on Forensic Orders (Mental Health) who have a co-occurring disability.

Recommendation

- 16 Re-allocate some existing staff of the Forensic Disability Service to provide statewide assessment and outreach services, and deliver adapted rehabilitative programs targeting criminogenic factors associated with offending behaviour to the whole forensic disability population.

It is also essential that clear organisational policies and procedures for the operation of the FDS, including policies and procedures regarding admission and discharge, structured and systematic risk assessment and management, critical incident debriefing and the

administration of clinical documentation, including that related to Limited Community Treatment, are implemented effectively and consistently. The review was informed that a range of policies and procedures have been recently reviewed and reissued. However, some FDS staff expressed concern that policies and procedures were not being consistently applied across the service. In regards to assessment processes, it is essential that baseline assessments of risk and clinical need are undertaken on admission to the FDS, enabling analysis of a client's benefit from the care and support provided by the FDS over time.

Recommendation

- 17 Ensure that clear organisational policies and procedures for the operation of the Forensic Disability Service are implemented effectively and consistently across the service.

Finally, in regards to the issue of length of stay, increased throughput of clients could be encouraged by a new examination and assessment order (as discussed earlier) to ensure that only those likely to benefit from the interventions offered by the FDS were admitted. Consideration should also be given to making orders which detain people to the FDS time-limited to a period of 18-24 months, with a capacity for the MHRT to renew the order on expiration. If no further benefit would be achieved by a person remaining at the service beyond the expiration of the order, an alternative service model should be sought, thereby encouraging the movement of people through the service and realigning its model of care to focus on rehabilitation and community reintegration. The alternative service model could include, if needed, transfer to an AMHS inpatient service or in the community with the support of an NGO. The notion of a short-term period of care at the FDS would also assist in maintaining links with clients' regional services, reducing the possibility that regions 'wipe their hands' of a client and improving the efficiency of the transition process.

Recommendation

- 18 Consider making orders which detain people to the Forensic Disability Service for a time-limited period of 18-24 months, with the authority for the Mental Health Review Tribunal to renew the order on expiration only if further benefit would be achieved by a person remaining at the service for an additional period of time. Given the limited options in existence to manage people on Forensic Orders (Disability), the AMHS, with the support of the Director of Forensic Disability and the Senior Practitioner/Centre of Excellence, would need to take responsibility for assisting with the management of the person's care.

Forensic Disability System

As noted earlier, many of the issues associated with the FDS stem from the fact that it is not embedded within a wider service system. Additionally, the narrow remit of the Director of Forensic Disability means that the vast majority of people subject to Forensic Orders (Disability) continue to be managed by mental health services without access to specialist forensic disability expertise. This is despite the criticisms of this situation by Justice Carter who observed that “a mental health service has nothing to offer a person who does not have a mental illness”.⁵¹ Indeed, for most people with an intellectual disability or cognitive impairment who are placed on a forensic order, the pre-Carter service landscape remains and the establishment of the FDS and creation of a Director of Forensic Disability has had negligible impact on the appropriateness of their care. In many ways, the introduction of a Forensic Order (Disability) distinguishes those with an intellectual disability or cognitive impairment from those with a mental illness in name only; unlike a Forensic Order (Mental Health), a Forensic Order (Disability) does not designate a clear care pathway and does not guarantee that a person receives the most appropriate services for their care.

That the current system requires AMHS to accommodate, care for and manage people with an intellectual disability or cognitive impairment, but not a mental illness, is the cause of much consternation. Numerous stakeholders in the mental health sector expressed significant concern and frustration regarding their lack of capacity and expertise to manage the unique needs of the forensic disability cohort, leading one stakeholder to describe the cohort as “the bane of our existence.”

Echoing concerns noted in the Carter Report,⁵² stakeholders’ central concerns related to problems of service delivery, lack of forensic disability expertise and inappropriate infrastructure, with mental health units providing a poor fit for the needs of those with an intellectual disability. Visits by the Review Team to mental health facilities currently accommodating people on Forensic Orders (Disability) confirmed stakeholder concerns, with mental health unit environments typically being austere, cramped, stimulus-free and providing limited opportunity for clients to exercise independent living skills. Moreover, the patient mix is troublesome, with acutely unwell psychiatric patients (some volatile), mixing with people with disabilities. While such environments may be appropriate for people with an acute mental illness, for relatively short periods of time, they are a poor fit for those with an intellectual disability and are likely to result in poor outcomes including vulnerability, stigma and atrophy of skills.

The lack of clear linkages and transition pathways to more appropriate services in the community also raises the very real danger of extended admissions and resultant institutionalisation. In this sense, while the lengthy periods of detention that have characterised admissions to the FDS is of concern, the lack of appropriate services in the community raises a similar danger for forensic disability clients of indefinite containment in

⁵¹ Carter Report, above n 3, 163.

⁵² Ibid 98.

discharge accommodation that has been designed to accommodate the needs of a completely different client group. This occurs on the backdrop of significant inter-departmental challenges created by the need for the FDS to traverse the mental health system in order to transition clients from the service.

In this regard, it must be noted that, just as it is inappropriate to accommodate people with an intellectual disability in facilities designed to manage people with acute mental illness, it is similarly inappropriate to treat and manage people with a mental illness alongside those with an intellectual disability, potentially impeding the rehabilitation and recovery trajectory of both client groups. Indeed, some stakeholders expressed concern about the required divestment of scarce mental health resources to the management of people with an intellectual disability and the consequential departmental conflict over roles and responsibilities in relation to the forensic disability population. Examples of ineffective allocation of resources provided by stakeholders included the legislative requirement that a psychiatrist review people managed in the community on Forensic Orders (Disability) every three months despite the majority of psychiatrists having no expertise in the area of disability and the sequestration by people on Forensic Orders (Disability) of valuable mental health inpatient beds.

In summary, then, many of the concerns identified in the Carter Report continue to pervade the current forensic disability service system which is fragmented, under-resourced and lacking in a clear supervision and management pathway. In order to address these issues and broaden the reach of specialised forensic disability services to all people on Forensic Orders (Disability), as well as those on a Forensic Order (Mental Health) with a dual disability, a decentralised 'hub and spoke' model should be adopted in preference to the current model which centralises care in the FDS. This could be achieved by establishing regional forensic disability service 'hubs' in the North, Central, South East and South West areas of Queensland which are also able to provide outreach services to remote areas.

Similar to the earlier discussion of governance options (see section entitled 'Governance Structure'), there are two possible models of service delivery for these 'hubs': a 'parallel' model or an 'integrated' model. In a parallel service, the 'hubs' would comprise specialist forensic disability teams operating alongside but independently of Authorised Mental Health Services, under the co-ordination and supervision of the forensic disability services. Such a model aligns with the recommendation in the Carter Report that a differentiated service catering to the specialist needs of people with an intellectual or cognitive disability who interact with the criminal justice system is required. Alternatively, in an 'integrated' model, the 'hubs' would be embedded in Authorised Mental Health Services, with specialist clinicians providing support to AMHS clients with forensic needs.

It has been argued in the research literature that the advantages of an integrated model include "availability of multi-disciplinary clinicians, development of forensic skills across wider groups of clinicians, reduction in stigma and avoidance of delay in transfer of care between

services”.⁵³ The avoidance of potential isolation of forensic services from other community services that may result from a parallel model has also been noted, as has the fact that, in areas with smaller populations, parallel services may not be feasible due to low case numbers. This is certainly the case in Queensland, with the small number of people on Forensic Orders (Disability) and their relatively sparse distribution outside of the Brisbane metro area (see Table 1).

Additionally, as noted earlier, an integrated model has the benefit of exploiting existing infrastructure, rather than having to establish a separate stand-alone forensic disability system. However, if an integrated model is to be preferred, it is essential that the resource demands of the forensic disability population required to be met by specialist clinicians are ‘ring-fenced’ in order ensure that resources are not subsumed by mental health services and the specialist aspect of the service lost. In this sense, the embedding of forensic disability service ‘hubs’ within AMHS may be better described as a hybrid service model in which specialist forensic disability services are provided in parallel to mental health services but with areas of integration and opportunities for joint working and the sharing of resources and expertise between forensic disability and mental health. The ‘ring-fencing’ of forensic disability expertise is also critical to ensuring that a return to the traditional medical model that received scrutiny in Justice Carter’s report is avoided.

Recommendations

- 19 Establish a decentralised ‘hub and spoke’ model for the delivery of forensic disability services by establishing regional forensic disability service ‘hubs’ in the North, Central, South East and South West areas of Queensland to provide outreach services to regional and remote areas within the existing AMHS/HHS framework.
- 20 Given the limited accommodation options for people on Forensic Orders (Disability) and the growing number of people on such orders, Queensland should explore alternative accommodation options over time. Such options might include, for example, supported forensic disability accommodation operated and staffed by NGOs with expertise in the management and support of disabled offenders.

In accordance with contemporary best-practice for working with people with disabilities, the forensic disability service ‘hubs’ would need to comprise multidisciplinary teams, including disability workers, psychology, allied health, disability and/or mental health nursing, and medicine/psychiatry. Neuropsychological expertise is particularly important, given the potential for assessment of the impact of cognitive impairment on behaviour to inform the provision of effective care and risk management to the forensic disability cohort (as well as the broader mental health and disability population) and, in turn, stem the need for placement in distant secure settings, such as the FDS.

⁵³ MacMahon and Clements, above n 19, 204.

Considerable advances have also been made in neuropsychology regarding neuropsychological rehabilitation. The review was informed that few neuropsychologists are employed in Authorised Mental Health Services and there is a widely recognised lack of ready access to neuropsychological expertise by Authorised Mental Health Services and frequent absence of clear service structures to facilitate the assessment of intellectual disability within HHHs.

Given the current lack of forensic disability (as well as general intellectual disability) expertise within Authorised Mental Health Services, it is acknowledged that the creation of 'hubs' of specialist forensic disability expertise will require a significant investment in workforce development and provision of cross systems training, education and supervisory opportunities. Nevertheless, such investment is essential if AMHS are to continue to be responsible for the vast majority of the forensic disability population, as well as effectively meet the needs of other clients in the general mental health system who have a co-occurring intellectual disability or cognitive impairment. It is noted that the University of Queensland has existing expertise in intellectual disability, as well as Queensland's only Clinical Neuropsychology program, and could potentially be engaged to expand this into forensic disability.

Recommendations

- 21 Establish multidisciplinary teams in the forensic disability service 'hubs,' comprising medical, psychiatric, nursing, psychology and allied health professionals possessing a range of skills and competencies across mental health, disability and forensic issues, including the administration of clinical and risk assessment tools relevant to the forensic disability population. These multidisciplinary teams will enhance the capacity of Authorised Mental Health Services to meet the needs of the forensic disability cohort, as well as the needs of other clients of Authorised Mental Health Services who have an intellectual disability or cognitive impairment. Particular priority should be given to addressing the current lack of access to neuropsychological expertise.
- 22 Harness and develop existing forensic disability expertise via workforce development and provision of cross-systems training, education and supervisory opportunities within the mental health and broader service sector. Consideration should be given to engaging the University of Queensland to expand its existing expertise in intellectual disability into forensic disability.
- 23 Enhance staff training, leadership development, professional development, and research opportunities in the area of forensic disability amongst Authorised Mental Health Service staff in order to enhance the expertise and capacity of Authorised Mental Health Services to manage the specialist needs of the forensic disability cohort.

As part of the forensic disability service ‘hubs’, a network of Disability Forensic Liaison Officers (DFLO) should be created, paralleling Community Forensic Outreach Service Teams. The role of these Officers would include co-case management of clients on Forensic Orders (Disability) alongside the AMHS. In particular, services provided by DFLOs would include:

- Preparation of Individual Development Plans, including a comprehensive risk management plan;
- Provision of support, liaison and clinical consultation to the supervising AMHS and other relevant stakeholders regarding appropriate supports and forensic interventions, and legislative requirements of forensic order including risk and community management, as well as support and education regarding legislative requirements of Forensic Orders;
- Monitoring and reporting, including provision of progress reports to the supervising AMHS and the Director of Forensic Disability to inform MHRT hearings;
- Liaison with the NDIS to ensure the proper consideration of complex disability support needs for people on Forensic Orders when formulating NDIS packages; and
- Provision of community liaison support to ensure smooth referral, admission and transition to the FDS, as well as assistance in graduated transition and risk management planning for clients transitioning from the FDS to the community.

Consideration will need to be given as to the most appropriate and efficient model for the operation of the DFLO network across Queensland. Where there is a critical mass of people on Forensic Orders (Disability), the DFLOs could be hosted by Authorised Mental Health Services and form part of the multidisciplinary team. However, this model will not be appropriate in those AMHS with lower forensic disability cohorts which may not warrant a dedicated DFLO position (see Table 1). In these AMHS, DFLOs could be attached to the FDS and provide ‘fly in fly out’ support in the form of a consultation-liaison model or be based in an adjoining AMHS. Where DFLOs are hosted by AMHS, it is important that the network not be subsumed within Queensland Health. Rather, in order to provide critical mass in the provision and development of specialist forensic disability expertise, DFLOs should be employed and supervised by the disability services division.

Recommendation

- 24 Address the current lack of expertise and resources in Authorised Mental Health Services to manage the specialist needs of the forensic disability cohort (including those on Forensic Orders (Disability) and those on Forensic Orders (Mental Health) with a co-occurring cognitive disability) by establishing a network of Disability Forensic Liaison Officers. As the service system is developed, consideration will need to be given as to the most appropriate and efficient model for the operation and oversight of the DFLO network across Queensland. Variations on the model may be required to better satisfy the needs of regions with a critical mass of forensic disability clients and those with few such people.

While no longer the central focus of the system, the FDS should be retained in this model as a statewide medium/high secure service. It is generally accepted that a small number of people with an intellectual disability or cognitive impairment may engage in serious challenging behaviours that present a high risk to the safety of themselves and the community. For these people, it is essential that the state retains an ongoing capacity to provide secure care in a purpose-built residential treatment facility, such as the FDS. Although additional analyses and projects would be required to be definitive, there is no apparent need at present for additional high secure beds.

Rather, the gap in Queensland's forensic disability service system lies outside the FDS, with essentially no facilities providing a dedicated transition pathway from the Service. Rather, the commissioning of extra beds needs to be focused on the creation of step-down facilities in the regional 'hubs'. In addition to providing a stable housing option, step-down facilities are an integral element in ensuring the provision of appropriate levels of security and support for the individuals at a time when they are most at risk of re-offending, as well as being essential to the facilitation of gradual community reintegration.⁵⁴ In the absence of such facilities, the options for community transition are limited, leading to lengthy admissions in restrictive and inappropriate settings, including acute and high-dependency units within mental health services which are not designed to meet forensic and disability needs. This has been described as "a fair demonstration of the law of unintended consequences" – "if less restrictive inpatient facilities are unavailable ... patients end up in far more restrictive forensic beds."⁵⁵ It should be noted that the lack of step-down beds was a consistent concern across all stakeholders. Where a step-down option is not available or there is no alternative but for a person on a Forensic Order (Disability) to be detained as an inpatient in an AMHS, consideration should be given to creating specialist units or beds within mental health units that better accommodate the needs of people with an intellectual disability or cognitive impairment.

Recommendation

- 25 Address the current absence of a clear supervision and management pathway for people on Forensic Orders (Disability) by establishing step-down facilities in regional 'hubs' to facilitate graduated community transition from the Forensic Disability Service and inpatient units within Authorised Mental Health Services (the latter of which are not designed to meet the care, support, habilitation and rehabilitation needs of the forensic disability cohort).

The proposed forensic disability service system model can be conceived of as a three-tiered interconnected system of nested circles, each adding an additional layer to the forensic disability population. As shown in Figure 2, at the centre of the model sits the FDS and forensic

⁵⁴ Australians for Disability Justice, above n 3, 15.

⁵⁵ Alexander et al., above n 9, 145.

disability clients. The FDS is embedded in the wider service system, providing clear care pathways to AMHS which is responsible for the next layer of people with an intellectual disability on Forensic Orders (including both those on Forensic Orders (Disability) and those with a co-occurring mental illness on Forensic Orders (Mental Health)). The next layer of the model covers the remaining people with an intellectual disability in the criminal justice system, including those managed by correctional services in prison and in the community, and those at risk of offending. The outer layer covers people with an intellectual disability in the general population who are managed by disability services with oversight provided by the Centre of Excellence/Senior Practitioner. Reflecting the research literature, an essential aspect of the model is the integration of the different levels of the service system. Additionally, it is critical that, at all levels of the model, people with an intellectual disability or cognitive impairment are provided with access to independent advocacy and support, including support in navigating the various junctures within the criminal justice system (such as police, courts and tribunals).

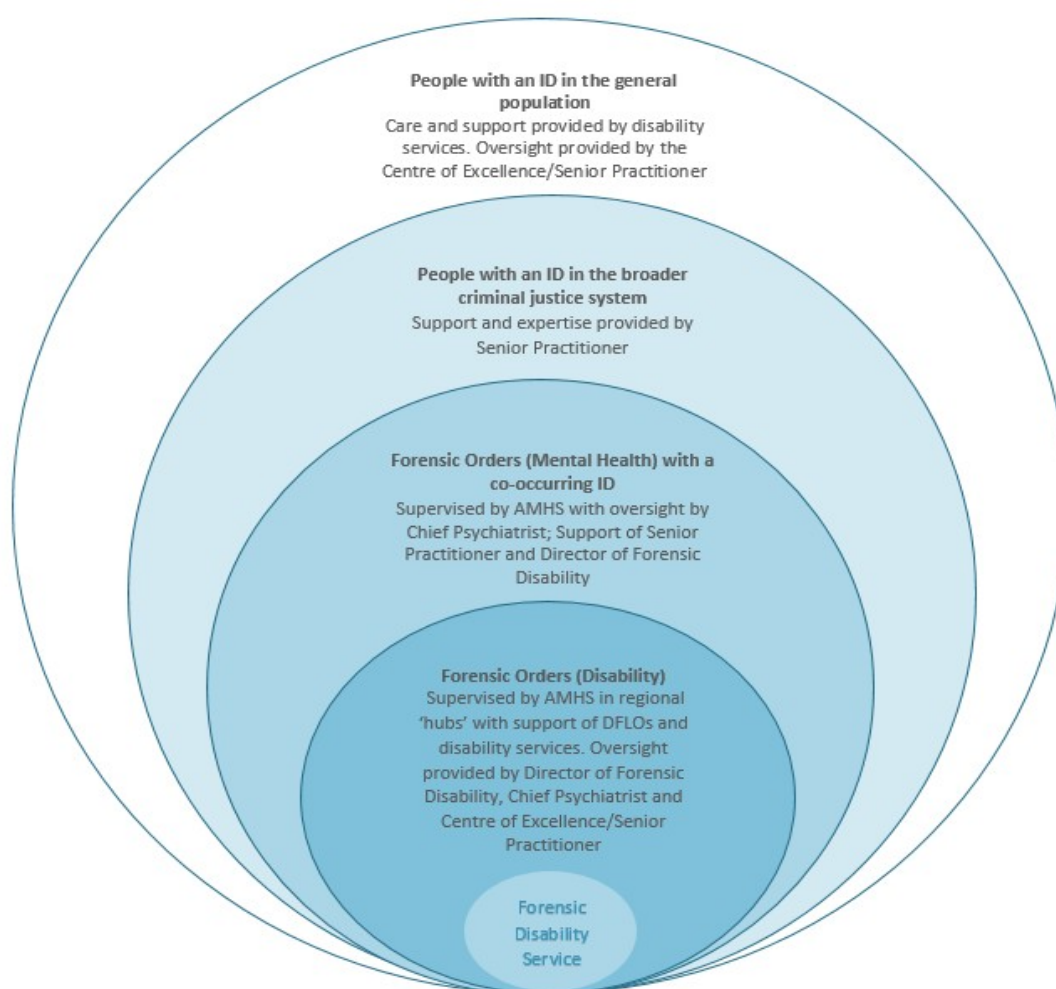


Figure 2. Proposed model of the forensic disability service system.

Indigenous Issues

The adoption of a decentralised ‘hub and spoke’ model would also provide greater opportunity to deliver culturally safe and appropriate care to the considerable number of Aboriginal and Torres Strait Islander people within the forensic disability cohort. As at December 2017, indigenous clients comprised approximately one-third of the forensic disability population. Of the 97 people on Forensic Orders (Disability), 29 (30%) were Aboriginal or Torres Strait Islander, with a similar proportion (n = 18, 29%) of Indigenous clients amongst the 64 people on Forensic Orders (Mental Health) with a co-occurring intellectual disability. Half of the six people detained to the FDS at the time of the review identified as Aboriginal. Such high numbers are unsurprising – but nonetheless greatly disconcerting – given that Aboriginal and Torres Strait Islander people are both over-represented in criminal justice systems across Australia,⁵⁶ including amongst those who are indefinitely detained following a finding of unfitness to be tried,⁵⁷ and are more likely to experience cognitive disabilities compared to non-Indigenous people.⁵⁸

It is essential that Indigenous people on Forensic Orders have access to culturally responsive and appropriate interventions and services. This includes access to translation, interpretation and plain language cross-cultural communication services. While this was universally acknowledged throughout the consultation process, stakeholders identified numerous concerns about the ability of the current forensic disability service system to meet this need. Notably, despite 50% of clients detained to the FDS identifying as Aboriginal, the service does not have a policy framework for the delivery of culturally competent services.

Additionally, Aboriginal and Torres Strait Islander people are not represented in the workforce and there is no access to an Indigenous Liaison Service to assist in negotiating barriers in communication and the provision of information, emotional and cultural support

⁵⁶ The Australia-wide percentage of prisoners identifying as Aboriginal or Torres Strait Islander is 27 per cent, whereas the total Aboriginal and Torres Strait Islander population aged 18 years and over in 2016 was approximately two per cent of the Australian population aged 18 years and over: Australian Bureau of Statistics, *Prisoners in Australia, 2016*, Cat No 4517.0, ABS, Canberra, 8 December 2016. See also Eileen Baldry et al., ‘A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system’ (Report, Indigenous Australians with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System Project, University of New South Wales, October 2015) <<https://www.mhdcd.unsw.edu.au/>>; Shepherd et al., above n 5.

⁵⁷ Mindy Sotiri, Patrick McGee and Eileen Baldry, ‘No End in Sight: The Imprisonment, and Indefinite Detention of Indigenous Australians with a Cognitive Impairment’ (Report, Aboriginal Disability Justice Campaign, September 2012) 22.

⁵⁸ Data indicate that 8% of Indigenous Australians have an intellectual disability (Australian Bureau of Statistics, *The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples, 2011*, Cat No 4704.0, ABS, Canberra, 17 February 2011) compared with 2.9% of the general population (Australian Bureau of Statistics, *Intellectual Disability, Australia, 2012*, Cat No 4433.0.55.003, ABS, Canberra, 30 June 2014). See also Piers Gooding, Anna Arstein-Kerslake, Louise Andrews and Bernadette McSherry, ‘Unfitness to stand trial and the indefinite detention of persons with cognitive disabilities in Australia: Human rights challenges and proposals for change’ (2017) 40 *Melbourne University Law Review* 816.

to clients and their families. Efforts by the service to maintain client connections to country and ancestors include the engagement of external services to provide culturally appropriate support and interventions, including visits by community Elders. However, such support is inconsistent and sometimes piecemeal.

Undoubtedly, its location in a metropolitan area is a fundamental challenge faced by the FDS in meeting the cultural needs of clients, as the only statewide secure facility for forensic disability clients. Inevitably, this means that many clients will be accommodated far from their home communities. While this may be unavoidable, the development of decentralised step-down accommodation options in regional 'hubs' is likely to facilitate quicker transition of people from the FDS to areas closer to family, community and country. Additionally, it is crucial that DFLOs hosted by the various AMHS possess cultural capability and are provided with the information, support and incentives to increase cultural knowledge and associated clinical skills.

Recommendation

- 26 Ensure that culturally competent standards, policies and services be implemented at systemic, organisational and individual levels across the forensic disability service sector to ensure that Aboriginal and Torres Strait Islander people on Forensic Orders (Disability) have access to culturally responsive and appropriate interventions and services, including access to translation, interpretation and plain language cross-cultural communication services.

Finally, just as there is a need to embed cultural competency within service delivery models, so too is there a need to provide Indigenous people on Forensic Orders with culturally appropriate assistance and support when navigating the legal system. In this regard, the funding of the Aboriginal and Torres Strait Islander Legal Service to represent Indigenous clients on Forensic Orders in MHC and MHRT hearings is positive, as is the recent appointment by the MHRT of a dedicated Indigenous Liaison Officer to develop culturally appropriate resources, engage with the Indigenous community and assist the Tribunal to encourage greater participation of Indigenous persons in Tribunal hearings. Further work could be done in increasing the number of Indigenous Tribunal Members to accommodate the high proportion of Aboriginal and Torres Strait Islander people on Forensic Orders; currently, there are nine Indigenous Tribunal Members (consisting of two legal Members and seven community Members), reflecting 12% of the Tribunal's membership.⁵⁹ In the meantime, the cultural knowledge and awareness of existing members could be strengthened through

⁵⁹ Queensland Mental Health Review Tribunal, *Annual Report 2016-17* (2017) 8.

professional development opportunities and, where at all possible, Indigenous Members should be aligned to hearings involving Aboriginal and Torres Strait Islander people.

Recommendation

- 27 Strengthen the cultural competency of the Mental Health Review Tribunal by increasing the number of Indigenous Tribunal Members and assigning those members to hearings involving Aboriginal and Torres Strait Islander people.

Service Delivery Landscape

One of the challenges of the review concerned the considerable uncertainty amongst stakeholders regarding the impact of the NDIS on the forensic disability service system. Transition to the NDIS is due to be completed by mid-2019, and then the DCDSS will cease to offer state-wide disability services and existing disability services regions will be dissolved. What this means for the forensic disability population is unclear. Particular areas of uncertainty raised by stakeholders include the following:

- Currently DCCSDS provides reports to the MHC and the MHRT regarding a person's disability support needs and the availability of appropriate supports. With the transition to the NDIS it is unclear who will provide court reports and assessments, and how they will be funded. Such reports are essential in providing the court with necessary information to determine whether an individual is safe to reside in the community and the types of supports that may be required. In the absence of such information, it is difficult to ameliorate a risk averse approach to the management of people on Forensic Orders.
- The extent to which the NDIS will support the needs of the forensic disability population is unclear. Indeed, stakeholders reported a variable and unpredictable response by the NDIS to people in the cohort, with packages varying widely from very large to inadequately small, and the MHRT observed in its 2015-16 Annual Report that "the introduction of the National Disability Insurance Scheme (NDIS) has not yet demonstrated an increase in resources for [the forensic disability] population under the provisions administered by the Tribunal".⁶⁰ In particular, while the NDIS will provide support to meet reasonable and necessary disability support needs, it is unclear how the NDIS will distinguish between disability and criminogenic needs. There is a concern that the NDIS will draw simplistic distinctions between challenging behaviour which is accepted to be the responsibility of the National Disability Insurance Scheme; and offending behaviour and resultant supervisory needs which is seen as the responsibility of the justice system. This is despite the fact that offending

⁶⁰ Queensland Mental Health Review Tribunal, *Annual Report 2015-16* (2015) 8.

behaviour by people with an intellectual disability or cognitive impairment is often directly related to their disability.

- It is uncertain how these individuals will access support to meet their forensic and supervisory needs that the NDIS determines are not specifically related to their disability. The justice system does not currently provide support to the forensic disability cohort and the Director of Forensic Disability is not funded either to advise on or provide ongoing treatment and support to those on Forensic Orders who are not detained to the FDS. Any gap in supervision and support may have an impact on the management of risk and has the subsequent potential to lead to an increase in offending behaviour. Indeed, research has noted that, in the absence of appropriate service provision, people with complex disability needs are more likely to be criminalised and cycle in and out of the criminal justice system more rapidly and more frequently than those without similar needs.⁶¹ In addition to this risk to the individual, so too is there a risk to community safety. It will be important to monitor the recidivism rate of the cohort over time in order to assess the impact of the NDIS and removal of state-funded supports.
- As has occurred in other jurisdictions,⁶² there is a very real potential for those with complex and high risk needs to find it difficult to engage a willing or suitable service provider through the NDIS to cover the services in their NDIS plans. The NDIS model relies on the disability services market ensuring that people funded by NDIS for services actually receive those services. However, 'market failure' may occur in relation to those with complex disabilities and difficult behaviours in relation to whom potential costs to services may be too great or specialist expertise and infrastructure is lacking. While previously state-based disability services would have stepped into the gap, under the NDIS, this safety net has been removed. This raises the prospect of indefinite detention in either the FDS or secure mental health units. Stakeholders were uncertain as to whether any residual state-based services will remain following the transition to the NDIS to meet the needs of this vulnerable group.
- With the devolution of disability resources to the NDIS sector, it is unclear to what extent specialist skills in forensic disability and opportunities for ongoing staff development, training, mentoring and expert consultancy will be available in the NDIS environment.
- It is unclear how the Director of Forensic Disability, and other stakeholders will interface with the NDIS to resolve issues, and work towards best outcomes for individuals on Forensic Orders.

⁶¹ Eileen Baldry et al., 'Reducing vulnerability to harm in adults with cognitive disabilities in the Australian criminal justice system' (2013) 10 *Journal of Policy and Practice in Intellectual Disability* 229; Holland and Persson, above n 4.

⁶² Victoria Legal Aid, *Fighting for Francis and better outcomes from the National Disability Insurance Scheme* (22 November 2017) <<http://www.abc.net.au/news/2017-11-09/emergency-intervention-to-remove-disabled-man-stuck-in-prison/9133634>>.

Clearly then, there are multiple concerns regarding the potential impact of the NDIS on the forensic disability population which urgently need to be considered and resolved. In particular, in order to address market failure and meet human rights obligations, it is essential that a clear framework for a 'provider of last resort' be established to meet service needs for those complex and high risk individuals who are at risk of becoming 'unattractive buyers' of NDIS services. It is important that the provider of last resort is established and framed within the need for contemporary disability approach which Queensland has built in response to the Carter Report. Given the experiences of the NDIS in Queensland and elsewhere in the country, it is important that this framework delivers the services people with disabilities will need in the event of market failure and does not default to detention in mental health units.

Additionally, there is a need for the state to retain or contract some degree of independent forensic disability expertise to ensure that the criminogenic needs of the cohort are met and that specialised disability skills amongst clinicians are not lost. Funding of such expertise needs to be 'ring-fenced' so as to ensure that it is not subsumed by mental health services.

Recommendations

- 28 As a matter of priority, consider and address the considerable uncertainties surrounding the potential impact of the National Disability Insurance Scheme on the forensic disability service system in Queensland.
- 29 NDIS legislation requires that each state establish arrangements for 'provider of last resort' services to meet service needs where a care provider has withdrawn or cannot be found. The Queensland Government will need to consider whether, at full scheme transition to the NDIS, the National Disability Insurance Agency will provide adequate support and services to people who transition out of the forensic disability service system and into the community. In the event that a person may not be able to access the services required to address their specific criminogenic needs, the Queensland Government should consider how it will address these support and service delivery gaps. It is important to establish and frame the provider of last resort in a contemporary disability service provision model and not default to ongoing detention in mental health facilities.

Finally, resources for the continued provision of court reports and assessments is required in order to ensure that the MHC and the MHRT are provided with information necessary to formulate a fair outcome for people on Forensic Orders with an intellectual disability. Provided that these issues are resolved, the introduction of the NDIS still has the potential to make a positive impact on individuals with disabilities who come into contact with the criminal justice system.

Recommendation

- 30 Allocate resources for the continued provision of court reports and assessments to the Mental Health Court and the Mental Health Review Tribunal, following transition to the National Disability Insurance Scheme, in matters involving people with an intellectual disability.

Disability Services in Broader Justice Context

In examining the operation of the forensic disability service system, it is impossible not to take into account the broader justice context in which it operates. Of particular importance is, first, the role of the key decision-making bodies – the MHC and the MHRT – in the management of the forensic disability cohort and, second, the ability of Queensland Corrective Services to meet individual disability needs.

In relation to the former, the unique nature of forensic disability poses significant challenges for the MHC and the MHRT, both of which are more accustomed to handling matters involving mental health issues. Stakeholders expressed concern regarding the limited specialist expertise amongst judges and sitting members in intellectual disability, a lack of strong legal representation of people on Forensic Orders (Disability) in tribunal hearings, and insufficient provision of rigorous assessments and information regarding transition planning by service providers in tribunal reviews of Forensic Orders (Disability). In relation to the last point, the review was informed that the MHRT is often required to issue notices to attend hearings to the representatives of Disability Services around the state to increase the attendance of and contribution by these representatives to Forensic Order (Disability) reviews.

Efforts to address these issues include a needed commitment by the MHRT to creating a base level of expertise in forensic disability amongst Members via professional development and education. The MHRT also advised that, where possible, experienced Members are allocated to matters involving Forensic Orders. In regards to the MHC, the *Mental Health Act 2016* (Qld) empowers the Governor in Council to appoint a person with expertise in the care of people with an intellectual disability as an assisting clinician (s 652). The functions of an assisting clinician include advising the MHC about clinical issues relating to the treatment, care and detention of people on Forensic Orders (s 651(c)). However, the review was informed that, while the MHC has appointed assisting clinicians with mental health expertise, it has not used the power to appoint someone with specialist disability expertise despite the obvious benefits such expertise would bring. This is unfortunate, particularly given the limited scope of the Director of Forensic Disability to elect into MHC references.

One of the reasons for this may be the dearth of clinicians with specialist forensic disability expertise in Queensland. This also impacts on the capacity of the MHC and the MHRT to obtain independent examinations under the *Mental Health Act 2016* (Qld) (ss 668 and 721) of those on Forensic Orders with an intellectual disability or cognitive impairment from

appropriately qualified clinicians. Combined with the often minimal engagement of service providers in MHRT hearings, the lack of expert information available to legal decision-makers regarding a person's risk level, service engagement and progress under the forensic order makes a conservative approach to decision-making hardly surprising. Accordingly, increasing the pool of clinicians with specialist forensic disability expertise across Queensland will not only ensure that people on Forensic Orders (Disability) are provided with appropriate care and support, but may also temper risk aversion by ensuring that decisions of the MHC and MHRT decisions are informed by a full understanding of the needs of the person and available supports. This re-emphasises the need to commit resources to the continued provision of specialist court reports and assessments following transition to the NDIS.

The second aspect of the broader justice context that warrants comment, relates to the provision of disability support within Queensland Corrective Services. While a central purpose of Forensic Orders is to divert people from the criminal justice system, the nature of the cohort means that many may come into contact with Corrective Services at some stage. Additionally, research has found an over-representation of people with intellectual disability amongst the Australian offender population, with rates ranging from eight to 15 percent⁶³ compared to approximately 2.9 percent of the general Australian population.⁶⁴ This pattern has also been observed in Queensland, with a 2002 survey conducted by Queensland Corrective Services finding that people with an intellectual disability comprised around ten percent of prisoners.⁶⁵ Given such high numbers, there is a clear need for a system-wide, coordinated approach to offenders and prisoners with an intellectual disability or cognitive impairment which addresses both offending behaviour and skills deficits, of which the forensic disability service system is but one specialised part.

However, stakeholders expressed concern that, despite the best intentions within Queensland Corrective Services, correctional services are poorly equipped to identify and support offenders with an intellectual disability or cognitive impairment. In particular, it was reported that there are limited resources for the screening and assessment of people entering into the prison system, resulting in disability needs often remaining unidentified. However, even in instances where a person's disability is recognised, a lack of specialist services and interventions within the prison system means that it is unlikely that the person's needs will be appropriately met. While efforts to cluster prisoners with a cognitive impairment together in one unit are undertaken, there is no specialist unit within Queensland which utilises an evidence-based approach to working with prisoners with a cognitive impairment and provides

⁶³ Shannon Dias et al., 'Co-occurring mental disorder and intellectual disability in a large sample of Australian prisoners' (2013) 47 *Australian & New Zealand Journal of Psychiatry* 938; Shepherd et al., above n 5.

⁶⁴ Australian Bureau of Statistics, *Intellectual Disability, Australia, 2012*, Cat No 4433.0.55.003, ABS, Canberra, 30 June 2014.

⁶⁵ Queensland Corrective Services, 'Intellectual Disability Survey' (2002) reported in Queensland Advocacy Incorporated, Submission No 60 to Australian Law Reform Commission, *Inquiry into Incarceration Rates of Aboriginal and Torres Strait Islander Peoples*, 4 September 2017.

adapted programs that address offending behaviour and social skills deficits. Indeed, stakeholders reported that, currently, Queensland Corrective Services facilitate only one adapted program for prisoners with an intellectual disability, which is targeted to those who sexually offend and is delivered at Wolston Correctional Centre. No other prison facility in Queensland delivers an adapted program to cater for the responsivity needs of people with intellectual impairments. As noted by the Anti-Discrimination Commission Queensland and Office of the Public Advocate in a joint submission to the Inquiry on Strategies to Prevent and Reduce Criminal Activity in Queensland, “without equal access to appropriate programs, people with impairments may be unfairly impacted upon in relation to rehabilitation and access to parole”.⁶⁶ Additionally, there is no capacity within the current system for individuals who have been identified as having an intellectual disability to transfer from prison to the FDS. Nor does Disability Services provide services to clients whilst incarcerated.

In addition to limited service provision during the course of a person’s imprisonment, the review was informed that significant issues are encountered when transitioning people with a cognitive impairment from the prison system. Stakeholders reported difficulty in securing co-operation from disability services to assist with release and re-entry, and expressed a need for outreach and liaison services. In this regard, the principles of the ‘Bridging the Gap’ program⁶⁷ which provided case management services to prisoners with intellectual disabilities for six months prior to release and nine months following release, were commendable and reflected best practice in post-release support which stresses the importance of through-care as central feature in pre-release planning.⁶⁸ However, funding for the program ceased in June 2012.

The introduction of the NDIS further complicates the transition of people with a cognitive impairment from prison. Thus, while disability services do not provide services to clients once they enter a correctional centre, current practice is for the NDIA to engage in planning for community based supports only once a prisoner is within 6 months of a release date. However, the review was informed that a significant number of people are in custody for short periods of time, those with complex disability support needs often cycling in and out of prison;⁶⁹ Queensland Corrective Services advised that 60% of prisoners are released within three months, rising to 80% within six months. This rapidly moving population not only creates challenges for the delivery of disability services within the correctional system, but it also means that the majority of prisoners do not reach the six-month trigger for NDIS

⁶⁶ Anti-Discrimination Commission Queensland and Office of the Public Advocate, Submission No 32 to Legal Affairs and Community Safety Committee, Parliament of Queensland, *Inquiry on Strategies to Prevent and Reduce Criminal Activity in Queensland*, November 2014, 14.

⁶⁷ Kathy Ellem, ‘Experiences of Leaving Prison for People with Intellectual Disability’ (2012) 3 *Journal of Learning Disabilities and Offending Behaviour* 127.

⁶⁸ Australians for Disability Justice, above n 3, 15; Maria Borzycki and Eileen Baldry, ‘Promoting integration: The provision of post-release services’ (2003) 262 *Trends and Issues in Crime and Criminal Justice* 1.

⁶⁹ Australians for Disability Justice, above n 3; Baldry et al., above n 59.

engagement. This is unsatisfactory and provision must be made for appropriate supports to be put in place prior to a person's release in order to maximise successful community reintegration of people with a cognitive impairment and reduce recidivism rates.

Observation

Although outside the scope of the terms of reference, significant limitations were identified in the provision of disability services in the broader criminal justice sector. As such, there would be benefit if Queensland commenced planning for the establishment of a system-wide, coordinated approach to prisoners with an intellectual disability or cognitive impairment that includes processes and resources for screening and assessment, delivery of targeted and adapted programs and interventions, and outreach and liaison services to assist in post-release transition and linkage to services.

References

- Alexander, Regi, Kimberley Crouch, Stephen Halstead and Jack Piachaud, 'Long-term outcome from a medium secure service for people with intellectual disability' (2006) 50 *Journal of Intellectual Disability Research* 305.
- Alexander, Regi, John Devapriam, Dasari Michael, Jane McCarthy, Verity Chester, Rahul Rai, Aezad Naseem and Ashok Roy, "Why can't they be in the community?" A policy and practice analysis of transforming care for offenders with intellectual disability' (2015) 9 *Advances in Mental Health and Intellectual Disabilities* 139.
- Australian Bureau of Statistics, *Intellectual Disability, Australia, 2012*, Cat No 4433.0.55.003, ABS, Canberra, 30 June 2014.
- Australian Bureau of Statistics, *Prisoners in Australia, 2016*, Cat No 4517.0, ABS, Canberra, 8 December 2016.
- Australian Bureau of Statistics, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2011*, Cat No 4704.0, ABS, Canberra, 17 February 2011.
- Australians for Disability Justice, Submission No PP342 to Productivity Commission, *The provision of services under the NDIS for people with disability who are in contact with the criminal justice system*, March 2017.
- Baldry, Eileen, Melissa Clarence, Leanne Dowse and Julian Trollor, 'Reducing vulnerability to harm in adults with cognitive disabilities in the Australian criminal justice system' (2013) 10 *Journal of Policy and Practice in Intellectual Disability* 229.
- Baldry, Eileen, Ruth McCausland, Leanne Dowse, Elizabeth McEntyre, 'A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system' (Report, Indigenous Australians with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System Project, University of New South Wales, October 2015).
- Benton, Carl and Ashok Roy, 'The first three years of a community forensic service for people with a learning disability' (2008) 10 *The British Journal of Forensic Practice* 4.
- Borzycki, Maria and Eileen Baldry, 'Promoting integration: The provision of post-release services' (2003) 262 *Trends and Issues in Crime and Criminal Justice* 1.
- Browning, Morna, Rosemary Gray and Rose Tomlins, 'A community forensic team for people with intellectual disabilities' (2016) 18 *Journal of Forensic Practice* 274.
- Butler, Brendan, 'Promoting Balance in the Forensic Mental Health System: Final Report' (Report, Queensland Government, December 2006).
- Carter, Honourable Justice William, 'Challenging Behaviour and Disability: A Targeted Response' (Report, Queensland Government, July 2006).
- Chan, Jeffrey, Phillip French, Colin Hudson and Lynne Webber, 'Applying the CRPD to Safeguard the Rights of People with a Disability in Contact with the Criminal Justice System' (2012) 19 *Psychiatry, Psychology and Law* 558.
- Robert Chaplin, 'General psychiatric services for adults with intellectual disability and mental illness. 48 *Journal of Intellectual Disability Research* 1.
- Robert Chaplin, 'New research into general psychiatric services for adults with intellectual disability and mental illness' (2007) 53 *Journal of Intellectual Disability Research* 189.
- Chester, Verity, Anthony Scott Brown, John Devapriam, Sharon Axby, Claire Hargreaves and Rohit Shankar, 'Discharging inpatients with intellectual disability from secure to community services: risk

- assessment and management considerations' (2017) 11 *Advances in Mental Health and Intellectual Disabilities* 98.
- Cumella, Stuart, 'Mental health services for people with a learning disability' (2009) 3 *Advances in Mental Health and Learning Disabilities* 8.
- Devapriam, John and Regi Alexander, 'Tiered model of learning disability forensic service provision' (2012) 3 *Journal of Learning Disabilities and Offending Behaviour* 175.
- Devapriam, John, Regi Alexander, Rohit Gumber, Judith Pither and Satheesh Gangadharan, 'Impact of care pathway-based approach on outcomes in a specialist intellectual disability inpatient unit' (2014) 18 *Journal of Intellectual Disabilities* 211.
- Dias, Shannon, Robert Ware, Stuart Kinner and Nicholas Lennox, 'Co-occurring mental disorder and intellectual disability in a large sample of Australian prisoners' (2013) 47 *Australian & New Zealand Journal of Psychiatry* 938.
- Dinani, Shamim, Wendy Goodman, Charlotte Swift and Teresa Treasure, 'Providing forensic community services for people with learning disabilities' (2010) 1 *Journal of Learning Disabilities and Offending Behaviour* 58.
- Ellem, Kathy, 'Experiences of Leaving Prison for People with Intellectual Disability' (2012) 3 *Journal of Learning Disabilities and Offending Behaviour* 127.
- Gaskell, George, Julie Dockrell and Hamid Rehman, 'Community care for people with challenging behaviours and learning disability: an evaluation of an assessment and treatment unit' (1995) 34 *British Journal of Clinical Psychology* 383.
- Glaser, William and Daniella Florio, 'Beyond specialist programmes: a study of the needs of offenders with intellectual disability requiring psychiatric attention' (2004) 48 *Journal of Intellectual Disability Research* 591.
- Gooding, Piers, Anna Arstein-Kerslake, Louise Andrews and Bernadette McSherry, 'Unfitness to stand trial and the indefinite detention of persons with cognitive disabilities in Australia: Human rights challenges and proposals for change' (2017) 40 *Melbourne University Law Review* 816
- Hayes, Susan, 'A Review of Non-custodial Interventions with Offenders with Intellectual Disabilities' (2005) 17 *Current Issues in Criminal Justice* 69.
- Heffernan, Ed, Bobbie Clugston and Steve Patchett, 'Review of the South Australian Forensic Mental Health Service' (Report, South Australian Government, July 2015).
- Holland, Shasta and Peter Perrson, 'Intellectual disability in the Victorian prison system: characteristics of prisoners with an intellectual disability released from prison in 2003–2006' (2011) 17 *Psychology, Crime and Law* 25.
- Holland, Tony, Isabel Clare and Tanni Mukhopadhyay, 'Prevalence of 'criminal offending' by men and women with intellectual disability and the characteristics of 'offenders': implications for research and service development' (2002) 46 *Journal of Intellectual Disability Research* 6.
- Lindsay, William, Derek Carson, Gregory O'Brien, Anthony Holland, Susan Johnston, John L. Taylor, Steven Young, Lesley Steptoe, Jessica Ruth Wheeler, Claire Middleton and Karen Price (2010) 'The relationship between assessed risk and security level for offenders with intellectual disabilities' (2010) 21 *Journal of Forensic Psychiatry and Psychology* 537.
- Lindsay, William, Hogue T. E., Taylor J. L., Steptoe L., Mooney P., O'Brien G, 'Risk assessment in offenders with intellectual disability' (2008) 52 *International Journal of Offender Therapy and Comparative Criminology* 90.

Lindsay, William, Anthony Holland, Derek Carson, John Taylor, Gregory O'Brien, Lesley Steptoe and Jessica Wheeler, 'Responsivity to criminogenic need in forensic intellectual disability services' (2013) 57 *Journal of Intellectual Disability Research* 172.

Lindsay, William, Lynn Steele, Anne Smith, Kathleen Quinn, and Ronald Allan, 'A community forensic intellectual disability service: Twelve year follow up of referrals, analysis of referral patterns and assessment of harm reduction' (2006) 11 *Legal and Criminological Psychology* 113.

Mackenzie-Davies, Naomi and Jim Mansell, 'Assessment and treatment units for people with intellectual disabilities and challenging behaviour in England: an exploratory survey' (2007) 51 *Journal of Intellectual Disability Research* 802.

MacMahon, Kenneth and Ricky McClements, 'Working together: making the case for integrated forensic services for people with intellectual disabilities' (2015) 6 *Journal of Intellectual Disabilities and Offending Behaviour* 204.

New South Wales Law Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: criminal responsibility and consequences*, Report No 138 (2013).

Purandare, Kiran and Anusha Wijeratne, 'Reflections on the use of a specialist acute assessment and treatment unit for adults with intellectual disability' (2015) 9 *Advances in Mental Health and Intellectual Disabilities* 132.

Queensland Advocacy Incorporated, Submission No 60 to Australian Law Reform Commission, *Inquiry into Incarceration Rates of Aboriginal and Torres Strait Islander Peoples*, 4 September 2017.

Richings, Ceri, Rachael Cook and Ashok Roy, 'Service evaluation of an integrated assessment and treatment service for people with intellectual disability with behavioural and mental health problems' (2011) 15 *Journal of Intellectual Disabilities* 7.

Sansom, David and Stuart Cumella, 'One hundred admissions to a regional secure unit for people with a learning disability' (1995) 6 *Journal of Forensic Psychiatry* 267.

Senate Standing Committee on Community Affairs, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* (2016).

Shepherd, Stephane, James Ogloff, Yin Paradies and Jeffrey Pfeifer, 'Aboriginal prisoners with cognitive impairment: Is this the highest risk group?' (2017) 537 *Trends and Issues in Crime and Criminal Justice* 1.

Simpson, Jim, Meredith Martin and Jenny Green, 'The Framework Report: Appropriate community services in NSW for offenders with intellectual disabilities and those at risk of offending' (Report, New South Wales Council for Intellectual Disability, 2001).

Mindy Sotiri, Patrick McGee and Eileen Baldry, 'No End in Sight: The Imprisonment, and Indefinite Detention of Indigenous Australians with a Cognitive Impairment' (Report, Aboriginal Disability Justice Campaign, September 2012) 22.

Appendix A: Reference Group

The review was guided by a Reference Group that was comprised as follows: Co-

Chairs:

Mr Tony Hayes, Department of Communities, Child Safety and Disability Services

Dr John Wakefield, Queensland Health

Members:

Professor John Allan, Queensland Health

Ms Mary Burgess, Public Advocate

Mr Keven Cocks, Anti-Discrimination Commission, Queensland

Ms Kim Chandler, Department of Justice and Attorney-General

Ms Helen Ferguson, Department of Communities, Child Safety and Disability Services

Mr Peter Johnson, Queensland Treasury

Ms Rebecca McGarrity, Department of Premier and Cabinet

Ms Jessica Martin, Queensland Mental Health Commission

Ms Michelle Moss, Queenslanders with Disability Network Ltd

Professor Karen Nankervis, Department of Communities, Child Safety and Disability Services

Ms Natalie Siegel-Brown, Queensland Public Guardian

Appendix B: Consultations

Consultations were held with the following stakeholders:

Organisation	Name	Position
Office of the Director of Forensic Disability	Ms Vanda Wieczorkowski	Director of Forensic Disability
	Mr Scott Dullaway	Principal Legal Officer
Department of Communities, Child Safety and Disability Services	Ms Helen Ferguson	Senior Executive Director
	Professor Karen Nankervis	Executive Director, Disability Practice and Service Improvement (Centre of Excellence for Clinical Innovation and Behaviour Support)
	Mr Matthew Lupi	Regional Executive Director, South West Region
	Dr Paul White	Clinical Director, Specialist Disability Assessment and Outreach Team
	Ms Shaylene Hughes	Principal Clinician, Positive Behaviour Support and Restrictive Practices Team
Department of Justice and Attorney-General	Ms Kim Chandler	Acting Director, Civil Law Team
	Ms Susan Masotti	Acting Director, Criminal Law Team
Mental Health Court	Ms Janette Conway	Registrar
	Mr Bojan Stojanovic	Senior Deputy Registrar
Mental Health Review Tribunal	Ms Annette McMullan	President
	Ms Virginia Ryan	Deputy President
	Ms Jade Madden	Executive Officer
Aboriginal and Torres Strait Islander Legal Service	Mr Ed Turkovic	Solicitor
Department of Premier and Cabinet	Ms Rebecca McGarrity	Executive Director, Social Policy
Queensland Treasury	Ms Catherine McFadyen	Acting Assistant Under Treasurer
Office of the Chief Psychiatrist	Dr John Reilly	Chief Psychiatrist
	Ms Bobbie Clugston	Director, Legislative Projects
Queensland Health	Professor John Allan	Executive Director, Mental Health Alcohol and Other Drugs Branch
Office of the Public Guardian	Ms Natalie Siegel-Brown	Public Guardian
	Ms Shayna Smith	Deputy Public Guardian
Queensland Corrective Services	Ms Kieren Bennett	Director, Offender Rehabilitation and Management
	Ms Kate Holman	General Manager, State-wide Operations (Qld Parole System Review Implementation Team)

Anti-Discrimination Commission Queensland	Mr Kevin Cocks	Anti-Discrimination Commissioner
Office of the Public Advocate	Ms Mary Burgess	Public Advocate
Statewide Court Liaison Service	Mr Bruce Hamilton	Program Coordinator
Queensland Forensic Mental Health Service	Mr Bob Green	Program Coordinator
	Dr Tim Lowry	Psychologist
	Ms Michelle Denton	Manager
	Ms Stephanie Linn	Program Coordinator, Statewide Forensic Liaison Officer Network
	Ms Natalie Walker	Forensic Liaison Officer
Queenslanders with Disability Network Ltd	Ms Michelle Moss	Business and Operations Manager
Queensland Advocacy Incorporated	Ms Michelle Flynn	Director, Systems Advocacy
The Park – Centre for Mental Health, Treatment, Research and Education	Dr Terry Stedman	Director of Clinical Services
	Dr Jonathan Mann	Clinical Director, Forensic and Secure Services
	Dr Karen Brown	Psychiatrist
	Consumers (various)	
Forensic Disability Service	Mr Graeme Kirkup	Acting Administrator
	Staff (various)	
	Consumers (various)	
Mental Health Service Group, Townsville	Mr Michael Catt	Service Group Director
	Mr John Baird	Nursing Director/Program Manager Rehabilitation
	Mr David Watkins	Mental Health Intervention Coordinator/Intellectual Disability Coordinator
	Ms Alison Davamoni	Acting Nurse Unit Manager, Adult Acute Mental Health Inpatient Unit
	Ms Shaylene Hughes	Principal Clinician, Positive Behaviour Support and Restrictive Practices Team
	Dr Sarah Moakes	Team Leader Consultation Liaison and Resource Team/Professional Senior for Psychology
	Ms Vicki Ford	Team Leader, North Queensland Adolescent Forensic Mental Health Service
	Ms Kylie Hay	Nurse Unit Manager, Community Care and Acquired Brain Injury Unit
	Ms Sue Froggatt	Nurse Unit Manager, Secure Mental Health Rehabilitation Unit

	Dr Roanna Byrnes	Clinical Director, Adult Mental Health Services
	Dr Rupak Dasgupta	Clinical Director, Rehabilitation Services
	Dr Satish Karunakaran	Clinical Director, Alcohol Tobacco and Other Drugs Services and Specialist Services
	Ms Joanne Stitt	Program Manager, Alcohol Tobacco and Other Drugs Services and Specialist Services/Director Allied Health