Queensland Advocacy Incorporated

Our mission is to promote, protect and defend, through advocacy, the fundamental needs and rights and lives of the most vulnerable people with disability in Queensland.

Systems and Legal Advocacy for vulnerable people with Disability

9 November 2018

The Hon. Coralee O'Rourke MP
Minister for Disability Services
Department of Communities, Disability Services and Seniors
1 William Street
Brisbane QLD 4000

By email: communities@ministerial.qld.gov.au

Dear Minister,

Response by Queensland Advocacy Incorporated to the Queensland Government's review of the operation of the *Forensic Disability Act 2011* (Qld)

Queensland Advocacy Incorporated (**QAI**) thanks the Department of Communities, Disability Services and Seniors (**Department**) for tabling their review of the *Forensic Disability Act 2011* (Qld) (**FDA**) on 9 October 2018 (**FDA Review**). We acknowledge that the FDA Review annexes the independent review of the Queensland Forensic Disability Service System prepared for the Department (**FDSS Review**) by the Centre for Forensic Behavioural Science, Swinburne University of Technology and thank the Department for facilitating that review.

We take this opportunity to respond to the FDA and FDSS review.

About QAI

QAI is an independent, community-based systems and individual advocacy organisation and a community legal service for people with disability. Our mission is to promote, protect and defend, through systems and individual advocacy, the fundamental needs and rights and lives of the most vulnerable people with disability in Queensland.

QAI has an exemplary track record of effective systems advocacy, with thirty years' experience advocating for systems change, through campaigns directed to attitudinal, law and policy reform and by supporting the development of a range of advocacy initiatives in this state. We have provided, for almost a decade, highly in-demand individual advocacy through our individual advocacy services – the Human Rights Legal Service, the Mental Health Legal Service, the Justice Support Program and, more recently, the NDIS Appeals Support Program.

QAI has worked, and continues to work, closely with FDS clients, both those currently detained at the facility and those who have transitioned to the community. QAI provides legal and advocacy services for these clients both at the Mental Health Review Tribunal (**MHRT**) and the Queensland Civil and Administrative Tribunal (**QCAT**), help to access the National Disability Insurance Scheme (**NDIS**) and general advocacy to support their access to legal rights, healthcare, services and to transition from the FDS to their communities of choice. At the date of this letter, QAI supports five of the six clients managed by the FDS.

1. QAI's response to the FDSS Review

The FDSS Review proposes significant reform to both the FDS and the broader forensic disability context in which this facility operates. The reforms propose to implement a new integrated service model for forensic disability services in Queensland, within which an improved FDS will operate, with a consistent framework for Restrictive Practices (**RPs**) across the sector and an expanded role for the Director – Forensic Disability (**DFD**) beyond the scope of the FDS; and address funding gaps for forensic disability clients created by the NDIS implementation.

We note the Queensland Government's expression of in principle support for the findings of the FDSS Review, which is qualified by the view that the reform suggested by the FDSS Review is 'significant and complex' and will require 'detailed and careful consideration'. QAI acknowledges the Government's concerns in this regard but considers that there is an urgent need for significant reform in this area, necessitated by the rollout of the NDIS, the impending legislative reforms discussed below and, most importantly, by the grave human rights breaches presently experienced by residents of the FDS. We propose the following timeframe for reform:

- *Within the next 3 months*: urgent attention is given to transitioning the remaining two clients from the original FDS cohort to the community which, as the DFD reviews has highlighted, requires multi-stakeholder buy-in from Disability Services, Department of Housing and Queensland Health.
- *Within the next 6 months*:
    - A plan and commitment of funding to address service gaps with the rollout of the NDIS;
    - Policies and practices applying to the FDS are updated, particularly in relation to appropriate admissions, development and review of IDPs, and transition planning. Improvements can be made within the existing legislation to aim for better practices.
- *Within the next 12 months:* draft legislation amending the FDA and *Mental Health Act 2016* (Qld) (**MHA**) is developed for consultation.
- *Within this term of government*: legislation is passed to protect the rights and ensure appropriate treatment, care and community transition of persons with intellectual disability managed by the FDS and AMHS.

2. QAI's response to the FDA review themes

QAI notes that the FDA Review has identified three key areas for improvement:

A. strengthening the FDA to promote the care, support and protection of FDS clients;

B. strengthening the FDA to ensure the effective oversight of the FDS by the DFD; and

C. ensuring the FDA provides a modern and contemporary legislative framework which is consistent with complementary Queensland legislation.

We now respond to each of these areas in turn, before proposing further ideas for improvement in this area.

A. Strengthening the FDA to promote the care, support and protection of FDS clients

QAI agrees that the FDA requires strengthening to promote the care, support and protection of FDS clients.

Alignment of FDA principles and provision of Statements of Rights: We support aligning the FDA with the expanded principles in the MHA and the *Guardianship and Administration Act 2000* (Qld) (**GAA**) and submit that these principles must be embedded in the FDA. We agree that this should include the provision of an expanded and modernised statement of

rights, which addresses long-term goals, to residents of the FDS and to their advocates and guardians. The statement of rights should also ensure that the person is included in decision-making as much as possible about their treatment, care and habilitation. QAI considers that mere provision of a statement of rights is inadequate, given that many residents may lack the necessary literacy or comprehension skills to understand the content or relevance of the statement. We propose that information and education about the statement of rights, as well as the CRPD and human rights more generally, should be provided to all FDS residents in an accessible format.

Lack of right to and process for community transition: QAI agrees that a significant problem with the FDA is the lack of mandatory rights around transitioning clients back into the community.

Development and oversight of Individual Development Plans: QAI supports the imposition of a timeframe for the development of individual development plans and also supports more frequent reviews of these plans. However, we emphasise that these reviews must not only be administrative processes which rubber stamp plans, measured against KPIs of the FDS, but should be bona fide reviews which actively involve the resident of the FDS and their advocate or supporters as well as a legal advocate (discussed below). In circumstances where individuals are not progressing in accordance with their Individual Development Plan (Plan), this should trigger review and adjustment of the methods used by the FDS.

Shortening the 5 year review: QAI supports shortening the review period for appraisal by the DFD of a client's benefit from care and support from five years, but we consider that the proposed three year timeframe is still too long. QAI proposes development of a legislative rule that the DFD cannot recommend a stay of more than 24 months, and the FDS must produce a transition plan no later than one month before the end of the recommended admission period, and file this with the DFD. The FDS must apply to the Tribunal for an extension on the timeframe, and the Tribunal can approve an extension of not more than six months.

Lack of attention to healthcare: QAI considers that it is a serious omission that the FDA does not require that residents' healthcare needs are attended to whilst they reside at the FDS, particularly having regard to the average duration of residency and concerns that have been raised about inadequate healthcare to date. The FDA should be amended to require that clients are provided with adequate and timely healthcare, with regular health assessments and with choice regarding their healthcare provider.

Human rights breaches: QAI holds grave concerns about the following human rights breaches of the FDS that are presently sanctioned by the FDA:

- The potential for indefinite detention within the FDS;
- The deprivation of liberty of residents of the FDS in circumstances where they have not been convicted and sentenced by a court applying the requisite criminal standard of proof;
- The denial of appropriate habilitative and rehabilitative therapy;
- The separation and isolation of residents of the FDS from the familial and cultural networks, which is particularly concerning given the over-representation within the FDS of persons of Aboriginal or Torres Strait Islander status.

(a) The indefinite nature of detention within the FDS

The FDS purports to not operate on a retributive, but rather a rehabilitative mandate –the FDS is designed to rehabilitate persons with an intellectual or cognitive disability charged with the commission of a serious offence and to safeguard the community from these persons for the duration of their rehabilitation. However, there are no mechanisms in place to effectively guarantee the release of a person from the FDS within a designated timeframe.

The MHRT is required to review FODs within six months of the order being made and thereafter at intervals of not more than six months.[1] However, the MHRT may only discharge a person into the community if they are satisfied that there is not an unacceptable risk to the community's safety (s 444) – reduction of risk being only within the clinical team's power to provide, and no power of the MHRT to compel the clinical team or other stakeholders to do so. There is limited precedent and guidance for Tribunals in understanding risk, particularly for forensic disability clients. The Tribunal defaults to a conservative, more restrictive, approach. Further, the 'closed' nature of MHRT hearings can give rise to concerns about accountability and consistency of decision-making, particularly in circumstances where a person is not adequately supported. The assessment of risk posed by a person with an intellectual or cognitive disability, and the notion of indefinite detention based on risk, is highly problematic having regard to the nature of intellectual and cognitive disabilities, which are not 'curable' or 'treatable'. It is also discriminatory when contrasted with normative sentences imposed by mainstream criminal justice courts, which have a designated end point and set criteria by which this end point may be moved forward.

The lengthy periods people can spend in FDS, unless that they are actively supported to achieve identified rehabilitation goals, will ultimately erode a person's capacity to live independently in the community.

(b) The deprivation of liberty of residents of the FDS in circumstances where they have not been convicted and sentenced by a court applying the requisite criminal standard of proof

The potential for indefinite detention is particularly concerning from a human rights perspective given that no 'clients' of the FDS have been convicted of the offence with which they were originally charged – a finding of unfitness or unsoundness nullifies the possibility of criminal culpability yet does not prevent deprivation of liberty.

As a medium secure facility, security features of the FDS include fully fenced outdoor areas, locked doors, provision for search and seizure of items from residents,[2] central security and refusal of visitors where their visits may 'adversely affect the client's care and support'.[3] We note that it is not only the physical features of the FDS but also the language and mindsets – QAI submits that care must be taken to avoid the use of language that creates or perpetuates damaging stereotypes about residents of the FDS and in particular, note that reference to the 'criminogenic needs'[4] of residents is inappropriate. Recruitment and training of staff impacts on language and mindsets. QAI considers it appropriate that staff of the FDS have a disability, rather than Corrections, background. We note that the lack of choice clients of the FDS have with respect to their staff is at odds with the choices people with disability in the community have with respect to NDIS-funded supports.

Incarceration within the FDS is often more isolating and the detention significantly longer than the sentence that would have been imposed had the person been convicted and sentenced for the same offence within the mainstream criminal justice system. This grave concern is not unique to the Queensland FDS but with any response involving institutional detention. Indeed, this concern was very recently highlighted by the Victorian Ombudsman regarding the case of a woman with a developmental delay found unfit to stand trial who spent 18 months in detention for a matter that would have likely attracted a one month term of imprisonment had she pled guilty.[5]

(c) The denial of appropriate habilitative and rehabilitative therapy

Limited Community Treatment (**LCT**) is the sole means by which an FDS resident is able to access community treatment and rehabilitation. The entitlement to LCT is therefore critical

[1] *Mental Health Act 2016* (Qld) s 433.
[2] *Forensic Disability Act 2011* (Qld), s 78.
[3] *Forensic Disability Act 2011* (Qld), s 82.
[4] Swinburne University. *Final Report: Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System.* March 2018, xv.
[5] https://www.ombudsman.vic.gov.au/News/Media-Releases/imprisonment-of-woman-found-unfit-to-stand-trial.

from a therapeutic perspective. However, while the right to LCT is based on the principle that persons under FODs have the same human rights as other people, in practice many residents of the FDS are slow to access LCT, if at all. QAI perceives the problems arise from the following factors:

- Failure to plan admissions and transitions (both from the community to mental health units, and to FDS) leads to interruptions to services and support. For example, we have some clients who received some NDIS-funded support packages, but either cannot access, or lose these supports when they are admitted to a MHU or to the FDS. They then need to reapply/submit a change of circumstances review, and may only obtain a package on exit from FDS. These support interruptions create significant additional administration, paperwork and process and disrupt relationships with support staff.
- With interruptions/suspension of community-based supports, there is a risk of clients losing approved LCT from the MHRT, which puts in place further barriers to their transition. From our experience, increases in LCT progress very gradually. It will likely take at least two years, perhaps more, for one of our clients to regain the supervised community access that they had in their home community.
- Whereas NDIS-funded, community-based supports are directed towards the person's individual goals, FDS-escorted community activities are planned by the FDs, and often involve group outings, with staff chosen by the FDS rather than the client.

(d) The separation and isolation of residents of the FDS from their familial and cultural networks

This is covered in our response to the recommendations, below. We note this is a significant concern.

B. Strengthening the FDA to ensure the effective oversight of the FDS by the DFD

QAI notes the Government's position that present oversight mechanisms are sufficient to ensure appropriate oversight of the FDS.

We respectfully disagree and consider that further oversight is required. We note that the impending implementation of the Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (**OPCAT**) will provide additional layers of oversight in this regard.

The Australian Government ratified OPCAT in December 2017. The Government made a declaration under Article 24 of OPCAT, postponing implementation of its obligations under OPCAT for period of up to three years. Australia must therefore achieve OPCAT compliance by December 2020. This requires that, by December 2020, Australia establish an effective National Preventive Mechanism(s) (**NPM**) to conduct independent inspections of places of detention within Australia, as well as facilitating periodic monitoring of Australian places of detention by the United Nations' Subcommittee on Prevention of Torture (**SPT**).

The second stage of consultations around OPCAT implementation in Australia is currently in progress, with matters including the scope of the treaty and the conduct of inspections currently under consideration. On any construction of the treaty, it is highly probable that the Forensic Disability Service (**FDS**) will be considered a place of detention subject to inspection by the relevant NPM(s) and the SPT, as it is a place where people are deprived of their liberty.[6] This will place increased focus on the operation of the FDS and in particular, the conditions and circumstances surrounding the detention of residents of the FDS. QAI considers this an opportune time for the Government to take all reasonable measures to ensure the FDS is compliant.

[6] See Article 1 of OPCAT and note that 'deprivation of liberty' is defined by Article 4.2 of OPCAT as 'any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority'.

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

QAI considers that the FDA framework is not consistent with complementary Queensland legislation, with best practice in other Australian jurisdictions, nor with our international obligations (in particular, under the CRPD and the CAT).

We agree with the findings of the FDA Review that the RPs regime in the FDA is out-of-date, and that vulnerable people have inconsistent rights with regard to RPs applied across similar legislative schemes. We also agree that it is concerning that the FDA does not provide for PBSPs for the reduction or elimination of the use of RPs.

QAI recommends that the operation and provision of supports by the FDS is monitored by independent oversight and reporting to the Commission. While the FDS is not an NDIS Provider, it is expected that the reporting and collection of data about the use of RPs will be monitored by the Commission. The CoE should ensure that all PBSPs meet the standards of quality, especially for the FDS clients due to their heightened vulnerability.

We are particularly concerned by the almost continuous application of the RP of solitary confinement to residents of the FDS. This is inconsistent with other legislation, is discriminatory when compared to the treatment of persons without disability in detention facilities and is in breach of the human rights of the FDS residents.

Consolidation of legislative framework

The treatment of people with intellectual or cognitive disability and forensic issues is covered by a fragmented legislative regime comprising four separate statutes: the FDA, the MHA, the GAA and the *Disability Services Act 2006* (Qld). This is far from ideal and, as noted in the FDA Review, can lead to inconsistencies, including in the RPs framework. QAI supports the consolidation of this legislation and its alignment with the fundamental human rights set out in the CRPD.

Further, we agree with the concerns raised in the FDSS Review that the majority of those on FODs reside outside of the FDS and therefore fall under the oversight of the Chief Psychiatrist, rather than the DFD. The conflation of mental illness and intellectual and cognitive disability has been an enduring, problematic feature of the forensic disability system in Queensland, with significant adverse implications for people with intellectual disability and no co-existing mental illness (for example, it has resulted in the incarceration of many within an Authorised Mental Health Service for 'treatment' despite the absence of a 'treatable' disease). We agree this this is a significant issue that requires further consideration and emphasise the urgency of the need for the Government to address it as soon as possible, rather than deferring its consideration. We note that, in moving to consolidate legislation, care must be taken not to conflate mental illness and intellectual and cognitive disability.

Offences and penalties under the FDA

QAI supports increasing offences and penalties imposed for the ill-treatment of an FDS resident to reflect the seriousness of these types of offences and to align with the MHA and contemporary sentencing standards.

It is well documented that the conditions of institutional settings can give rise to incidents of violence, abuse and neglect of people with disability within them.[7] The 'closed' nature of institutional settings makes it difficult to detect, investigate and prosecute acts of violence.[8] For this reason, deterrents to mistreatment are particularly important.

[7] See Joint NGO Submission to the 2015 Universal Periodic Review of Australia. Available from Human Rights Law Centre < http://hrlc.org.au/upr/>.

[8] Phillip French, Julie Dardel and Sonya Price-Kelly, People with Disability Australia, *Rights Denied: Towards a National Policy Agenda about Abuse, Neglect and Exploitation of Persons with Cognitive Impairment* (2009).

3. QAI's Response to Recommendations

QAI supports all 30 of the recommendations made by the FDSS Review, subject to the following qualifications:

No.	Recommendation	Comment
3	Expanding the role of the DFD	**Support** QAI supports the proposal to expand and strengthen the role of the DFD to provide oversight over all FODs, not restricted to residents of the FDS. The indefinite nature of FODs also imposes significant restrictions for people living in the community. We reiterate that it is inappropriate that a person with disability and no co-existing mental illness should be in the mental health, rather than forensic disability, system.
5	Future of functions performed by the Centre of Excellence	**Qualified Support** QAI considers that the most effective use of the Centre of Excellence for Clinical Innovation and Behaviour Support (**CoE**) is to retain the CoE's function of collecting data related to RPs and reporting to the NDIS Quality & Safeguards Commission (**Commission)**, the Queensland government and the public. The CoE should assist with the training of clinicians in the development of Positive Behaviour Support Plans (**PBSPs**) and review and monitor all PBSPs for quality and effectiveness, prioritising PBSPs for persons subject to a Forensic Order (Disability) (**FOD**). The CoE should be empowered to: o review and make recommendations where the use of RPs has not been reduced within the timeframe specified in the PBSP, including mandating staff training; o review the allocation of Service Provider (**SP**) in circumstances where, despite further training and review, the SP has not succeeded in reducing or eliminating the use of RPs in accordance with the person's PBSP. The CoE should report on their perspectives on the development and implementation of the PBSP at the FDS to oversight bodies, discussed further below.
6	Information and reporting systems for the forensic disability cohort	**Qualified Support** Information recorded should not be limited to persons on FODs, but broadened to all clients/patients with a diagnosis of intellectual disability. This will ensure that persons with a dual disability, and those without a mental illness, but inappropriately placed on FO-MH, can be identified, their support needs monitored and key issues able to be identified and escalated. The information should record whether they are inpatient or community, the level of leave achieved, whether they are subject to restrictive practices, including receiving psychotropic medication, whether key plans (such as PBSPs, NDIS Packages) are in place, and any appointed decision-makers and support persons clearly identified.
9	Restrictive Practices	**Qualified Support** We support the recommendation to align the RP framework that applies at the FDS to the regime established by the DSA.

		While we agree with the recognised need for consistency in the use of RPs across the sector, the overarching focus of any RPs reforms must be on the elimination of the use of RPs, consistent with the obligations Australia assumed by signing and ratifying the Convention on the Rights of Persons with Disabilities (**CRPD**). We challenge the conclusion that it is reasonable that the current MHA RP framework continues to apply to clients with intellectual disability. There are broader concerns with the effectiveness of the MHA RP regime. In our practice experience, 'Reduction and Elimination Plans' are underdeveloped, lack an evidence base or timely review of their effectiveness in reducing the behaviours of concern. There is no opportunity for independent scrutiny or oversight. Alignment of all systems (under the FDA, MHA and DSA) in line with the CRPD and OPCAT will benefit all clients receiving involuntary treatment and/or care from the FDS and AMHS. A small, achievable improvement in this area that would benefit FOD clients and support changes in culture/practice and clinician literacy without legislative reform is to require REPs to incorporate, to the greatest extent possible, any Positive Behaviour Support Plan or other evidence-based behaviour support strategies for the person.
10	Examination and assessment order to assess suitability for admission to FDS	**Qualified support** The Director of Forensic Disability is already implementing changes to ensure that referrals are appropriate and targeted towards those who are likely to benefit from the programs that FDS offers. *How this is currently working:* When a referral is made by an AMHS the DFD goes through an assessment process, including at least one (but generally two) visits to the person and the service, obtaining full documentation, and functional assessment reports and any other health care plans. The DFD will prepare an Assessment of Suitability which includes a risk assessment (based on the ARMADILLO), habilitative and criminogenic needs, as well as protective factors/strengths, identifying the programs likely to benefit the client, and recommendations for the progression of the referral. If the person is considered suitable for admission, an Agreed Plan will be completed between the AMHS and the FDS setting out respective actions to be taken by the AMHS and FDS in preparation for, during and after the transfer. It gives an estimated length of stay and contains a provision that if, within three months, there is 'strong evidence that the person cannot benefit from the programs and services, or their wellbeing is suffering', the person will be transferred back to the AMHS. Once agreed with the AMHS, the DFD seeks the OCP's consent to the transfer (or could apply to the MHRT). The transfer considerations apply to the determination by both bodies. These are – the person's (1) mental state and psychiatric history; (2) treatment and care needs; (3) best interests of the person; and (4) security requirements (if relevant). *How this can be strengthened:* QAI holds concerns that a temporary examination/assessment order

		for a 'trial stay' at FDS may be disruptive and that it is necessary for the DFD and AMHS to go through a rigorous assessment before transferring any person to the FDS. We note the relevance of the human rights to family and cultural (recognised in the Human Rights Bill 2018) and propose these rights provide a basis for legislating a 'right to return' after three months. To ensure natural justice in decision processes, we propose that transfer applications should go through the MHRT unless there are urgent/exceptional circumstances. The Mental Health Court should be empowered to make directions for assessment processes to be completed and the report provided to the MHC when deciding whether to order detention at the FDS on a reference.
11	Less restrictive 'step down' order for FOD clients similar to the Treatment Support Order	**Qualified support** We support the proposal to develop a less restrictive form of FOD, similar to a Treatment Support Order, to provide opportunities for people with intellectual and cognitive disability to be managed in the least restrictive way possible and to promote transition through the system without the ongoing stigma that is attached to a "forensic order". We propose calling this order a 'Care Support Order' to provide clarity about the nature of the order, the involuntary care authorised under it and differentiate it from a mental health Treatment Support Order. However, our experience from the confused and conservative consideration of TSO step downs under the new Act shows it is important that legislative and policy guidance regarding the assessment of risk, meaning of unacceptable risk and transition pathways for patients with intellectual disabilities is introduced simultaneously to guide Tribunals, treating teams and legal representatives alike.
12	Decision-making presumption in favour of reduced supervision on review of a forensic order by the MHRT	**Strongly support** The reverse presumption operates for all clients on forensic orders and implies that patients must bear the onus to establish or prove that they are not an unacceptable risk to progress. When combined with a lack of legislative explanations, published precents or policies about the processes for making risk assessments and the meaning of 'unacceptable risks' this has resulted, in our experience, in dishearteningly slow progress for clients that does not align with the principles and objects of the MHA. We would strongly advocate for a reversal of the onus for both FOD and FO-MH clients, where, on a review of a forensic order, there is a legislated presumption that the level of supervision is to be reduced unless there is positive evidence as to why more restrictive approach is *the only means* necessary to protect the community from risk of harm.
13	Retain the FDS with a reviewed model of service and clear linkages and pathways for transition	**Qualified support** While QAI's position is to see the eventual closure of all institutions, if the FDS is to be retained, it ought to be as a specialist service of last resort where persons are unable to access the interventions necessary to progress their habilitation and rehabilitation in the community. Clear linkages and pathways need to be established to support the transition of current and future clients from the service

		(noting some clients remain who were admitted as part of the first cohort).
18	Time-limited orders	**Qualified support** QAI proposes development of a legislative rule that the DFD cannot recommend a stay of more than 24 months, and the FDS must produce a transition plan no later than one month before the end of the recommended admission period, and file this with the DFD. The FDS must apply to the Tribunal for an extension on the timeframe, and the Tribunal can approve an extension of not more than six months. QAI also submits that there should a (funded) right to independent advocacy at the quarterly IDP reviews, with the requirement that a legal representative is appointed for any Tribunal hearing considering application for extension of detention; the requirement for AMHS to be involved in the IDP reviews; and a requirement to 'do all things reasonably necessary' to facilitate the persons transition back to the community.
19	Hub and spoke model	**Support** We support the recommendation in the FDSS Review to establish a decentralised 'hub and spoke' model, with regional hubs dispersed throughout Queensland, for the delivery of forensic disability and outreach services throughout Queensland that support people to remain living in their community. This should take the form of service outreach and capacity-building, rather than separate stand-alone 'mini-FDS' physical facilities.
26	Culturally responsive and appropriate services for Aboriginal and Torres Strait Islander people on FODs	**Qualified support** QAI considers the separation and isolation of residents of the FDS from their familial and cultural networks particularly concerning given the over-representation of persons of Aboriginal or Torres Strait Islander status in the FDS. Geographical separation from their community coupled with limited or very brief periods of LCT can result in extreme isolation. Resourcing constraints often preclude family members from visiting. QAI supports the introduction of policies and reforms designed to enhance the cultural competency of the FDS system. In particular, the Government must look at ways to keep Aboriginal and Torres Strait Islander persons living in their community with appropriate supports as an urgent priority (this will be increasingly important with the passage of the Human Rights Bill 2018). We also strongly endorse proposals 26 and 27 of the FDSS Review as means of increasing the cultural competency of the FDS system. However, in our view, the proposals do not go far enough. There needs to be careful consideration of the cultural and family needs of Aboriginal and Torres Strait Islander clients in the referral and transfer process. Clients should only be transferred to the FDS (or to AMHS) if their treatment/care needs cannot be met in their local communities. This should be included as one of the 'transfer

		considerations' under s 350 of the MHA. For Aboriginal and Torres Strait Islander clients, their specific cultural needs, the right to country, family and cultural connection, should be included as an additional consideration. If after considering these rights, an application is made for consent/approval to transfer the person, the Tribunal is given the power to call evidence and make directions regarding the supports required to maintain the person's cultural social and emotional wellbeing throughout the transfer.
28 / 29	Address the uncertainties in the impact of the NDIS on the forensic disability service system	**Strongly support** The rollout of the NDIS has created many gaps and uncertainties, and left certain groups at risk of disadvantage, and this must be addressed. The Government must develop and implement a plan to address these gaps and uncertainties.

4. Issues not identified by FDSS review

While detailed in its scope, the Review has failed to identify some key issues that have emerged or remain unresolved in our practice representing persons on Forensic Orders with intellectual disabilities (both in the FDS and in the community)

No.	Issues	Comment
i.	Transfers	While the Review touched on the issue of inappropriate transfers, it did not consider the way in which assessments and decisions about transfers to (and also from) the FDS are made. Having supported two people who are recent admissions to the FDS through this process, we highlight the following issues: • Transfers to the FDS can be made either with the agreement between the DFD and the CP, or on application to the Tribunal. In practice, admissions to the FDS have been through agreement, and the DFD and the relevant AMHS 'manage' the process. • As an administrative decision that has a significant impact on a person's life and liberty, it is important that procedural fairness is afforded to potential FDS clients. However, there is no formal process and no right to representation or support. • A number of assessments are made, which are not provided to the person, or explained in a manner that the person can understand. • Assessments have not adequately considered the resources and supports available in the local community. This may be because the DFD has relied largely on information provided by inpatient mental health units, who do not necessarily have a developed understanding of the needs of forensic disability clients nor the supports available. To address these issues, we recommend: • That all admissions to the FDS are made through the Tribunal, to ensure an open and transparent process and the affording of natural justice. The Tribunal should appoint a legal representative in these matters to support the person and assist in an independent analysis of the evidence, and transfer considerations.

		• The transfer considerations should be amended to require the consideration of the supports available in the person's local community. This could be strengthened further with a provision that a transfer to the FDS may ***only*** be approved if the necessary supports ***are not*** available in the person's community, or unlikely to be able to be accessed within the proposed detention period at the FDS. • New rules should be introduced, similar to the rule regarding the provision of clinical reports for MHRT hearings, to require the DFD to provide the person the subject of a proposed transfer with copies of the relevant documents (e.g. the Suitability Assessment), and explain it to them in a way they are most likely to understand.
ii.	Clarification of 'Treatment' vs 'Care' permitted under the MHA for persons under FODs in the community	There appears to be substantial confusion about what clinical teams are authorised to do under Forensic Orders. The MHA differentiates between persons with mental illness and intellectual disabilities by providing that: • A Forensic Order (mental health) provides for involuntary treatment and care for a person's mental illness or other mental condition and, if the category is inpatient, the person's detention in an AMHS. Treatment is defined as things done, or proposed to be done, with the intention of having a therapeutic effect on the person's illness. • A Forensic Order (disability) provides for involuntary care for a person's intellectual disability, and if the category is inpatient, their detention in an AMHS. Care is defined as the provision of rehabilitation, development of living skills, and the giving of support, assistance, information and other services. For clients with intellectual disability living in the community, the treating team plays more of a 'care coordination' role. Treating teams in AMHS have limited skills and experience in these roles, and lack understanding of the other systems of support that will affect clients, including the guardianship and restrictive practices regimes under the DSA and G&AA. We recommend clarification, through policies, practices and clinician training of the difference between treatment and care under the Act, and the other systems and stakeholders involved in the care of people with intellectual disability.
iii.	Prescription of medication for behaviour management by AMHS clinicians to FOD clients	A particularly concerning example of the gaps in understanding highlighted in point (ii) is the prevalence of prescribing medications to persons with intellectual disability who do not suffer (and in many cases never suffered) from a mental illness. We are aware of at least 10 individuals on FODs who are prescribed anti-psychotic medication from their treating team with their supervising AMHS. There likely are many more. Prescribing medication in these circumstances is a Restrictive Practice, for which consent can only be provided by a guardian for Restrictive Practices, appointed by QCAT. Our direct advocacy to date around this point has revealed not only a lack of understanding, but a concerning resistance to alternative approaches and laws.

iv.	Transitioning of persons on FO-MH to FO-D	We are aware of a handful of individuals on FO(MH) who do not, and never have had, a mental illness. Prior to 2011, persons who were permanently unfit for trial by reason of their intellectual disability could only be placed on one kind of order – a Forensic Order (Mental Health Court). There was a provision in the Mental Health Act 2000 for persons on Forensic Orders to be transitioned to a Forensic Order (Mental Health Court – Disability) on application to the Mental Health Court. Unfortunately not all relevant orders were transitioned in this way. There is no provision under the new Mental Health Act for the MHRT to change the class of their order, and so some individuals with intellectual disabilities remain on FO-MH, and some are inappropriately prescribed antipsychotic and anti-libidinal medications. This gap needs to be addressed by amending the MHA.
V	Legal representation at hearings	QAI considers it a significant concern that persons under FODs can still be unrepresented at the reviews of their orders by the MHRT. There are many factors – notably, the vulnerability of the person by virtue both of their disability and the innate power imbalance that exists between a person and an institution, the potential human rights impact and the significance of the outcome for a person's life experience – that support the introduction of a compulsory right to free legal advocacy in all FOD reviews, and not just when the Attorney-General's representative elects to attend.

5. Prioritisation and progression of reforms

We note the Department's position that the reforms are significant and should therefore be considered after further and comprehensive review in this area and the development of a new service delivery model. QAI commends the Government on its commitment to comprehensive review and reforms in this area. We consider that, in the intervening period, there are meaningful reforms that should be actioned, in accordance with the timeline proposed above.

Conclusion

Thank you for taking the time to consider this response. We are happy to provide any further information that may assist and would welcome the opportunity to meet with you to discuss these issues further. QAI would also welcome the opportunity to participate in any reference group or participate in ongoing consultation to contribute our current practice experience to ensure that the implementation of the Review's recommendations is based on the best current evidence from the lived experience of people with intellectual disabilities in Queensland.

Yours Faithfully,

Michelle O'Flynn
Director

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