Adults with cognitive disability in the Queensland criminal justice system

Discussion Paper 3: The Forensic System (Mental Health and Disability)

August 2025

The Public Advocate

Influencing change to transform lives

Acknowledgement of Country

The Public Advocate and staff acknowledge Aboriginal and Torres Strait Islander peoples as Australia's first peoples and as the Traditional Owners and custodians of the land on which we live. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging.

Acknowledgement of Lived Experience

We acknowledge the experiential expertise of adults with impaired decision-making ability, whose rights we seek in our work to promote and protect.

Acronyms

AHRC	Australian Human Rights Commission
ALRC	Australian Law Reform Commission
AMHS	Authorised Mental Health Service
ARMC	Assessment Risk Management Committee
the Panel	Chief Psychiatrist Complex Care Panel
DFSDSCS	Department of Families, Seniors, Disability Services and Child Safety
Disability Royal Commission	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
FDS	Forensic Disability Service
GLM	Good Lives Model
IDP	Individual Development Plan
LCT	Limited Community Treatment
MHAOD	Mental Health Alcohol and Other Drugs
MHRT	Mental Health Review Tribunal
MoC	Model of Care
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
OCP	Office of the Chief Psychiatrist
OPCAT	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
OPG	Office of the Public Guardian
QAI	Queensland Advocacy for Inclusion
QDAP	Queensland Disability Advocacy Program
QMHC	Queensland Mental Health Commission
SDA	Specialist Disability Accommodation
SIL	Supported Independent Living
SFDA	Specialist Forensic Disability Accommodation
TSO	Treatment Support Order
UNCAT	United National Committee Against Torture or other Cruel Inhuman or Degrading Treatment or Punishment
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

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Summary and critical questions

The Public Advocate is undertaking a project on the interactions between adults with cognitive disability and the criminal justice system in Queensland. The aim of this project is to identify opportunities for reform to ensure that the rights of adults with cognitive disability are upheld during these interactions.

This discussion paper is the third in a series of papers that will be used to guide stakeholder consultation.

The focus of the current paper is the Queensland Forensic System (Mental Health and Disability). It aims to provide an overview of issues that may be experienced by adults with cognitive disability who are referred to the Mental Health Court and placed under a Forensic Order.

These issues include:

- the effectiveness of tests to determine fitness for trial;
- detention without trial;
- the indefinite nature of Forensic Orders (Mental Health and Disability), which may include indefinite detention;
- the fragmentation of the current forensic system (across multiple government agencies);
- barriers to transition back into the community, including concerns around the current use of limited community treatment;
- the institutionalisation of those on inpatient orders, including those with the Forensic Disability Service;
- the potential misuse of regulated behaviour controls;
- authorised mental health services being responsible for the oversight of the majority of people on inpatient and community Forensic Orders Disability;
- elements of the Forensic Order review process; and
- compliance monitoring associated with the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The paper also includes a summary of key policies and legislation relevant to the Forensic System (Mental health and Disability) including:

- the *Mental Health Act 2016* (Qld);
- the *Forensic Disability Act 2011*(Qld);
- the *Criminal Code 1899* (Qld);
- policies from the Office of the Chief Psychiatrist; and
- policies from the Director of Forensic Disability.

Relevant recommendations from previous reports, studies and inquiries are also discussed.

The following **key questions** are posed for further discussion:

1. **What reforms are required to improve Queensland's Forensic System (Mental Health and Disability)?**

2. **Should greater support be provided to enable people to be deemed fit to stand trial. If so, what form should that support take, and who should provide it?**

3. **Should nominal terms be applied when a person is detained following a finding that they are unfit to stand trial or are not guilty by reason of being of 'unsound mind'?**

4. **Should new governance arrangements be developed for people on Forensic Orders (Disability), most of whom have their treatment and support (in inpatient or community settings) provided by authorised mental health services?**

Introduction

The Public Advocate

The Public Advocate is a position established under chapter 9 of the *Guardianship and Administration Act 2000* (Qld) to promote and protect the rights and interests of Queensland adults with impaired decision-making ability through systemic advocacy.

Section 209 of the *Guardianship and Administration Act* states that the functions of the Public Advocate are:

a) promoting and protecting the rights of adults with impaired capacity (the adults) for a matter;
b) promoting the protection of the adults from neglect, exploitation, or abuse;
c) encouraging the development of programs to help the adults to reach the greatest practicable degree of autonomy;
d) promoting the provision of services and facilities for the adults;
e) monitoring and reviewing the delivery of services and facilities to the adults.[1]

Cognitive disability

The term used to describe the people who are the focus of this paper is 'adults with cognitive disability'. Cognitive disability, as the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) has noted, 'arises from the interaction between a person with cognitive impairment and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.'[2] People may experience cognitive impairment if they have an intellectual disability, acquired brain injury, neurological disorders (such as dementia), or if they have a mental health condition.[3]

People with cognitive disability may experience difficulty with communication, attention, concentration, memory, thinking, and learning.[4] Sometimes a person with cognitive disability will have impaired decision-making ability. This may be episodic or temporary for some, requiring intensive supports at specific times, while others may require lifelong support with decision-making and communicating their choices and decisions.

Other terms used in reports, legislation, policies, research and official documents referenced in this paper include; 'people with impaired decision-making ability', 'people with impaired capacity', 'people with an intellectual disability', people with an 'impairment of the mind', 'people with cognitive impairment', 'people with psychiatric impairment' or, more broadly, 'people with disability' or 'people with a mental health condition'.

In this paper, the terms 'mental health' and 'disability' are used as separate categorisations, given the definitions employed in relevant pieces of legislation.

The criminal justice system

The criminal justice system in Australia is complex, with considerable variability evident at Commonwealth, state and territory levels when it comes to the existence of particular criminal offences and the ways that police services and courts deal with alleged breaches of them. Each jurisdiction also differs in terms of enforcement, prosecution, and judgement of criminal charges.

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[1] *Guardianship and Administration Act 2000* (Qld) s 209.
[2] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Executive summary: Our vision for an inclusive Australia and recommendations', *Final report*, 2023, p. 316.
[3] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Executive summary: Our vision for an inclusive Australia and recommendations', *Final report*, 2023, p. 316; D V Jeste, G M L Eglit, B W Palmer, J G Martinis, P Blanck, E R Saks, 'Supported decision making in serious mental illness', *Psychiatry*, vol. 81, no. 1, 2018, pp. 28-40.
[4] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Executive summary: Our vision for an inclusive Australia and recommendations', *Final report*, 2023, p. 316.

Given this variability, it is important to note that this paper explores the criminal justice system in Queensland and the issues that arise in this state.

The criminal justice system in Queensland involves a vast array of people and roles, including the police service, prosecutors, defence lawyers, support groups and advocates, the courts, the corrections system, forensic care systems and the parole system.

People with cognitive disability may interact with the criminal justice system for a number of reasons, including as witnesses, as victims of crime, or as those accused of committing a criminal offence. There have been many concerns raised in the past regarding how the criminal justice system interacts with people with disability, including recently in the work of the Disability Royal Commission.

In short, people with cognitive disability are overrepresented in the criminal justice system. This leads to concerns about the lack of access to justice for people with disability, and about the mainstream criminal justice system's failure to make sufficient accommodations for the needs of people with disability.

These matters are highly relevant to the Public Advocate's systemic advocacy functions in relation to adults with impaired decision-making ability.

Adults with cognitive disability in the Queensland criminal justice system

This project aims to explore the various issues faced by people with cognitive disability in Queensland when they interact with the criminal justice system and identify opportunities for reform to ensure that their rights are upheld during these interactions.

The Public Advocate will be seeking feedback from key stakeholders and asking questions focusing on issues relevant to people with cognitive disability.

A series of discussion papers have been or will be developed and used as the basis for consultations. The papers and consultations will explore key elements of a person's potential involvement with the criminal justice system, and will include these topics (in addition to the forensic system):

- policing (released in April 2024),
- courts (released in March 2025),
- detention, and
- victims of, and witnesses to, crime.

The findings from the consultations will inform the development of reform recommendations for consideration by the Queensland government.

Scope of this paper

The focus of this discussion paper is the Forensic System (Mental Health and Disability).

The first part of this paper provides a brief overview of key concerns that have been identified in previous reports and research, and publicly available policies and strategies that have been adopted to address identified issues. It also includes a summary of some of the recommendations that have been made, or actioned, with the aim of improving this part of the criminal justice system for people with cognitive disability.

The second part of this paper, attached as an appendix, provides additional details about key policies and legislation, primarily the *Mental Health Act 2016* (Qld) (*Mental Health Act*), that apply in this area.

The Queensland Forensic System (Mental Health and Disability)

An adult's journey through the Queensland Forensic System (Mental Health and Disability) can be complex and may be indefinite. It might commence if an adult with cognitive disability commits an act that leads to interaction with police and possibly being charged with an offence. This may lead to a determination of whether a person's cognitive disability (including a mental health condition) significantly affects their ability to participate in mainstream court processes.

If a person is found not to have the ability to participate in court proceedings, or if they were not criminally responsible at the time of offending, they will either be discharged by the Magistrates Court or be referred to the Queensland Mental Health Court. More detailed information on this process can be found on pages 40 - 44 in the Appendix to this paper.

If they are found to be unfit for trial or of unsound mind, the Mental Health Court can make a Forensic Order to guide the person's next steps through the system.

There are two types of Forensic Orders which can be made:

- Forensic Order (Mental Health), which is made if the 'person's unsoundness of mind or unfitness for trial is due to a mental condition other than an intellectual disability, or the person has a dual disability (a mental illness and intellectual disability) and needs involuntary treatment and care for their mental illness, as well as care for their intellectual disability'.[5]
- Forensic Order (Disability), which is made if 'the person's unsoundness of mind or unfitness for trail is due to an intellectual disability, and the person needs care for their intellectual disability but does not need treatment and care for any mental illness'.[6]

Both types of orders can be made as either an inpatient or community category order.

If a person is issued with a Forensic Order (Mental Health), responsibility for implementation of the order lies with an Authorised Mental Health Service (AMHS) operated by Queensland Health.

If the order is an inpatient order, the adult will reside and be treated (or cared for) at an AMHS (normally a designated unit within a public or, in some cases, a private hospital).

If the order is community based, the adult is free to reside in the community but must abide by the conditions noted on the order, which could include regular treatment or potentially restrictions on things like places they can visit and their use of technology.

If a person is issued with a Forensic Order (Disability), the order's implementation is the responsibility of either an AMHS or the Forensic Disability Service (FDS) (a unit operated by the Department of Families, Seniors, Disability Services and Child Safety (DFSDSCS)).

If the Forensic Order (Disability) is an inpatient order, the adult will reside and be cared for at either an AMHS or the FDS (a purpose built 10 bed facility in Wacol).

The FDS is a specialised service designed explicitly for people with cognitive disability as distinct from a mental health condition. It was developed following a series of reports recommending that people with intellectual disability who are charged with serious offences, and who have challenging behaviours, be detained in a facility other than an AMHS. The service provides a range of different supports and capacity building activities designed to facilitate a person's transition back into the community.

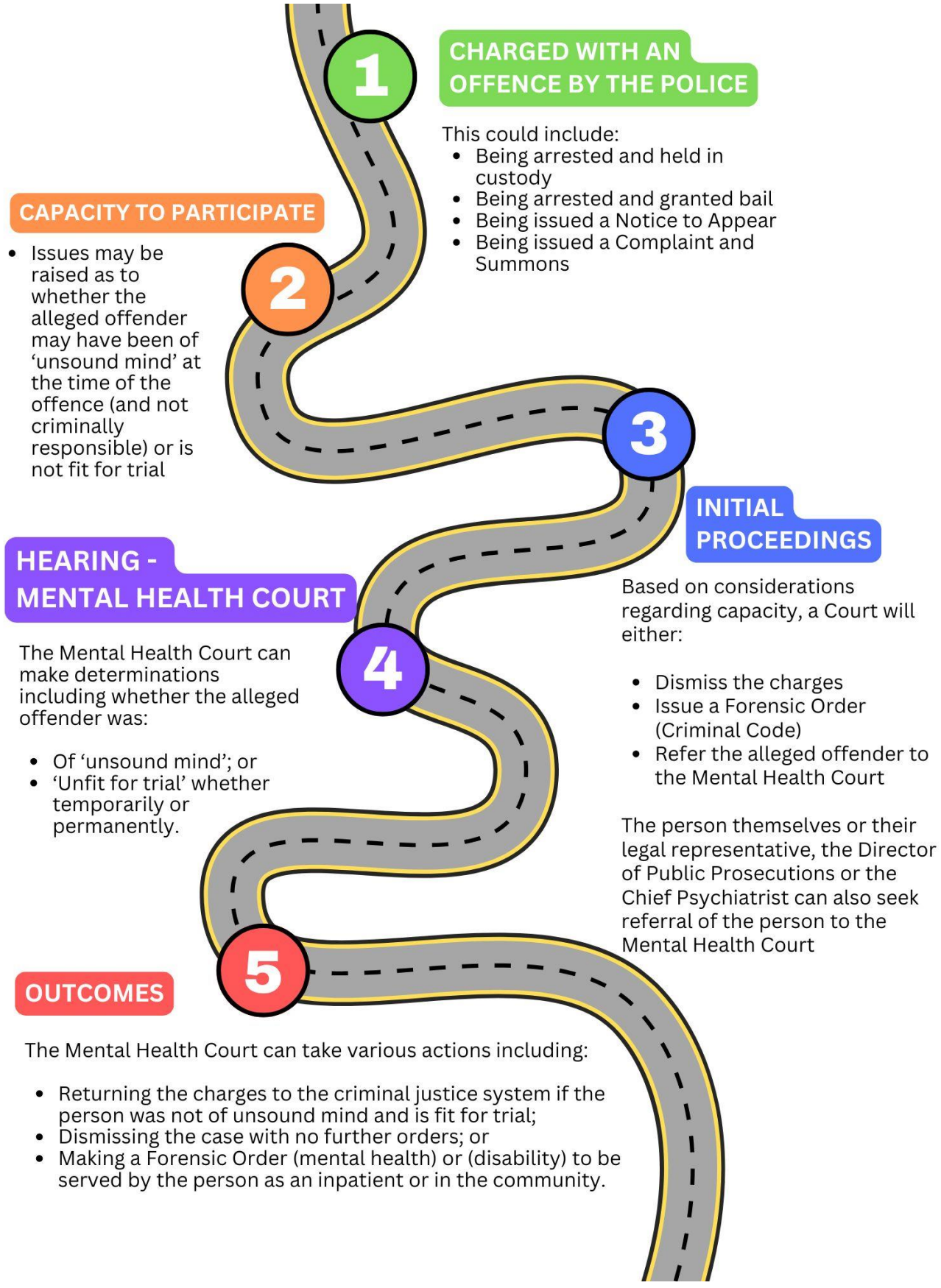
[5] Queensland Health, *Mental Health Act 2016 Fact Sheet*, < https://www.health.qld.gov.au/__data/assets/pdf_file/0035/635498/forensic-order-fs.pdf>, n.d., p.1.
[6] Ibid., p.1.

As with a Forensic Order (Mental Health), if the Forensic Order (Disability) is community based, the adult is free to reside in the community but must abide by the conditions noted on the order. As noted above, an AMHS will be responsible for the order's implementation.

Regardless of the type of order or where a person lives, a Forensic Order is routinely reviewed once every six months by the Mental Health Review Tribunal (MHRT). A review of an order can also be requested by the person themselves or various government officials, including the Attorney-General. The MHRT can make decisions including whether to:

- Revoke an order (meaning that the order no longer applies to the person and they are free to reside in the community without restriction or treatment).
- Step-down an order (if the person is on a mental health related order) to what is known as a Treatment Support Order, which generally involves less oversight than Forensic Orders and allows for treatment in the community unless otherwise absolutely necessary.
- Change the category of an order (inpatient or community).
- Authorise Limited Community Treatment, which works to transition people back to living in the community with appropriate treatment and care.

Summary of a person's journey through the criminal justice system: Forensic System (Mental Health and Disability)



Issues and challenges

In Queensland, under the *Human Rights Act 2019* (Qld), 'Every person is equal before the law and is entitled to the equal protection of the law without discrimination'.[7] The Act also includes a number of 'Rights in criminal proceedings'[8] and rights in relation to a 'Fair hearing'.[9]

'Equal recognition before the law'[10] and 'Access to justice'[11] are also amongst the rights outlined in the United Nations *Convention on the Rights of Persons with Disabilities* (UNCRPD), which Australia has ratified.

However, despite these commitments and protections, there are a range of issues and challenges that adults with cognitive disability may experience that can affect their participation in court processes and their equal access to justice. This also applies to the processes associated with the Forensic System (Mental Health and Disability) in Queensland.

Mental Health Court

Fitness for Trial

There have been concerns raised about the effectiveness of the current common law and statutory tests for fitness for trial and to plead,[12] which are the key tests by which an alleged offender is diverted to the Mental Health Court and enters the forensic system.

The Australian Law Reform Commission (ALRC) has observed that 'the common law may place an undue emphasis on a person's intellectual ability to understand specific aspects of the legal proceedings and trial processes, and too little emphasis on a person's decision-making ability'.[13]

A Victorian Parliamentary Law Reform Committee in 2013 concluded that 'most defendants with an intellectual disability or cognitive impairment will be fit to stand trial when information is given in simple terms and support is available to help them understand court proceedings.'[14]

The Disability Royal Commission also concluded that people with cognitive disability should be supported to participate on an equal basis to others in legal proceedings. The Commission observed that, 'a person can be found fit to be tried provided their impairment is recognised and addressed during the course of the trial by the provision of appropriate supports or assistance.'[15]

Unfortunately, as the Australian Human Rights Commission (AHRC) found, people with cognitive and/or psychiatric impairment who interact with the criminal justice system are often not provided with adequate support and adjustments to enable them to effectively participate in the system.[16]

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[7] *Human Rights Act 2019* (Qld) s 15(3).
[8] *Human Rights Act 2019* (Qld) s 32.
[9] *Human Rights Act 2019* (Qld) s 31.
[10] United Nations, *Convention on the rights of persons with disabilities*, GA Res 61/106, 76th plen mtg, UN Doc A/RES/61/106 (adopted on 13 December 2006), Article 12.
[11] Ibid., Article 13.
[12] Queensland Advocacy for Inclusion, 'Submission to Tasmanian Law Reform Institute', *Review of Insanity and Fitness to Plead Laws,* May 2019, p. 4.
[13] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, ALRC Report 124, August 2014, p. 196.
[14] Law Reform Committee, Parliament of Victoria, *Inquiry into Access to and Interaction with the Justice System by People with an Intellectual Disability and their Families and Carers*, 2013, p. 226.
[15] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Volume 8: Criminal justice and people with disability', *Final Report*, 2023, p. 147.
[16] Australian Human Rights Commission, 'Submission to the Senate Community Affairs References Committee', *Inquiry into the Indefinite detention of people with cognitive and psychiatric impairment in Australia*, March 2016, p. 4.

The absence of adequate supports could also be seen to run contrary to Australia's obligations under Article 14(2) of the UNCRPD, which requires state parties to ensure that:

> if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.[17]

The ALRC recommended that the existing tests for fitness for trial and to plead should be 'reformulated to focus on whether, and to what extent, a person can be supported to play their role in the justice system, rather than on whether they have capacity to play such a role at all.'[18]

The ALRC has further recommended that the tests should be consistent with the National Decision-Making Principles.[19] The National Decision-Making Principles are four general principles that reflect the key ideas and values upon which the ALRC's approach in relation to legal capacity is based.

They are:

> *Principle 1: The equal right to make decisions*
> All adults have an equal right to make decisions that affect their lives and to have those decisions respected.
>
> *Principle 2: Support*
> Persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.
>
> *Principle 3: Will, preferences and rights*
> The will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.
>
> *Principle 4: Safeguards*
> Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.[20]

To better reflect the National Decision-Making Principles, the ALRC recommended a new fitness for trial test in the context of proposed changes to the *Crimes Act 1914* (Cth), but similarly applicable to Queensland state law, that would make the availability of support a consideration in assessing a person's fitness for trial.[21]

The new test would provide that a person cannot stand trial if the person cannot be supported to:

> (a) understand the information relevant to the decisions that they will have to make in the course of the proceedings;
> (b) retain that information to the extent necessary to make decisions in the course of the proceedings;
> (c) use or weigh that information as part of the process of making decisions; or
> (d) communicate the decisions in some way.[22]

Proving the offence

Other jurisdictions have different approaches to Queensland in terms of determining whether the alleged offending occurred when the person was of unsound mind or was unfit for trial.

[17] United Nations, *Convention on the rights of persons with disabilities*, GA Res 61/106, 76th plen mtg, UN Doc A/RES/61/106 (adopted on 13 December 2006), Article 14(2).
[18] Ibid.
[19] Australian Law Reform Commission, 'Equality, Capacity and Disability in Commonwealth Laws', ALRC Report 124, *Final Report*, August 2014, p. 63.
[20] Ibid., p. 64.
[21] Ibid., p. 200.
[22] Ibid., pp. 200-201.

In New South Wales, a person can raise the defence of 'mental health impairment or cognitive impairment' before a jury in a criminal trial.[23] After this, the jury can return a verdict of 'act proven but not criminally responsible'.[24]

Similar provisions exist in New South Wales in relation to fitness for trial. Issues of fitness can be raised prior to a criminal trial,[25] and a special inquiry is held by a judge alone to determine the defendant's fitness.[26] If a defendant is found to be unfit to be tried, a 'special hearing' is then conducted.[27] The special hearing is to be conducted via a process as similar as possible to a regular criminal trial, but the defendant is taken to have pleaded not guilty, and can raise defences and give evidence if they choose to.[28] The trial can be conducted by a judge alone or in front of a jury if the defendant or the prosecutor elects that the matter go before a jury.

The verdicts available at the end of a special hearing include that the defendant is: not guilty; act proven but not criminally responsible; or, on the limited evidence available, the defendant committed the offence or an available alternative offence.[29]

The Northern Territory has a similar process to New South Wales. A defence of 'mental impairment' can be established during a criminal trial,[30] where a jury will determine whether the person is: not guilty of the offence; not guilty due to mental impairment; or committed the offence or an alternative offence.[31] If a question of fitness for trial is raised, the court conducts an 'investigation' before a jury.[32] If the person is found not to be fit for trial, a 'special hearing' is conducted before a jury where one of the following findings can be made: not guilty; not guilty due to mental impairment; or committed the offence or an alternative offence.[33]

The distinction between the above jurisdictions and Queensland is that neither New South Wales nor the Northern Territory has a Mental Health Court – instead each relies solely on the mainstream criminal justice system in relation to mental health issues. Although a similar process can be undertaken in Queensland in terms of raising unsound mind and/or fitness defences during a criminal trial, accused persons are generally referred to the Mental Health Court if such defences are to be raised, and Mental Health Court processes are then employed to determine the case. If the process occurs during a criminal trial (such as in the New South Wales and Northern Territory processes above), the criminal conduct must be proven beyond reasonable doubt to a jury.

In Queensland, where the Mental Health Court makes a finding that the person is unfit to plead or not guilty due to being of unsound mind, it must only be satisfied on the balance of probabilities that the person committed the alleged offence.[34] This contrasts with the standard of proof applied in a standard criminal trial of 'beyond reasonable doubt'. The higher burden of proof applied in criminal trials reflects the power imbalance between the government as prosecutor, and the position of the individual accused.[35]

The AHRC has observed that people with cognitive disability who have been deemed 'unfit to stand trial' because of impairment, 'are locked out from the usual criminal trial process (which contains fair trial guarantees and safeguards against arbitrary and indefinite detention).'[36]

[23] *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 28.
[24] *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 30.
[25] *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 37.
[26] *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 44.
[27] *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 54.
[28] *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 56.
[29] *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) s 59.
[30] *Criminal Code Act 1983* (NT) s 43C.
[31] *Criminal Code Act 1983* (NT) s 43G.
[32] *Criminal Code Act 1983* (NT) s 43P.
[33] *Criminal Code Act 1983* (NT) s 43V.
[34] *Mental Health Act 2016* (Qld) s 685(2).
[35] *Lee v The Queen* [2014] HCA 20 (21 May 2014) [32].
[36] Australian Human Rights Commission, 'Submission to the Senate Community Affairs References Committee', *Inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia*, March 2016, p. 4.

This conflicts with Article 14(1)(b) of the UNCRPD which commits state parties to ensure that people with disability:

> are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.[37]

The AHRC further commented that the detention of people with cognitive and/or psychiatric impairment who have not been convicted of a crime is 'inappropriate and contrary to their right to health, habilitation and rehabilitation, and may expose them to cruel, inhuman or degrading treatment.'[38] This also runs contrary to Australia's obligations under the UNCRPD relating to habilitation and rehabilitation.[39]

A consequence of the current system in Queensland is that it may lead to innocent people with cognitive disability pleading guilty to a charge in the mainstream court system, in order to avoid the consequences of unfitness and diversion to the Mental Health Court.[40] This has been observed by Queensland Advocacy for Inclusion (QAI), which noted that some people who are at risk of failing the test for fitness for trial will choose to plead guilty to 'avoid the possibility of diversion into the forensic system and having to endure a considerably longer period of incarceration or community monitoring than they would have served if convicted for the alleged offence/s.'[41]

A 2014 review of the Queensland *Mental Health Act 2000* recommended that in circumstances where the Mental Health Court makes a Forensic Order following a finding of permanent unfitness or a finding of temporary unfitness that lasts longer than 12 months, the accused person's lawyer should be able to elect to have a special hearing into 'whether the accused person did the act that constituted the offence'.[42] If the court found the accused did not, the person would be discharged and the relevant Forensic Order would be revoked.[43] If the court found the accused did commit the offence, the order would be confirmed.[44]

The Hon Justice Catherine Holmes noted that such an approach has the advantage of providing an accused person with choice as to how they wish to proceed, as opposed to automatically exposing them to another court hearing, which may create additional trauma.[45]

Indefinite nature of Forensic Orders

As noted above, Queensland legislation does not impose any limiting terms on how long a person who is alleged to have committed an offence can be subject to a Forensic Order. Once a person is placed on a Forensic Order by the Mental Health Court, the MHRT, which conducts a review of a person's order once every six months, has the power to decide when an individual may be released from that order, or when the conditions of the order can be changed.

For people under an inpatient category, this means they can be held indefinitely in an AMHS or the FDS. In many cases a person can be subject to a Forensic Order for much longer than the maximum penalty for the offence they allegedly committed.

A stakeholder consulted to inform the writing of this paper advised that Forensic Orders are not intended to replicate the mainstream criminal justice system and are not designed as a punishment, rather as the provision of necessary supports to reduce the risk the person presents to

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[37] United Nations, *Convention on the rights of persons with disabilities*, GA Res 61/106, 76th plen mtg, UN Doc A/RES/61/106 (adopted on 13 December 2006), Article t 14(1)(b).
[38] Australian Human Rights Commission, 'Submission to the Senate Community Affairs References Committee', *Inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia*, March 2016, p. 5.
[39] United Nations, *Convention on the rights of persons with disabilities*, GA Res 61/106, 76th plen mtg, UN Doc A/RES/61/106 (adopted on 13 December 2006), Art 26.
[40] Australian Law Reform Commission, 'Equality, Capacity and Disability in Commonwealth Laws', ALRC Report 124, *Final Report*, August 2014, p. 196.
[41] Queensland Advocacy for Inclusion, 'Submission to the Tasmanian Law Reform Institute', *Review of the Defence of Insanity in s 16 of the Criminal Code and Fitness to Plead*, 24 April 2019, p. 5.
[42] Queensland Health, 'Review of the Mental Health Act 2000', *Discussion paper*, May 2014, Recommendations 4.21 and 4.22, p. 16.
[43] Ibid., Recommendation 4.22, p. 16.
[44] Ibid.
[45] The Hon Justice Catherine Holmes, *Queensland's Mental Health Court*, Speech from Australian Judicial Officers Association Colloquium, October 2014, p. 7.

themselves or members of the community. The seemingly indefinite nature of some Forensic Orders reflects an assessment made by the MHRT that the person still presents an unacceptable risk to the safety of themselves, and the wider community, should they not be subject to the provisions of, and supports provided under, a Forensic Order.

Indefinite detention

As noted, an ongoing concern about people with a cognitive disability on inpatient Forensic Orders in Queensland is that they may be subject to an indefinite period of involuntary detention in the FDS or an AMHS.

In 2022, the United Nations Committee Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) urged the Australian government to 'stop committing persons with intellectual or psychosocial disabilities who are considered unfit to stand trial or not guilty due to "cognitive or mental health impairment" to custody and for indefinite terms or for terms longer than those imposed in criminal conviction.'[46]

The AHRC has also recommended that:

> All state and territory laws which allow for people to be detained following a finding of unfitness to stand trial, or a verdict of not guilty by reason of mental impairment:
>
> (1) impose effective limits on the total period of detention
> (2) require regular reviews of the need for detention
> (3) require a plan to be put in place including actions to be taken for the person's rehabilitation to facilitate their transition into progressively less restrictive environments, and eventually out of detention.[47]

QAI has noted that 'indefinite detention denies people certainty about their future and keeps people involved in the forensic system beyond a point where it can be reasonably argued that continued detention and/or supervision is appropriate or beneficial.'[48]

The ALRC has proposed that:

> limits on the period of detention should be set by reference to the period of imprisonment likely to have been imposed, if the person had been convicted of the offence charged. If they are a threat or danger to themselves or the public at that time, they should be the responsibility of mental health authorities, not the criminal justice system. The framework for detention and supervision orders should be flexible enough to ensure that people transition out of the criminal justice system, in a way consistent with principles of community protection and least restriction of rights.[49]

While the *Mental Health Act* makes provision for a person on an inpatient Forensic Order (Disability) to have their category changed to community,[50] this will only occur if an authorised doctor of an AMHS or a senior practitioner of the FDS is satisfied that 'there is not an unacceptable risk to the safety of the community because of the patient's mental condition, including the risk of serious harm to other persons and property.'[51]

However, a person with intellectual disability, for instance, may not be able to provide medical evidence associated with their progression and skill development in a similar way to someone with a mental health condition that has stabilised with medication.

This could potentially affect the assessment of risk made in relation to the person, which may not change significantly over time.

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[46] United Nations Committee Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Concluding observations on the 6th periodic report of Australia*, CAT/C/AUS/CO/6, Geneva Switzerland, 5 December 2022, 40(b), p. 12.
[47] Australian Human Rights Commission, Submission to the Senate Community Affairs References Committee, *Inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia*, March 2016, p. 6.
[48] Queensland Advocacy for Inclusion, 'Indefinite detention and solitary confinement – the awful reality of Queensland's Forensic Disability Service', *Position Statement by Queensland Advocacy for Inclusion*, October 2023, p. 7.
[49] Australian Law Reform Commission, 'Equality, Capacity and Disability in Commonwealth Laws', ALRC Report 124, *Final Report*, August 2014, p. 209.
[50] *Mental Health Act 2016,* s 212 (1)(a).
[51] *Mental Health Act 2016*, s 212(3); *Forensic Disability Act 2011* (Qld), s 20(2).

In its final report, the Disability Royal Commission also identified concerns about the laws in Queensland where there is no fixed maximum term of detention.[52] In comparison, under Commonwealth and Australian Capital Territory laws,[53] a Forensic Order can be made for a defined period. That period is determined by considering the sentence that would have been imposed if the person was convicted in criminal proceedings. There is no provision for a term of detention to be extended.

As a previous Public Advocate (Queensland) observed in 2016, under Queensland's current laws, people with cognitive disability may be detained indefinitely if the treatment and/or supports provided do not generate substantial improvements in mental wellbeing or sufficiently decrease the risk of reoffending.[54] A concern is the lack of existing standards against which to evaluate the success of these treatments and supports. There is also no independent process to evaluate the quality of treatments and/or supports provided to determine whether they are appropriate and adequate to the task of restoring a person's health and/or stabilising a person's presentation.[55]

The involuntary and indefinite detention of persons who have not been convicted of an offence could potentially be seen to amount to a prima facie breach of the fundamental human right to liberty.[56]

Fragmentation

The current scheme for people on Forensic Orders is spread across:

- the *Mental Health Act 2016* (Qld) (Forensic Orders for people who have been found unfit to plead or unsound of mind);
- the *Forensic Disability Act 2011* (Qld) (detention in the Forensic Disability Service, including provisions for behaviour control medication); and
- health care provisions of the *Guardianship and Administration Act 2000* (Qld).

Ogloff and colleagues observed, in a 2018 review of the Queensland Forensic Disability System, that the number of agencies involved in the provision of care to people on Forensic Orders under this legislative framework, including now the Director of Forensic Disability, DFSDSCS, the Chief Psychiatrist, Queensland Health, AMHSs, and non-government organisations, can create confusion around decision making pathways and clinical reporting lines.[57]

This confusion is compounded by the legislative division between the small number of the forensic disability cohort detained to the FDS (who fall under the responsibility of the *Forensic Disability Act 2011* (Qld) (*Forensic Disability Act*) and the Director of Forensic Disability), and the vast majority of those under Forensic Orders (Disability) who are managed by AMHSs (under the *Mental Health Act*, with clinical oversight provided by an AMHS).[58]

The Chief Psychiatrist reports on the number of people on forensic orders being managed by AMHSs. According to the annual report of the Chief Psychiatrist:

> As at 30 June 2024, there were:
>
> - 729 open forensic orders in Queensland.
> - The majority (608) were forensic order (mental health), of which 70 per cent were community category.

[52] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Criminal justice and people with disability', *Final report*, Volume 8, 2023, p. 143.
[53] Section 20BC of the *Crimes Act 1914* (Cth) provides that the 'order of detention' cannot exceed the maximum period of imprisonment that could be imposed if the person has been convicted for the offence for which they were charged. See also ss 301 and 305 of the *Crimes Act 1900* (ACT).
[54] Public Advocate (Qld), 'Submission to the Senate Community Affairs Committee', *Inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia*, April 2016, p. 21.
[55] Ibid.
[56] Anti-Discrimination Commission Queensland, 'Submission', *Forensic Disability Bill 2010 – Information Paper*, October 2010, p. 5.
[57] J Ogloff, J Ruffles and D Sullivan, *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System.* Unpublished Report, Centre for Forensic Behavioural Science, Swinburne University of Technology, 2018, p. 34.
[58] Ibid., p. 29.

- The remaining open orders (121) were forensic order (disability), of which 90 per cent were community category.[59]

As at the same date, there were four people detained to the FDS on Forensic Orders (Disability).[60]

Ogloff and colleagues observed in 2018 that there is 'a lack of whole-of-system practice leadership, monitoring, direction and oversight.'[61]

Ogloff and colleagues proposed that the forensic disability service system and the mental health system be brought together within a single agency, such as Queensland Health.[62] A single agency framework could minimise duplication and have the capacity to build alliances and bridge the current divisions between the forensic disability and mental health sectors.[63] This could potentially create a model for continuity of care and encourage the development of forensic disability expertise across all sectors which engage with forensic disability clients.

At the same time, there would be concerns about a health focused agency having responsibility for those people on forensic orders who do not have a health related disability.

Any changes to the current framework would need to consider how best to integrate the key features of these systems, such as the person-centred and supports-oriented approach of the disability system, the treatment and recovery orientations of mental health, decision-making supports available through the guardianship regime, and the risk management and community protection components of the justice system. A holistic, as opposed to a fragmented, response, could enable coherent, consistent and integrated care and support options for people under forensic disability orders.[64]

Barriers to transition

Research suggests that a graduated transition is the safest process to reintegrate individuals out of institutionalised settings back into the community.[65]

However, in the absence of appropriate alternative secure accommodation and support services for people with cognitive disability who are detained in the FDS or an AMHS, the opportunities to transition back to the community are limited. This can lead to people being detained for longer periods of time in restrictive and inappropriate settings, such as high-dependency units within AMHSs, which are not designed to meet forensic and disability needs.[66]

The Senate Committee inquiry into indefinite detention in 2016 noted concerns about the FDS, finding that 'there are few issues of greater injustice, than the continued detention of people because of a lack of appropriate spending on disability accommodation.'[67]

The Office of the Public Guardian (OPG) has observed a funding gap between the Queensland forensic disability service system and the National Disability Insurance Scheme (NDIS), which affects the opportunities for clients to transition from the FDS or an AMHS.[68] In Public hearing 15 of the Disability Royal Commission, witnesses from government agencies around Australia also raised concerns that the distinction between disability-related supports and criminogenic-related supports contributes to 'uncertainty, complexity and confusion in relation to NDIS funding.'[69] Witnesses

[59] Queensland Government, *Chief Psychiatrist Annual Report 2023-2024*, 2 September 2024, p.42.
[60] Public Advocate (Qld), *Public Advocate Annual Report 2023-24*, 23 October 2024, p. 25.
[61] Ibid., p. 6.
[62] Ibid., p. 34.
[63] Ibid.
[64] Public Advocate (Qld), *Submission to Review of the Mental Health Act 2000 Discussion Paper*, August 2014, p. 13.
[65] Ogloff et al., p. 28.
[66] Ibid., pp. 28-29.
[67] Senate Standing Committee on Community Affairs, Parliament of Australia, *Indefinite detention of people with cognitive and psychiatric impairment in Australia report*, 2016, p. 120.
[68] Office of the Public Guardian (Qld), 'Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability', *The Criminal Justice System*, June 2020, p. 20.
[69] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Criminal justice and people with disability', *Final report*, Volume 8, 2023, p. 211.

expressed specific 'concerns that the distinction encourages the National Disability Insurance Agency (NDIA) to make decisions limiting NDIS funding available to participants.'[70]

The Disability Royal Commission heard from a Queensland stakeholder about the disparity between the hours of Supported Independent Living (SIL) support the NDIA deems is reasonable and necessary because of a person's disability needs, and the hours of support Queensland's Mental Health Court and MHRT deemed necessary for a person on a forensic disability order to live safely in the community and mitigate their risk of reoffending.[71]

The Disability Royal Commission identified that insufficient access to Supported Disability Accommodation (SDA) and supports for participants with complex needs transitioning from the criminal justice system is an ongoing issue, representing a significant barrier to a successful transition back into the community for many participants.[72]

A stakeholder consulted to inform this project also advised that in situations where an individual could otherwise be under a community Forensic Order, the lack of safe and appropriate accommodation can result in that person remaining as an inpatient at an AMHS.

In relation to the FDS, QAI has noted the need for appropriately robust accommodation outside of the institutionalised setting of the FDS for high-risk people with disability in the forensic disability system to allow them to access supports in the community without institutionalisation.[73]

The OPG has commented that 'many [existing] FDS clients would be able to live in regular housing with NDIS Supported Independent Living arrangements if their additional offending support risks were also funded.'[74]

For forensic disability patients held in an AMHS requiring extended rehabilitation to assist their transition into the community, the OPG observed that these clients have 'limited, or sometimes no, options available to skill or be re-skilled in fundamental life skills, to manage their challenging behaviour, or to learn how to live either independently, or with support, in the community.'[75]

A stakeholder consulted to inform this project observed that the NDIS has been known to withdraw all supports for an NDIS participant when a Forensic Order is made, asserting that any supports to be provided are criminogenic in nature, as opposed to disability related, when the forensic disability order is made and in force.

A stakeholder also reported that every effort is made by AMHS case managers, once a person shifts from an inpatient to community order, to facilitate a person's linkages with the NDIS.

However, based on the obstacles faced by those on a Forensic Order (Disability) when transitioning back into the community, there may a need to be improved mechanisms for individuals with cognitive disability to automatically trigger engagement with the NDIS earlier in the process. This would allow for the person's eligibility for ongoing supports within the disability system to be assessed, and linkages between the criminal justice and other more appropriate support systems to be established. The aim of this process would be to facilitate the earliest possible transition from a mental health facility or forensic disability environment to supported community living arrangements.

[70] Ibid.
[71] Ibid., p. 212.
[72] Ibid., p. 227.
[73] Queensland Advocacy for Inclusion, *Indefinite detention and solitary confinement – the awful reality of Queensland's Forensic Disability Service*, October 2023, p. 7.
[74] Office of the Public Guardian (Qld), 'Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability', *The Criminal Justice System*, June 2020, p. 20.
[75] Office of the Public Guardian (Qld), Submission to the Senate Community Affairs References Committee, *Inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia*, April 2016, p. 7.

Institutionalisation

There is broad recognition that institutionalised environments can be harmful to the rights and lives of people with disability.[76] United Nations guidelines on deinstitutionalisation state that people with disability have a right to live independently and be included in the community.[77]

QAI has also noted the likelihood that 'the longer people are detained, the more their capacities will diminish, particularly given the sterile environment and limited opportunities to use those capacities.'[78] This can erode the possibility that the MHRT will favourably consider their prospects of community re-integration.[79]

Concerns around the operation of the FDS

The FDS was designed to operate as a transitional facility for eligible people under disability Forensic Orders,[80] providing opportunities for habilitation[81], leading to community participation and reintegration.[82] However, stakeholders have expressed concern that the FDS is not offering a human rights compliant alternative to the mainstream criminal justice system for people with cognitive disability.[83]

In 2019, the Queensland Ombudsman investigated the operation of the FDS. The review found there to be an overall failure of the FDS to safeguard the care, protection and rehabilitation of the vulnerable persons detained there.[84]

The Ombudsman identified several concerns around the operation of the FDS. These concerns included:

- poor administrative practices;
- lack of care and support for people detained;
- lack of transition planning;
- lack of records of regulated behaviour controls;
- extended detention periods and delays in transition;
- non-compliance with legislative requirements around the use of restrictive practices; and
- a lack of processes for police attendance and criminal charges.[85]

As a result of its investigation, the Queensland Ombudsman recommended that the FDS implement a range of strategies, including:

- a comprehensive review of all of its policies, and making publicly available policies about detention, care, support and protection of people detained at the FDS;
- ensuring that records about the detention, care and support of people detained at the FDS adequately protect their rights and interests;
- ensuring that any restrictive practice regimes implemented at the Service are supported by Individual Development Plans and display a contemporary, evidence-based approach to positive behaviour support plans;

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[76] Queensland Advocacy for Inclusion, *Indefinite detention and solitary confinement – the awful reality of Queensland's Forensic Disability Service,* Position Statement by Queensland Advocacy for Inclusion, October 2023, p. 8.
[77] United Nations Committee on the Rights of Persons with Disabilities, *Guidelines on institutionalization, including in emergencies*, CRPD/C/5, Art 38.
[78] Queensland Advocacy for Inclusion, *Submission to the Tasmanian Law Reform Institute regarding fitness for trial laws*, 24 April 2019, p.7.
[79] Queensland Advocacy for Inclusion, *The Queensland Forensic Disability Service, Shining light on a closed system through an examination of forensic disability orders for persons with an intellectual or cognitive disability*, October 2015, p. 12.
[80] J Lynas, *Director of Forensic Disability Policy: Transfer of responsibility and exit from the Forensic Disability Service*, 9 January 2023, p. 1.
[81] *Habilitation refers to the process of helping individuals, particularly those with disabilities, to acquire, maintain, or improve skills and functional abilities that they have not yet developed or are not developing normally. It focuses on learning new skills rather than regaining lost ones, as in rehabilitation*. Sourced from the NAPA (Neurological and Physical Abilitation) Centre, < https://napacenter.org/>.
[82] *Explanatory Notes*, Forensic Disability Bill 2011 (Qld), p. 3.
[83] Queensland Advocacy for Inclusion, *Indefinite detention and solitary confinement – the awful reality of Queensland's Forensic Disability Service,* Position Statement by Queensland Advocacy for Inclusion, October 2023, p. 2.
[84] Queensland Ombudsman, *The Forensic Disability Service report*, August 2019, p. ii.
[85] Queensland Ombudsman, *Forensic Disability Service – second report,* August 2024, pp. 8-9.

- reviewing the adequacy, appropriateness and quality of programs delivered to people detained at the Service;
- reviewing processes associated with Limited Community Treatment Orders for those detained at the service; and
- developing and implementing an appropriate and evidence-based risk management framework for people detained at the FDS.[86]

Following the 2019 investigation, the Ombudsman conducted a second review into the operation of the FDS, observing that progress had been made against the 15 recommendations.

In its follow up report in August 2024, the Ombudsman identified that the FDS has made efforts to improve systems and processes by:

- reviewing policies and procedures and publishing them online or on the departmental intranet
- establishing electronic recordkeeping and keeping accurate records of decisions about the management, care and support for people detained to the FDS
- enhancing individual development plans for people detained to the FDS to have a greater focus on rehabilitation and skill development
- establishing processes for transitioning people detained to the FDS into the community.[87]

In this second report, the Queensland Ombudsman found that:

> The FDS is closer to achieving its goal of being a transitional facility. The FDS now makes transition planning part of each individual development plan and includes stakeholders in managing the transition progression, especially for people with complex needs.[88]

In addition to commenting on the progress of the FDS since 2019, the Ombudsman made a further series of recommendations in the 2024 report including:

- expanding the recordkeeping system to allow entries to record the use of medication, and
- tracking program delivery to make it easy to identify and address an individual's treatment needs.[89]

The Ombudsman also recommended that:

> The Director continues to progress the transition of all people detained to the Forensic Disability Service (FDS), with a particular focus on developing processes to monitor and prevent the detention of any person at the FDS for extended durations.[90]

The second report acknowledged advice from the Department of Child Safety, Seniors and Disability Services (now the Department of Families, Seniors, Disability Services and Child Safety) that no person then residing at the FDS was subject to ongoing seclusion on a long-term basis.[91]

However, the Ombudsman expressed continued concern about the use of prolonged seclusion at the FDS and recommended improvements to the *Forensic Disability Act* to ensure that 'long term seclusion of the type identified in the 2019 report never occurs again.' [92]

Further details regarding the use of regulated behaviour controls (including seclusion) in the forensic system are provided below.

Regulated behaviour controls

The use of regulated behaviour controls (also known as restrictive practices), particularly seclusion, on people under Forensic Orders is an ongoing issue of concern in both the FDS and AMHSs in Queensland.

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[86] Queensland Ombudsman, *The Forensic Disability Service report*, August 2019, pp xv-xix.
[87] Queensland Ombudsman, *Forensic Disability Service – second report,* August 2024, p. 3.
[88] Ibid., p. 22.
[89] Ibid., p. 1.
[90] Ibid., p. 22.
[91] Queensland Ombudsman, *Forensic Disability Service – second report: Snapshot,* August 2024, p. 3.
[92] Queensland Ombudsman, *Forensic Disability Service – second report*, August 2024, p. 3.

The *Forensic Disability Act* provides a regulatory framework for behaviour control in the FDS.[93] Regulated behaviour controls can be used at the FDS in limited and prescribed circumstances, and can only be used as an option of last resort to ensure the safety of the person or others in the FDS.[94] Under the *Forensic Disability Act*, 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.[95] The *Forensic Disability Act* defines restraint as the use of an approved mechanical appliance to prevent the free movement of a part of the client's body.[96] Depending upon the type of behaviour control, in most cases it must be authorised by the Director of Forensic Disability (for use of restraint),[97] or a senior practitioner (for use of seclusion).[98]

As noted above, in the 2019 report the Queensland Ombudsman identified serious concerns about the use of seclusion at the FDS. More information on the legislative requirements surrounding seclusion is provided on pages 54-55 of this paper.

There were general concerns about the use of seclusion by the FDS that did not comply with all legislative requirements, as well as specific concerns about the use of seclusion for one person detained at the FDS, referred to under the pseudonym, 'Adrian'.[99]

The Ombudsman noted that seclusion had been authorised when strategies to reduce the use of seclusion were not in place. If strategies had been recorded, they were not linked to the Individual Development Plan (IDP) in place for the person who had been in seclusion and were not incorporated into their care and support.[100] More information on IDPs can be found on page 54 of the Appendix to this report.

Following the Ombudsman's second investigation into the FDS in 2024, it was identified that the sections of the *Forensic Disability Act* governing the use of seclusion had not changed since the 2019 investigation.

The Ombudsman reported that the current sections of the Act are inadequate, as they do not provide guidance or boundaries on the use of repeated seclusion orders that enable seclusion to continue beyond a period of three hours.[101]

As such, the Ombudsman recommended that the *Forensic Disability Act* be reviewed and amended to address this situation, in addition to these reforms:

- providing guidance about decision-making in situations where it is considered necessary for seclusion to exceed three hours
- escalation of seclusion decisions to more senior officers when the decision results in a person being secluded for a cumulative period of more than three hours
- allowing for rights of external review of longer periods of seclusion
- clear provision for how people detained to the FDS can obtain support to access review.[102]

Acknowledging the time it can take for legislative changes to come into effect, the Ombudsman recommended a review of 'current FDS policies and departmental procedures governing the use of seclusion so that they better address the issue of ongoing seclusion.'[103]

OPCAT compliant monitoring

The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) was ratified by Australia in 2017.

[93] *Forensic Disability Act 2011* (Qld), Chapter 6.
[94] The Honourable Curtis Pitt MP, First Reading Speech, *Forensic Disability Act*, Hansard 7 April 2011, p. 3.
[95] *Forensic Disability Act 2011*(Qld) s 42.
[96] *Forensic Disability Act 2011*(Qld) s 45 (1).
[97] *Forensic Disability Act 2011*(Qld) s 56.
[98] *Forensic Disability Act 2011*(Qld) s 61.
[99] Queensland Ombudsman, *The Forensic Disability Service report*, August 2019, p. 79.
[100] Ibid.
[101] Queensland Ombudsman, *Forensic Disability Service – second report*, August 2024, p. 30.
[102] Ibid.
[103] Ibid.

OPCAT requires (Article 1) the establishment of 'a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment'.

Article 4 provides that deprivation of liberty 'means 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'.

While not a measure specifically related to the implementation of OPCAT requirements in Queensland, the former Queensland Government introduced an Inspector of Detention Services in 2022.

Queensland's Inspector of Detention Services is responsible for promoting:

> the improvement of detention services and places of detention with a focus on promoting and upholding the humane treatment of detainees, including the conditions of their detention, and preventing detainees being subjected to harm, including torture and cruel, inhuman or degrading treatment.[104]

The *Inspector of Detention Services Act 2022* (Qld) defines 'place of detention' to include the following:

> (a) a community corrections centre;
> (b) a prison;
> (c) a watch-house;
> (d) a work camp;
> (e) a youth detention centre.[105]

At present the *Inspector of Detention Services Act* does not extend to cover inspections in facilities like the FDS or AMHSs where people are held involuntarily.

The AHRC has noted, in its *Implementing OPCAT in Australia report*, that 'OPCAT has broad application to any place where an individual cannot leave of their own free will, and where that place of detention is linked, either directly or indirectly, to a public authority'.[106]

The AHRC also noted that it is the Commonwealth Government's view that 'primary places of detention' should be prioritised for OPCAT compliance purposes.[107]

Further to this, the Commonwealth Ombudsman, in the *Implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment report*, noted that 'primary places of detention' would include,

> closed facilities or units where people may be involuntarily detained by law for mental health assessment or treatment (where people are held for equal to, or greater than, 24hrs such as a locked ward at a residential institution) and closed forensic disability facilities or units where people may be involuntarily detained by law for care (where people are held for equal to, or greater than, 24hrs).[108]

Suitability of AMHSs

As discussed above, the limited capacity of the FDS has resulted in many people with disability under a Forensic Order and with no 'mental illness requiring involuntary treatment' currently residing in mental health facilities.[109]

This can have a particular impact on people with intellectual disability who are on inpatient Forensic Orders.

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[104] Inspector of Detention Services Regulation 2023, p. 1.
[105] *Inspector of Detention Services Act 2022* (Qld) s 6.
[106] Australian Human Rights Commission, *Implementing OPCAT in Australia report*, 2020, p. 42.
[107] Ibid., p. 43.
[108] Commonwealth Ombudsman, *Implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment report*, 2019, p. 5.
[109] Public Advocate (Qld), *Submission to Review of the Mental Health Act 2000 Discussion Paper*, p.13.

Intended to accommodate the clinical needs of people with acute mental illness, AMHSs are typically stark and stimulus-free environments designed for short stays, with small bedrooms and limited communal space.[110] Clients are often subject to wrap-around control and observation, with no access to appropriate disability supports or programs and limited opportunities to exercise independent living skills.[111]

The needs and experiences of people with various forms of cognitive impairment are often significantly different to those of people living with mental illness or psychiatric impairment. For example, the appropriate response for mental illness (which may be fluctuating or episodic) is treatment, whereas cognitive impairment may require ongoing supports to facilitate functional everyday living.[112]

A stakeholder consulted in the preparation of this paper noted there have been significant improvements to Queensland AMHS environments since the Ogloff report in 2018. AMHSs now include longer term options including Secure Mental Health Rehabilitation Units and the Extended Forensic Treatment and Rehabilitation Unit which provide a more comfortable environment for inpatients. Specialised Intellectual and Developmental Disability (IDD) teams have been established in each Hospital and Health Service (HHS) and linkages with NDIS programs have increased.

The New South Wales Law Reform Commission found that 'people with cognitive disability are often seriously disadvantaged by being included in the forensic system – not least because their disability is not amenable to medication or treatment in the same way that mental illness often is.'[113]

A general lack of disability expertise amongst mental health staff in AMHSs has also been identified as an issue affecting outcomes for forensic disability clients being managed by AMHSs.[114]

Stakeholders consulted for the Ogloff report 'expressed significant concern and frustration regarding their lack of capacity and expertise to manage the unique needs of the forensic disability cohort'.[115]

A stakeholder consulted for this paper did note, since Ogloff's review, that there have been enhancements made to staff development and skill building.

In a study specifically involving autistic people, family carers and health professionals, experiences with the mental health system were predominantly negative.[116]

The study identified common themes in the responses of the people involved, namely:

- The participants had a 'lonely, frustrating and difficult experience with the services'. They required the services to be flexible in adjusting to their communication and style of interaction, but this did not occur.[117]

- An over-reliance on medication in the mistaken belief that people with autism cannot engage in talk therapies.[118]

The study noted that the current system could potentially cause more harm than good for this cohort, with the risk of worsening an individual's condition.[119]

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[110] Ibid., p. 29.
[111] Ibid.
[112] Public Advocate (Qld), Submission to the Senate Community Affairs References Committee, *Inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia*, April 2016, p. 28.
[113] E Baldry, *Disability at the margins: limits of the law*, Griffith Law Review, Vol. 23, No. 3, 2014, p. 380.
[114] Ogloff et al, p. 29.
[115] Ibid., p. 54.
[116] R McConkey, *Nurturing the Positive Mental Health of Autistic Children, Adolescents and Adults alongside That of Their Family, Care-givers: A Review of Reviews*, Brain Sci. 2023, 13, 1645, p. 4.
[117] Ibid.
[118] Ibid., pp. 4-5.
[119] Ibid., p. 5.

While the study had a primary focus on individuals with autism, the conclusions do concur with that of Ogloff (below), in relation to AMHSs potentially not being best placed to provide the care and supports required by people with cognitive disability.

As Ogloff observed:

> 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.[120]

The report noted by Ogloff (above) was prepared by Hon William J Carter QC in July 2006 and preceded the development of the FDS, identifying concerns around the Mental Health Court being restricted to ordering a person with an intellectual disability to be detained in a mental health service, which 'objectively and in the mind of the Court is a totally unacceptable outcome.'[121] Justice Carter further recognised that:

> 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.[122]

The Butler Report, released in December 2006, was the result of the Queensland Government's review of the *Mental Health Act 2000*. Led by Brendan Butler AM SC, the report concluded that detaining people with a sole diagnosis of intellectual disability in a mental health facility is inappropriate.[123] Butler observed that:

> 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.[124]

The explanatory notes for the Queensland Mental Health Bill 2000 also stated that it would be inappropriate and ineffective to provide psychiatric treatment to people with conditions that are not mental illnesses.[125] However, the explanatory notes also provide that, in situations where a person is found to be of unsound mind in relation to a criminal offence as a result of their intellectual disability, that person could be detained in an AMHS. Notably, the explanatory notes also state that this was because there was currently no other suitable scheme.[126]

In 2007, Edwards and colleagues examined Queensland psychiatrists' attitudes and perceptions of adults with intellectual disability and found the following:

- the majority of psychiatrists involved in the study had treated patients with an intellectual disability, with only 17% (n=30) not having seen adults with an intellectual disability in the previous 6 months;
- 88% of psychiatrists reported having not received training relating to the mental health needs of adults with intellectual disability in the last 12 months;
- 68% agreed that adults with dual diagnosis receive a relatively poor standard of psychiatric care;
- 70% agreed that psychiatric treatment of these adults is usually symptomatic, rather than diagnosis based;
- only 35% agreed that psychiatrists receive sufficient training in behavioural management of adults with dual diagnosis;

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[120] Ogloff et al, p. 40.
[121] Hon William J Carter QC, *Challenging Behaviour and Disability: A Targeted Response*, 31 July 2006, p. 13.
[122] Ibid., p. 162.
[123] B Butler, *Review of the Queensland Mental Health Act 2000, Promoting Balance in the Forensic Mental Health System*, December 2006, p 101.
[124] Ibid.
[125] *Explanatory notes*, Mental Health Bill 2000, p. 5.
[126] Ibid.

- 85% agreed specialised psychiatric units for adults with dual diagnosis would provide a higher standard of care; and,
- 58% of psychiatrists agreed they would prefer not to treat adults with an intellectual disability.[127]

These responses, along with the repeated concerns raised by experts about the treatment of forensic disability patients in AMHSs, indicate that, in the current framework, individuals under a forensic disability order may not be receiving the targeted care they need to facilitate their reintegration into society when managed by an AMHS.

In 2022, the Public Advocate (Queensland) submitted that:

> A series of reports have called for governance and operational reforms in this arena: see Ogloff, Ruffles and Sullivan, *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System* (unpublished report, Centre for Forensic Behavioural Science, Swinburne University of Technology, 2018); State of Queensland (Department of Communities, Disability Services and Seniors), *Section 157: Review of the operation of the Forensic Disability Act 2011 Final report*, 2018; Queensland Ombudsman, *The Forensic Disability Service report*, 2019. This submission echoes those reports' calls for reform.[128]

One critical reform to address these concerns would be to make provision for the Director of Forensic Disability to have expanded oversight of people on Forensic Orders (Disability). This may require an increase in the range and number of accommodation and community support services under the Director's oversight to ensure people on these orders receive the care required.

Advocacy

A stakeholder consulted to inform this project observed that adults benefit from having someone to advocate for them and link them with supports while on a Forensic Order. A strong advocate can serve to assist a person in presenting evidence that can lead to the MHRT being satisfied that the individual no longer presents a risk to the community or themselves – which may lead to an order being revoked.

Unfortunately, not all people on a Forensic Order have access to a person (or organisation) with the capacity and resources to provide this level of advocacy.

Forensic Order (Mental Health)

People who are under a Forensic Order (Mental Health), and who are an inpatient in an AMHS, face many challenges and issues like other categories of inpatient (including those under involuntary treatment orders) residing in these facilities.

In August 2022, the Public Advocate (Queensland) released a report, *Better Pathways: Improving Queensland's delivery of acute mental health services*, which examined many of the issues facing patients receiving treatment in AMHSs. The report included recommendations across a range of areas including, of relevance to people on Forensic Orders, reforms to improve the experience of mental health patients in AMHSs, the operation of the MHRT, and system safeguards and protections.

Many of these recommendations remain under consideration by Queensland Health and associated agencies.

Patients with dual disability

People who have a dual diagnosis of intellectual disability and mental illness will often have more complex needs, requiring a combination of treatment for mental illness and ongoing lifestyle supports.[129]

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[127] N Edwards, N Lennox and P White, 'Queensland psychiatrists' attitudes and perceptions of adults with intellectual disability', *Journal or Intellectual Disability Research*, Vol. 50, part 1, 2001, pp. 75-81.
[128] Public Advocate (Qld), Submission No. 143 to the Queensland Mental Health Select Committee, *Inquiry into the opportunities to improve mental health outcomes for Queenslanders,* February 2022, p.17.
[129] Public Advocate (Qld), *Indefinite detention of people with cognitive and psychiatric impairment in Australia* submission, April 2016, p. 28.

The Public Advocate (Queensland) has previously proposed that the Queensland Government fund a specific service to provide assessment, treatment and care of patients with a dual disability (such as a mental illness and an intellectual disability, dementia or acquired brain injury).

This service could:

a) provide expert consultation services for the assessment and treatment of mental health patients with a dual disability;
b) be accessible to mental health practitioners across all Hospital and Health Services, including in regional and remote areas; and,
c) operate as a centre of excellence for people with a dual disability.[130]

A service of this nature could offer the opportunity for individuals with a dual disability who are on a Forensic Order to receive the targeted care they need to reintegrate into the community.

A similar recommendation was made by the Queensland Mental Health Select Committee, following its parliamentary 'inquiry into the opportunities to improve mental health outcomes for Queenslanders', conducted in 2022.

Recommendation nine of the report states:

> **Recommendation 9 – Enhance mental health services for people living with intellectual or developmental disability.**
> The committee recommends the Queensland Government:
> a) invests in a centre of excellence for intellectual or developmental disability and neurodivergent conditions, such as the Mater Intellectual Disability and Autism Service.
> b) establishes more nurse navigator roles to help people living with intellectual or developmental disability and their families navigate the mental health services available to them.[131]

The Queensland Government supported this recommendation, and the Queensland Centre of Excellence in Autism and Intellectual Disability Health officially commenced operations under this name in 2024 (it was previously known as the Queensland Centre for Intellectual and Developmental Disability Clinical Service and the Mater Intellectual Disability and Autism Service).

This service undertakes research, develops health resources, provides training for health professionals, and provides a clinic which operates as a 'specialist outpatient service for patients referred by GPs, specialists or the Queensland Mental Health Service for additional health assessment and advice'.[132]

Queensland Health is also progressively releasing resources statewide that assist in the assessment and support of people with dual disability. For example, a progress update for Queensland Health's *Better Care Together Plan* includes a commitment to establishing new intellectual and developmental disability mental health teams to improve the mental health responses for people living with intellectual and developmental disability throughout Queensland.[133]

Use of regulated behaviour control practices - seclusion and restraint

Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.[134]

Mechanical restraint refers to the restraint of a person by the application of a device to the person's body, or a limb of the person, to restrict the person's movement.[135]

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[130] Public Advocate (Qld), *Better Pathways: Improving Queensland's delivery of acute mental health services*, 2022, p. 4.
[131] Queensland Parliament, Report no.1, 57th Parliament, Mental Health Select Committee, *Inquiry into the opportunities to improve mental health outcomes for Queenslanders*, June 2022.
[132] Queensland Centre of Excellence in Autism and Intellectual Disability Health, *About Us*, <https://www.qceidah.com.au/home-2/about-us/>, n.d., accessed 12 June 2025.
[133] Queensland Health, 'Annual progress update', *Better Care Together: A plan for Queensland's state-funded mental health, alcohol and other drug services to 2027*, September 2024, p. 22.
[134] *Mental Health Act 2016* (Qld) s 254.
[135] *Mental Health Act 2016* (Qld) s 244(1).

Queensland's regulatory regime under the *Mental Health Act* does appear to provide a detailed and robust set of requirements and safeguards for the use of seclusion and restraint, namely:

- They are regulated under legislation, not just policy.[136]
- Seclusion and restraint may only be used as a 'last resort', where there is no other reasonably practicable way to protect the patient or others from physical harm.[137]
- Any force used must be no more than is necessary and reasonable in the circumstances.[138]
- Patients subject to seclusion or restraint must be continuously or regularly (every 15 minutes) observed.[139]
- Seclusion and restraint must comply with the Chief Psychiatrist's policy[140] which includes minimum conditions for seclusion and restraint and minimum requirements for staff training.
- Limits are placed on the amount of time a patient may be secluded, and how long an approval may be used for.[141]
- The doctor, nurse unit manager and Chief Psychiatrist have an ongoing obligation to review the necessity for seclusion or restraint, and if satisfied that it is no longer necessary to protect the patient or others from physical harm, must direct the end of the seclusion or restraint, even if the approved time has not lapsed.[142]
- Extended use of seclusion or restraint must be accompanied by a plan that provides for the reduction and elimination of the restrictive practice,[143] by detailing information about previous and proposed strategies to reduce and eliminate seclusion and/or restraint.[144]
- There is a level of independent oversight by the Chief Psychiatrist, who may give directions about the use of seclusion and restraint,[145] and in the case of restraint, must give prior approval.[146]
- An independent visitor scheme is in place (the Office of the Public Guardian's Community Visitor Program).
- Administrators are required under law or policy to escalate serious complaints to an independent external body.
- Use of restrictive practices contrary to law is an offence under the Act.[147]

However, there are concerns as to how these legislative monitoring, safeguarding and oversight mechanisms are working in practice.
While the continued use of seclusion and restraint in AMHSs requires a Reduction and Elimination Plan under the *Mental Health Act*,[148] there are no ultimate limits on how long restrictive practices can be continued. At the time of writing, there are no guidelines or evidence-based frameworks or assessments to inform the development and review of Reduction and Elimination Plans. Provided that the requirements are met and signed off by the authorised persons, the use of the restrictive practice, even on a long-term or indefinite basis, is lawful.

A 2010 survey of nursing attitudes in Queensland mental health services reported that, despite acknowledgment of the detrimental effect of seclusion, nurses still supported its use.[149] This appeared to reflect a lack of alternative approaches to managing patient behaviours such as violence and aggression, as well as finding a correlation between support for seclusion measures and the emotional exhaustion of nursing staff responding to the survey.[150]

A 2019 study commissioned by the Queensland Mental Health Commission (QMHC) involving focus groups of consumers, families and carers in Queensland found that over half of participants

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[136] *Mental Health Act 2016* (Qld) s 24 and Chapter 8.
[137] *Mental Health Act 2016* (Qld) ss 250(1)(a), 253(2), 258(1)(a).
[138] *Mental Health Act 2016* (Qld) ss 246(2)(g), 256(2)(e).
[139] *Mental Health Act 2016* (Qld) s 246(2)(h).
[140] *Mental Health Act 2016* (Qld) s 246(2)(e).
[141] *Mental Health Act 2016* (Qld) ss 249(2)(a), 250(2)(a)(c) and (d), 250(2)(4).
[142] *Mental Health Act 2016* (Qld) ss 252, 261.
[143] *Mental Health Act 2016* (Qld) ss 246(2)(f), 264.
[144] *Mental Health Act 2016* (Qld) s 265.
[145] *Mental Health Act 2016* (Qld) ss 248, 249(2)(a)-(e).
[146] *Mental Health Act 2016* (Qld) s 246(2)(c).
[147] *Mental Health Act 2016* (Qld) ss 245, 255.
[148] *Mental Health Act 2016* (Qld) ss 246(2)(f), 256(2)(d).
[149] B Happell and S Koehn, 'Seclusion as a necessary intervention: the relationship between burnout, job satisfaction and therapeutic optimism and justification for the use of seclusion', *Journal of Advanced Nursing*, vol 67, no. 6, 2011, pp 1222-1231.
[150] Ibid.

reported experiencing trauma when security guards were involved in restraining practices at inpatient facilities. This included physical pain, injury, fear and distress.

> The security guards and nurse staff when I went there virtually attacked me instead of treating me like another person and the security hit me and threw me down on the bed and they give me an injection and they hit you right in the sciatic nerve and just goes straight in hurts like all hell, like nothing you've ever felt.
>
> To put me down on a mattress, like probably nurses would have been fine. And it just adds that extra element of like … danger … And I felt like I'd done something wrong and … I hadn't done anything wrong. So that wasn't a good feeling.
>
> - Consumer participants[151]

The QMHC study further reported a need for improved de-escalation techniques to be used by mental health staff before security personnel were called.

> I know personally with my son, and he is a very difficult patient when he's unwell. And he's been in the system for so long, he knows what to say and what to do. It probably had been over 20 years since he'd had a pat down or seclusion. And talking to other carers, rather than de-escalating, or spending the time to de-escalate, it was easier to call security.
>
> February when I was in hospital was a bad experience. I was a little elevated and venting just verbally and they had me in the HDU and I don't remember the staff trying to talk me down or offering me oral medication or anything like that. The next thing I knew there were three security guards there and I noticed that the nurse had a syringe in his hand and I've just gone and flipped out and they took me down. Sometimes in the past staff have spent a bit of time trying to deescalate me verbally and that normally works. But that last time I don't remember any of that. It was just take him down and inject him and throw him in the room.
>
> - Consumer and carer participants[152]

Limited Community Treatment

Limited Community Treatment (LCT) is intended to support a person's recovery by transitioning them to living in the community with appropriate treatment and care.[153] In the 2019 Ombudsman's report, several concerns were raised about the use of LCT at the FDS. These included LCT not being linked to measurable goals in IDPs,[154] and LCT not being used to inform and guide transition decisions for people detained at the FDS.[155]

It was also noted that, at times, 'a lack of appropriate planning led to failed LCT events and outcomes that placed the person, FDS staff, and the community at risk.'[156]

In response to the Ombudsman's investigation, the Director of Forensic Disability conducted a review of the LCT policy and procedure and introduced ongoing monitoring of the implementation of procedures. An LCT practice guide was also prepared to 'provide direction for FDS staff about planning, authorising, implementing, recording and reviewing LCT events.'[157]

The Ombudsman noted in his second report in 2024 that LCT planning had been adequately integrated into IDPs.[158]

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[151] G Giuntoli, V Stewart, A Wheeler, S Gendera, C Ryan, D McAuliffe, and KR Fisher, K.R. (2019) *Human Rights protection frameworks for people being treated involuntarily for a mental illness: Study findings*, Sydney: Social Policy Research Centre, UNSW Sydney, p. 55.
[152] Ibid.
[153] *Forensic Disability Act 2011* (Qld) s 20(3)(a).
[154] Queensland Ombudsman, *The Forensic Disability Service report*, August 2019, p. 54.
[155] Ibid., p. 56.
[156] Ibid.
[157] Queensland Ombudsman, *Forensic Disability Service – second report*, August 2024. p. 17.
[158] Ibid.

Rehabilitation vs. Habilitation

Rehabilitation, in the context of the criminal justice system, is aimed at addressing criminogenic needs to reduce the risk of recidivism.[159]

Habilitation, alternatively, is about helping individuals to attain or improve skills and functions for daily living,[160] which enables someone to participate in society and their community.

It has been recognised that the key to protecting people with cognitive and/or psychiatric impairment from being inappropriately 'managed' by the criminal justice system is to support them to function in the community.[161]

Article 26 of the UNCRPD addresses habilitation and rehabilitation and states:

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:
    a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
    b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.
2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.
3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.[162]

Examples of habilitation programs offered at the FDS include:

- literacy and numeracy;
- healthy living and life skills;
- cooking and shopping skills;
- money management;
- vocational skill building or education including through enrolments with formal training providers such as TAFE Queensland and/or on-the-job skills development through volunteering; and
- computer and technology literacy.[163]

While the FDS has initiatives that focus on habilitation, there is concern that AMHSs are not equipped to provide appropriate habilitation programs for people with cognitive disability. Ogloff observed that AMHSs provide limited opportunities for adults with cognitive disability to exercise independent living skills.[164] This can hinder the potential for someone on an inpatient forensic disability order to transition back into the community. This is despite the 'development of living skills' being recognised in the *Mental Health Act*, alongside rehabilitation, as being a key element in the recovery of people on Forensic Orders (Disability).[165]

A stakeholder noted that AMHSs do recognise the specific needs of people with cognitive disability on forensic disability orders, developing care plans with the individual that work towards their specific recovery goals. This includes sharing information with the patient about the NDIS and

[159] Ibid., p. 18.
[160] Ibid., p. 8.
[161] Australian Human Rights Commission, Submission to the Senate Community Affairs References Committee, *Inquiry into indefinite detention of people with cognitive and psychiatric impairment in Australia*, March 2016, p. 12.
[162] United Nations, *Convention on the rights of persons with disabilities*, GA Res 61/106, 76th plen mtg, UN Doc A/RES/61/106 (adopted on 13 December 2006), Article 26.
[163] Director of Forensic Disability, *Director of Forensic Disability Annual Report 2022-23*, 29 September 2023, p. 15.
[164] Ogloff et al, p. 29.
[165] Section 8(c) of the *Mental Health Act 2016* (Qld) – 'a reference in the Act to recovery of a person means a reference to the rehabilitation, and development of living skills, of the person'.

providing them with choice on which services they wish to access to meet the goals in their care plan.

Further to this, AMHSs have an Assessment and Risk Management Committee (ARMC) in place which provides a forum for clinical discussion and case review of patients under treatment support orders or forensic disability orders.[166] The ARMC will review the treatment and care of a patient, make recommendations about their treatment and care, identify systemic issues in relation to the management of the Forensic Order, and determine the frequency of monitoring and assessment of forensic and other higher risk patients by the case manager, forensic liaison officer and an authorised psychiatrist.[167]

The facilities available at an AMHS to facilitate a person achieving their goals in particular areas related to independent living may, however, be somewhat limited.

Less restrictive orders

For people with a mental illness, the Mental Health Court and MHRT have the option of making a Treatment Support Order (TSO), which is a less restrictive form of order than a Forensic Order (further details are on p.45-46 of this paper).

However, a person who is found to be of unsound mind or unfit for trial but who does not have a mental illness cannot be placed on a TSO. Currently, the option of a less restrictive form of Forensic Order is not available to all people with a cognitive disability who interact with the criminal justice system.

There have been suggestions that consideration be given to introducing a similar type of order for people on Forensic Orders (Disability) to provide equal opportunities for people with cognitive disability to be managed in the least restrictive way possible.[168] The availability of such an order could potentially serve to reduce the number of people being placed on Forensic Orders (Disability), as well as facilitate transition through the system by providing the MHRT with a 'step-down' option to revocation.[169]

Forensic Orders - Community

If the Mental Health Court considers there is not an unacceptable risk to the safety of the community, including the risk of serious harm to other people or property, it can impose a community category Forensic Order.[170] This permits a person to reside in the community rather than an AMHS or FDS.[171]

Most people on Forensic Orders (both Mental Health and Disability) are on 'community' orders.

A person on a community order can reside in any of a range of settings, from a private home, a community care unit, in supported accommodation, in a hostel or boarding house, accommodation support and respite services provided by DFSDSCS, or even in prison. Some people on Forensic Orders have no fixed address and are homeless.

There is no publicly available information on what proportion of 'community category' Forensic Order and Treatment Support Order patients are living in each type of accommodation (or are homeless).

When a community order is made, the order is made to an AMHS and the administrator of the relevant AMHS will be responsible for oversight of the order. The patient will be allocated a treatment team, including a case manager, who will normally be a mental health clinician or a forensic liaison officer. The case manager will be responsible for many decisions affecting the

[166] J Reilly, 'Treatment and care of patients subject to a treatment support or Forensic Order or other identified higher risk patients', *Chief Psychiatrist* Policy, 1 June 2020, p. 18.
[167] Ibid.
[168] Ogloff et al, p. 45.
[169] Ibid., p. 44.
[170] *Mental Health Act 2016* (Qld) s 138(2).
[171] *Mental Health Act 2016* (Qld) sch 3.

person's life while on the order. A consultant psychiatrist will also be allocated to the patient to provide clinical guidance, including for patients who are under a forensic disability order.

This arrangement may become problematic if a case manager does not have the skills or experience in disability required to adequately meet the support and referral needs required by a person under a forensic disability order. Without a targeted plan to provide specialised care and supports to a person with cognitive disability, there may be a reduced likelihood that an order will be revoked.

Forensic Order - Community conditions

There are conditions imposed by a forensic community order. These restrictions are discretionary and will be specific to the individual. However, all Forensic Orders, by their very nature, involve some degree of restriction on a person's liberty and autonomy.

Formal restrictions in the conditions of the Forensic Order will require, as a minimum, compliance with treatment and medication (where relevant), a note of the location where a person resides, attendance at appointments with psychiatrists, case managers and other clinicians, and a return to hospital if directed by the consulting psychiatrist.

Other conditions will depend on the individual and may, for example, relate to a person's use of alcohol, or require a person to submit to regular alcohol and drug testing.

As part of a study performed by the University of Queensland, practitioners who advocate for and/or provide support to people with disability expressed concern about there being no end date to a Forensic Order and the restrictive conditions that apply to what individuals can do, where they can go and who they can see, potentially for the rest of their lives.

Clients reported 'wishing that they weren't on those orders and that they had been able to proceed through the criminal justice system. So, while the intention is rehabilitative, people experience them as punitive'.[172]

The University of Queensland study also reported concerns held by practitioners and professionals regarding the difficulty of having Forensic Orders removed and people with disability being 'effectively imprisoned in the community'.[173] In one example, a practitioner described the following:

> We recently had a gentleman who did his time 11 years ago, and he's still on the same Forensic Order 11 years down the line. He's got a disability. And basically, in his home, he might as well be in prison because he can't leave the home alone, he can't have a phone with pictures, he can't have internet, he can't have that. We kind of said, 'Well, we need to phase this off. It's 11 years gone with no other crime. This was his first crime. We need to start giving him his life back.[174]

Review of Forensic Orders

MHRT proceedings in relation to inpatient Forensic Orders determine whether a patient will continue to be detained and, as such, represent an important protection against ongoing detention for a person under a Forensic Order. However, in practice, MHRT review outcomes indicate that the revocation of a Forensic Order is relatively uncommon.

In the 2023/2024 financial year, 1802 Forensic Orders were reviewed by the MHRT. Of those, 1369 orders were confirmed, 75 revoked, and the remaining 358 resulted in an alternative outcome, such as an adjournment.[175]

The reasons given for not revoking a Forensic Order are varied and have included:

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[172] K Ellem, L Dowse, S Rowe, L Holland, J Cullin, M Parker, C Henderson, 'Insights from people with lived experience of disability and the justice system', *Final Report*, University of Queensland School of Nursing, Midwifery and Social Work, 3 July 2023, p. 66.
[173] Ibid.
[174] Ibid.
[175] Queensland Government, *Mental Health Review Tribunal Annual Report 2023-24*, 2 September 2024, p. 22.

- A young adult considered to be very vulnerable and needing the support, structure, boundaries and supervision provided by the Forensic Order (Disability).[176]
- A patient lacking insight into the existence of his chronic mental illness, the fragility of his mental state or the impact of illicit substances on his physical and mental state.[177]
- The absence of local supports outside of the Forensic Order structures.[178]
- A patient not abiding by a condition to not leave the state of Queensland and the lack of independent evidence that a patient had abstained from illicit substances and alcohol.[179]

While these may be reasons to provide ongoing care for a person who is under a Forensic Order, the restrictive nature of a Forensic Order goes beyond the mere provision of supports, often extending to restrictions on travel and other activities.

Frequency of reviews

The *Mental Health Act* requires that Forensic Orders be reviewed at least every six months by the MHRT. However, only 14 Forensic Orders (Disability) were revoked in the six and half year period following the commencement of the *Forensic Disability Act* in 2011.[180] This situation has changed (as noted above), however the proportion of orders revoked (in comparison with those confirmed) remains small.

The fact that Forensic Orders (Disability) are only occasionally revoked raises questions as to whether the current system adequately drives, or acknowledges, an individual's progress, in order for the MHRT to determine that any ongoing risk can be managed adequately in the community.

Procedural fairness

Some concerns have been raised about procedural fairness in the MHRT that may be contributing to the low number of Forensic Orders being revoked.[181]

Under the *Mental Health Act*, people who are the subject of MHRT proceedings must be provided with written notice of their hearing.[182] However, a Queensland study published in the *Journal of Psychiatry, Psychology and Law* found that clients do not always receive these notices.[183]

According to this study, even when clients did receive written notice of the hearing, they often did not understand the purpose of the hearing or the nature of the MHRT's processes unless they had attended a hearing before,[184] impacting on their ability to participate.

The Queensland study further reported that clients often found hearings to be 'intimidating' and 'stressful'. QAI has also observed that, in terms of MHRT processes, 'punishment is not a part of the Tribunal's remit, but the proceedings are no less intimidating and often more so in the patient's subjective experience.'[185]

The location of a hearing can also affect a person's ability to participate in proceedings. Where proceedings were held at a hospital, clients can be reluctant to attend or speak up in front of their treating team. An impression can also be created that the MHRT is not independent when operating in a hospital-based environment.[186]

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[176] Mental Health Review Tribunal, *Published SOR-105 – FOD confirmed (inpatient),* 8 October 2024.
[177] Mental Health Review Tribunal, *Published SOR-101 – FOD confirmed (inpatient),* 7 May 2024.
[178] Mental Health Review Tribunal, *Published SOR-099 – FOD confirmed (inpatient),* 7 May 2024.
[179] Mental Health Review Tribunal, *Published SOR-090 - FO (disability)(community)*, 14 July 2023.
[180] Ogloff et al, p. 4.
[181] S Boyle and T Walsh, 'Procedural fairness in mental health review tribunals: the views of patient advocates', *Psychiatry, Psychology and Law*, vol. 28, no. 2, 2021, pp. 78 – 79.
[182] *Mental Health Act 2016* (Qld) ss 418(2), 471(2), 487(2), 508(2)(b).
[183] S Boyle, p. 167.
[184] Ibid., p. 168.
[185] Queensland Advocacy for Inclusion, 'Submission to Australian Law Reform Commission', *Equity, Capacity and Disability in Commonwealth Laws*, January 2014, p. 12.
[186] S Boyle et. al, p. 169.

Concerns have also been expressed regarding the quality and accuracy of evidence put before the MHRT.[187] According to participants involved in the Queensland study noted above, clinical reports, which normally constitute the main piece of evidence before the tribunal, 'generally contained inaccuracies, were out of date and mostly comprised historic information'.[188]

Participants involved in the Queensland study also agreed that one of the only methods by which to challenge the evidence of the treating team was to obtain an independent report, however this was generally not financially possible for clients.[189]

The same Queensland study reported accounts from participants that the MHRT is risk averse, often basing its decisions on the 'worst' or 'most conservative' report.[190]

Conversely, according to a stakeholder consulted to inform this paper, natural justice is important for the MHRT, with the patient given the opportunity to read reports and address any concerns they may have, as well as having the option to self-report. Members of the MHRT are provided with detailed guidance on how to ensure patients are afforded natural justice.

A stakeholder also advised that the reports provided to the MHRT by a patient's treating team capture medical information, updates on therapeutic interventions, information about a person's family and social supports and progress against capacity building. If the ARMC is involved, its reports will also be included in the information provided to the MHRT to provide a full picture of the patient's progress.

However, if there is limited knowledge amongst this team of the person's disability and the therapeutic and capacity building supports they require to reduce their level of risk, then it does remain difficult for an order to be revoked.

A stakeholder acknowledged that people may not always understand their rights, particularly in relation to the ability to self-report to the MHRT. A self-report affords a person subject to a Forensic Order the opportunity to provide their views on their available supports, the impacts of being on a Forensic Order, their treatment and rehabilitation, their goals and aspirations, and their care and treatment.[191] A self-report also allows the patient to comment on their potential risk to community safety and how that could be managed.

The Office of the Chief Psychiatrist's access and equity project (described further on page 35) is currently in development. It aims to address this gap by increasing access to free legal and non-legal advocacy services for people appearing before the MHRT, to ensure they are aware of their rights, including the opportunity to self-report.

Support people

A person attending an MHRT hearing may be accompanied by a member of their support network, for example, a nominated support person, family member, carer or other support person. With the MHRT's permission, more than one person may provide support during the hearing. Providing for this additional support acknowledges the challenges of appearing in front of the MHRT.

However, obstacles arise when a person without a support network must appear before the MHRT. The Public Advocate (Queensland) has previously raised the issue of the need for clear policies to be in place around the provision of support persons, such as Independent Patient Rights Advisers, at MHRT hearings for people who do not have an identified support person.

Provision of information

It is important that all participants who appear before the MHRT fully understand the processes involved over the course of the hearing.

[187] Ibid., p. 170.
[188] Ibid., p. 169.
[189] Ibid., p. 171.
[190] Ibid.
[191] Mental Health Review Tribunal, *Forensic Order self-report – your views*, 2023, pp.1-2.

All information needs to be easily understood by people who are acutely unwell, have a dual disability, or are from a culturally and linguistically diverse background.[192]

It is important that the MHRT regularly review and, where necessary, revise all written information provided to patients, their families and support persons explaining the role and functions of the tribunal and the outcomes of tribunal hearings.

Further information regarding the MHRT's strategies and activities in this area are provided below (page 37).

Oversight

Outside of the MHRT's role in reviewing forensic orders, there are other agencies that perform an oversight function for the forensic system in Queensland.

These agencies include:

- OPG - OPG community visitors conduct independent monitoring of visitable sites, including the FDS and AMHSs, to protect and promote the rights and interests of people at these sites.[193]
- Public Advocate - The Public Advocate has a systemic function to promote and protect the rights of adults with impaired decision-making ability, including protecting adults from neglect, exploitation or abuse, and monitoring and reviewing the delivery of services to such adults.[194]

As for all government agencies and systems in Queensland, broad oversight is also provided by the Queensland Ombudsman (as noted above), and the Crime and Corruption Commission.

If adults on Forensic Orders receive limited community treatment (as noted above), NDIS service providers are also potentially involved. When this occurs, the safeguarding functions of the NDIS Quality and Safeguards Commission are also enlivened.

Current strategies and opportunities for improvement

Many of the reports and reviews that have explored the forensic system have made targeted recommendations for improvement.

Reforms have also been made and strategies developed to address several areas of concern that have been identified above. Some of these strategies are outlined below, along with potential areas for ongoing improvement to the forensic system.

Chief Psychiatrist policy review

In July 2023, the Office of the Chief Psychiatrist commenced a three-year rolling review of the Office's policies, practice guidelines and other resources that support the effective operation of the *Mental Health Act*.[195] The project is designed to ensure that the policies are fit for purpose and effectively support delivery of high-quality mental health care into the future.

The review of these policies is ongoing and presents the opportunity for reforms to the delivery of treatment to forensic patients in AMHSs, both as inpatients and outpatients.

Discretionary locking of wards

As of 1 July 2024, the mandate for public adult acute mental health inpatient units to remain locked at all times was removed.

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[192] Public Advocate (Qld), *Better Pathways: Improving Queensland's delivery of acute mental health services*, 2022, p. 4.
[193] *Public Guardian Act 2014* (Qld) s 39.
[194] *Guardianship and Administration Act 2000* (Qld) s 209(1)(e).
[195] Queensland Government, *Office of the Chief Psychiatrist Annual Report 2023-24*, 2 September 2024, p. 23.

According to the Chief Psychiatrist's annual report 2023-24, the 're-introduction of discretionary locking promotes a least-restrictive, therapeutic environment in adult acute mental health inpatient units while maintaining the safety, dignity and wellbeing of consumers, staff and the community.'[196]

At this stage, data has not been made available on the impact of the discretionary locking of wards policy, so it is not yet possible to determine how often the discretion is being exercised under the new policy.

Complex care panel

The Chief Psychiatrist Complex Care Panel (the Panel) is in place to ensure systemic responses across Government for individuals who are, or are likely to be, referred to the Mental Health Court and who require coordinated support services across the mental health, disability or other sectors.[197]

The Panel primarily consists of representatives from the Office of the Chief Psychiatrist (OCP), the Queensland Forensic Mental Health Service, OPG, and the department responsible for disability services.[198] The Director of Forensic Disability is also a member of the Panel and will attend meetings when a person may be placed under a Forensic Order (Disability). Meetings of the Panel provide an opportunity for the Mental Health Alcohol and Other Drugs (MHAOD) Branch, and where relevant, other agencies, to discuss issues and facilitate coordinated responses to aid the support, treatment, care, rehabilitation and recovery of the person involved.[199]

A stakeholder advised that the Panel identifies complex cases or individuals for whom a restrictive order may be put in place. The team then examines ways to prevent a restrictive setting. The Panel is most effective when engaged early in the process, which relies to some extent on the Mental Health Court's early release of reports in relation to the individual, which does not always occur. There were five Panel meetings held in the 2023-24 period.[200]

In the period 2023-24, 29 complex care pathway meetings were held for 45 individuals. Of these, two were forensic disability care consultations.[201]

Access and equity project

The Office of the Chief Psychiatrist has commenced an Access and Equity project with the intention of increasing 'access to free legal and non-legal advocacy services for people appearing before the MHRT and on appeals before the Mental Health Court to ensure access to representation and that human rights are upheld'.[202]

The project has included a comprehensive consultation process, involving people with lived experience.

A model of support has now been developed as part of the project, and further work is ongoing.

Queensland Disability Advocacy Program

DFSDSCS has established the Queensland Disability Advocacy Program (QDAP) to 'fund organisations to deliver advocacy services to Queenslanders with disability, their family members and carers.'[203] A stakeholder consulted as part of this project advised that in 2025-26, $11.63 M is being invested in the QDAP. The stakeholder also confirmed that QDAP advocacy services are available to clients under Forensic Orders (Disability).

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[196] Queensland Government, *Office of the Chief Psychiatrist Annual Report 2023-24*, 2 September 2024, p. 20.
[197] Office of the Chief Psychiatrist, *Terms of Reference: Chief Psychiatrist Complex Care Panel*, 19 May 2023, p. 1.
[198] Ibid., pp. 2-3.
[199] Queensland Government, *Office of the Chief Psychiatrist Annual Report 2023-24*, 2 September 2024, p. 5.
[200] Ibid.
[201] Ibid.
[202] Queensland Health, *Better Care Together Annual Progress Update 2023-24*, September 2024, p. 29.
[203] Queensland Government, 'Advocacy supports', <https://www.qld.gov.au/disability/legal-and-rights/advocacy>, accessed 14 July 2025.

Better Care Together

Queensland Health's *Better Care Together* is a five-year plan setting the strategic directions and priorities across the state-funded mental health, alcohol and other drug service system.[204]

As part of the priority key actions under the plan there is a commitment to enhancing existing Community Forensic Outreach Services to south-east, central and north Queensland and developing service coverage to western Queensland.[205]

There is also a commitment to strengthening oversight, governance, quality and standards of care and integration across Queensland's forensic mental health services.[206]

Under the plan, investment is being made in the Queensland Forensic Mental Health Service to enhance the provision of clinical and complex case advice, state-wide service development and research and evaluation activities.[207]

As noted above, Queensland Health's *Better Care Together* also includes a commitment from Queensland Health to introduce new intellectual and developmental disability mental health teams across the state.

NDIS Justice Panel

The NDIS Justice Panel, announced in June 2024, will examine the management of prisoners exiting jails who have been identified as current or potential participants in the NDIS.[208]

The Panel will identify the role of other service systems, including state housing, law enforcement and corrections agencies, to ensure appropriate supports are in place to manage community safety concerns and the risks of recidivism.[209]

Reducing the use of seclusion

Recognising that seclusion significantly affects a person's rights and liberty, and the comparatively higher rates of seclusion authorisations for patients in high security AMHSs, the Office of the Chief Psychiatrist is working with AMHSs to monitor and reduce the use of seclusion and to support statewide and local quality improvement efforts.[210]

This is in response to the *Mental Health Act 2016 Report Review into the use of Seclusion, Mechanical Restraint and Physical Restraint under the Queensland Mental Health Act* and a review of matters referred to the Office of the Chief Psychiatrist Complex Care Pathway.[211]

Forensic Disability Service

The FDS has undertaken several initiatives to improve outcomes for clients of the FDS, including:

- Implementation of the Good Lives Model (GLM) program. The GLM is a 'strengths-based approach to offender rehabilitation, based on the idea that to reduce a person's risk of reoffending there is a need to build capabilities and strengths in people.'[212]
- Appointing a dedicated transition officer to support effective planning for clients transitioning back to the community.[213]

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[204] Queensland Health, *Better Care Together: A plan for Queensland's state-funded mental health, alcohol and drug services to 2027*, 2022, p. 4.
[205] Ibid., p. 28.
[206] Ibid., p. 37.
[207] Ibid., p. 29.
[208] National Disability Insurance Scheme, 'Decorated top cop to lead NDIS panel of justice experts', <https://www.ndis.gov.au/news/10184-decorated-top-cop-lead-ndis-panel-justice-experts>, published 21 June 2024.
[209] National Disability Insurance Scheme, 'Justice system', <https://www.ndis.gov.au/understanding/ndis-and-other-government-services/justice-system>, published 5 July 2024.
[210] Queensland Government, *Office of the Chief Psychiatrist Annual Report 2023-24*, 2 September 2024, p. 50.
[211] Ibid.
[212] Director of Forensic Disability, *Annual report 2023-24*, 18 November 2024, p. 18.
[213] Ibid., p. 13.

- Leading a continuous improvement program focusing on improving client outcomes and building connections with external support providers, including the NDIA, to ensure clients have access to a range of supports.[214]
- The Director of Forensic Disability conducted a review into the ongoing implementation of a Model of Care (MoC). The FDS MoC broadly outlines key evidence-based practice frameworks that underpin services, assessment and planning approaches.[215]
- Incorporation of Easy Read documents to improve accessibility and client engagement.[216]
- Updating operational practices that reflect contemporary practices within the service.[217]

In June 2024 the Director of Forensic Disability also completed a review of Regulated Behaviour Controls to ensure compliance with legislative and policy provisions.[218]

According to the Director of Forensic Disability 2023-24 Annual Report:

> There were no instances where behavioural control medication was administered at the FDS in the 2023-24 financial year. The Director's review identified evidence that regular medication reviews occurred for all clients in accordance with the FDA, including clarification of the purpose of medication. These practices provide assurance that any use of behaviour control will be identified.[219]

MHRT

Electronic recording of proceedings in the MHRT

Historically, the MHRT has not recorded its proceedings, with only handwritten or typed records being prepared by tribunal members as a summary of proceedings.[220] In the absence of recorded proceedings, there was limited detailed information about specific conversations and representations made at hearings. This may have prevented people from raising their concerns about hearing processes and outcomes.

In recognition of this, in November 2023, the MHRT improved the transparency and accountability around the conduct of hearings by introducing the use of electronic audio recording as its default method of producing records of proceedings.[221]

Human Library Video Project

The MHRT is currently working on the Human Library Video Project.[222] The aim of this project is to create a series of short, recorded interviews with persons with a lived experience of matters relevant to MHRT decision-making that Tribunal members will be able to view on-demand.[223]

It is anticipated that this project will lead to Tribunal members having a greater understanding of the views and needs of the people who interact with the Tribunal, including those with cognitive disability.

Alternative jurisdictional approaches

Victorian Forensic Disability Services

The Public Advocate (Queensland) has been advised that, in Victoria, the Director of Forensic Disability Services has responsibility for just over 30 people in a range of accommodation settings. Approximately half of this cohort reside in one treatment facility, with the other half housed in a range of community settings.

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[214] Ibid.
[215] Ibid., p. 16.
[216] Ibid., 17.
[217] Ibid.
[218] Ibid., p. 22.
[219] Ibid., p. 23.
[220] Queensland Government, *Mental Health Review Tribunal Annual Report 2023-24*, 2 September 2024, p. 5.
[221] Ibid.
[222] Ibid., p. 6.
[223] Ibid.

The range of forensic disability housing options available in Victoria includes:

- Forensic Residential Services (FRS)
  FRS is a network of secure and non-secure statewide houses and units that provide accommodation where a person with forensic disability treatment and support needs requires a residential setting to reduce their behaviours of concern and increase their adaptive functioning skills. These services aim to provide clinical treatment and a therapeutic environment, integrating forensic clinical and disability direct care supports.[224]

- Specialist Forensic Disability Accommodation (SFDA)
  SFDA is a network of 12 community based residential services primarily operated by Community Service Organisations providing specialised disability accommodation to people with a cognitive disability involved in the justice system who require additional forensic disability supports not otherwise available or funded through the NDIS. These services are joint funded by the NDIS and Victorian Forensic Disability Service.[225]

The Victorian Director of Forensic Disability Services also has oversight of clinical services and Disability Justice Coordination services.[226]

The Forensic Disability Clinical Service provides offence-specific assessment and treatment programs which are targeted to people with cognitive disability. The programs are designed to:

> address criminogenic behaviour, as well as other behaviours of concern related to disability, to reduce risk of offending. This service also provides behaviour support planning and consultancy to other services and providers about the person's forensic disability treatment and support needs.[227]

The Disability Justice Coordination service:

> assesses and coordinates forensic disability supports for a person based on their needs, risks and goals and advocates for any other supports they require through other universal service systems.[228]

New Zealand Forensic Coordination Service for Intellectual Disability

In 2021, the New Zealand Ombudsman released a report regarding the care provided to people with intellectual disability requiring secure care and rehabilitation. The Ombudsman made several findings based on his investigation. One of these findings was that 'service users whose needs related primarily to an intellectual disability were inappropriately accommodated in mental health units.'[229]

The Ombudsman also made several recommendations to improve New Zealand's High and Complex Framework.[230] This Framework provides a pathway for offenders with an intellectual disability away from the criminal justice and mental health systems towards more appropriate disability services.[231]

Following on from the New Zealand Ombudsman's report, the Forensic Coordination Service was transferred from Health New Zealand to the Ministry of Disabled People (Whaikaha).

The Forensic Coordination Service is a highly specialised service that provides needs assessment and service coordination for people with an intellectual disability who access New Zealand's High

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[224]Department of Families, Fairness and Housing, *Forensic Disability Services*, [Forensic Residential Services], <https://www.dffh.vic.gov.au/forensic-disability-services>, published 14 October 2024.
[225] Department of Families, Fairness and Housing, *Forensic Disability Services*, [Specialist Forensic Disability Accommodation], <https://www.dffh.vic.gov.au/forensic-disability-services>, published 14 October 2024.
[226] Department of Families, Fairness and Housing Government of Victoria, Forensic Disability Services, <https://services.dffh.vic.gov.au/forensic-disability-services>, n.d., accessed 30 May 2025.
[227] Department of Families, Fairness and Housing, *Forensic Disability Services*, <https://www.dffh.vic.gov.au/forensic-disability-services>, published 14 October 2024.
[228] Ibid.
[229] Chief Ombudsman, 'Oversight: An investigation into the Ministry of Health's stewardship of hospital-level secure services for people with an intellectual disability', *Final opinion of the Chief Ombudsman*, July 2021, p. 7.
[230] Ibid., p. 9.
[231] Disability Support Services, *High and Complex Framework Operational Strategy*, <https://www.disabilitysupport.govt.nz/providers/high-and-complex-framework-operational-strategy>, published 15 January 2025.

and Complex Framework.[232] This includes the provision of care and rehabilitation focused services and the appropriate transition of people with disabilities out of the framework when appropriate.[233]

The Ministry of Disabled People is now also leading the High and Complex Framework Strategy to improve wellbeing outcomes for people in secure and supervised care.[234]

[232] Ministry of Disabled People, 'Forensic Coordination Service transferred from Te Whatu Ora to Whaikaha', <https://www.whaikaha.govt.nz/news/news/forensic-coordination>, published 5 March 2024.
[233] Ministry of Disabled People, *High and Complex Framework Strategic Statement 2023-2028*, 2023, pp. 3, 5 and 7.
[234] Ministry of Disabled People, 'Forensic Coordination Service transferred from Te Whatu Ora to Whaikaha', <https://www.whaikaha.govt.nz/news/news/forensic-coordination>, published 5 March 2024.

Appendix 1
The Mental Health Act 2016 and the criminal justice system

The *Mental Health Act 2016* (Qld) (*Mental Health Act*) enables people charged with criminal offences to be diverted from the usual processes and outcomes associated with the criminal justice system.[235] The *Mental Health Act* contains principles that protect the rights of all persons who the Act applies to, including that treatment and care is provided only if it is appropriate for promoting and maintaining the person's wellbeing.[236]

When a person charged with a criminal offence is diverted under the *Mental Health Act*, this can result in charges being discontinued and further orders and findings being made, depending upon the seriousness of the offending, by either the Magistrates Court[237] or the Mental Health Court.[238]

This section of the paper is intended to be a summary of key laws regarding people charged with offences and how the *Mental Health Act* applies to them.

The *Mental Health Act* also contains provisions regarding:

- prisoners (called classified patients), which will be addressed in another paper in this series regarding detention; and
- victims, which will also be covered in another paper that specifically addresses challenges and issues for adults with cognitive disability acting as witnesses or being victims of crime in Queensland.

Mental Health Act and criminal defences

One of the key objects of the *Mental Health Act* is to divert a person from the criminal justice system if they are found to have been of 'unsound mind' when they were alleged to have committed an unlawful act, or if they are 'unfit for trial'.[239]

The concept of unsound mind is linked to the 'insanity' defence of the *Criminal Code,*[240] and the concept of being unfit for trial comes from the common law.[241]

The forensic aspects of the *Mental Health Act* apply to people with a mental illness and/or an intellectual disability.[242] For the purposes of the Act, mental illness is defined as a 'condition characterised by a clinically significant disturbance of thought, mood, perception or memory',[243] while an intellectual disability is defined to include both cognitive disability and intellectual disability.[244]

When being diverted from the criminal justice system, the Magistrates Court or the Mental Health Court can determine whether the accused person was either of unsound mind or is unfit for trial.[245]

There are several options open to the Magistrates Court and the Mental Health Court after they make a determination of unsoundness of mind or unfitness for trial, which are described below.

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[235] *Mental Health Act 2016* (Qld) s 3(1)(b).
[236] *Mental Health Act 2016* (Qld) ss 5, 8.
[237] *Mental Health Act 2016* (Qld) ch 6, pt 2.
[238] *Mental Health Act 2016* (Qld) ch 5.
[239] *Mental Health Act 2016* (Qld) s 3.
[240] *Criminal Code* (Qld) s 27.
[241] *R v Presser* [1958] VR 45.
[242] *Mental Health Act 2016* (Qld) s 134(3).
[243] *Mental Health Act 2016* (Qld) s 10.
[244] *Mental Health Act 2016* (Qld) sch 3.
[245] *Mental Health Act 2016* (Qld) ss 21, 22.

Unsound mind

As noted above, the concept of 'unsound mind' is defined through the criminal law defence of insanity, as found in the *Criminal Code*.[246]

The *Criminal Code* states that a person is not criminally responsible if, at the time of the offending, they were in such a state of 'mental disease' or 'natural mental infirmity' as to deprive the person of capacity to:

- understand what they were doing;
- control their actions; or
- know that they should not commit the offence.[247]

It must be established that the person's mental disease or natural mental infirmity was of a sufficient degree to deprive them of at least one of these three capacities. However, unsoundness of mind does not include a state of mind that has resulted in any way from intentional intoxication.[248]

Fitness for trial

The *Mental Health Act* does not define or provide a test for determining whether a person is fit for trial. Instead, the common law test is relied upon to make this determination.[249]

The case of *R v Presser*[250] is the Australian case that sets out the test for fitness for trial.[251]

The elements that must be satisfied to find that a person is fit for trial are that they are able to:

- understand the charge, such as having a basic understanding of the main facts and elements of the offending;
- plead to the charge and exercise the right of challenge, in that the person must understand that a plea of guilty is the acceptance of the essential facts and elements of the offence, and they must understand that they can challenge the selection of jury members;
- understand the nature of the proceedings, including that they are involved in a process to determine their responsibility for what is being alleged and the consequences of the process;
- follow the proceedings and understand what is happening, including understanding the roles of all of the participants in the proceedings;
- understand the effect of the evidence that can be given; and
- make a defence or answer the charge, by being able to provide their own version of the events and being able to answer questions if they wish to give evidence in court.[252]

The person must also be able to do the above through their lawyer by giving their lawyer instructions.[253]

Magistrates Court

When a person is charged with a simple offence (any offence that a Magistrates Court can convict an offender for),[254] and the court is satisfied on the balance of probabilities that the person charged was of unsound mind when the offending happened or is unfit for trial, the court can dismiss the charge.[255]

[246] *Mental Health Act 2016* (Qld) s 109.
[247] *Criminal Code* (Qld) s 27.
[248] *Mental Health Act 2016* (Qld) s 109(2).
[249] Explanatory Notes, *Mental Health Bill 2015* (Qld) 29.
[250] *R v Presser* [1958] VR 45.
[251] See, for example, *In the matter of GZW* [2024] QMHC 2 [65].
[252] Legal Aid Queensland, *Criminal Law Duty Lawyer Handbook*, 6th edition, 2014, 210.
[253] *R v Presser* [1958] VR 45, 48.
[254] *Mental Health Act 2016* (Qld) s 171, *Justices Act 1886* (Qld) s 4.
[255] *Mental Health Act 2016* (Qld) s 172.

If the Magistrates Court finds that the person is temporarily unfit for trial and is likely to become fit for trial within six months, the court can adjourn the matter.[256] If the person is still unfit for trial six months after the initial adjournment, the court can then dismiss the charge.[257]

If the Magistrates Court dismisses the charge or adjourns the matter as noted above, the court can refer the person to a relevant agency, health department, or another entity for appropriate treatment and/or care.[258] These entities include Queensland Health, the Department of Families, Seniors, Disability Services and Child Safety (DFSDSCS), and the NDIS.[259] However, this provision in the *Mental Health Act* only allows the court to refer a person, and does not empower the court to require services to be delivered to the person.

Upon dismissal or adjournment of the charge, if the court is reasonably satisfied that the person has a mental illness, or is unable to decide that the person has a mental illness or another mental condition (such as an intellectual disability), the court can make an examination order.[260]

An examination order authorises a doctor at an authorised mental health service (AMHS) to examine the person without their consent (details of AMHSs are discussed further below).[261] The doctor, upon examination, can decide whether to make a treatment authority (an involuntary treatment order) for the person, make a recommendation for the person's treatment and care, or if the person is already on an involuntary treatment order (such as Treatment Authority, Treatment Support Order or Forensic Order, discussed further below) change the nature and extent of the treatment and care under that order.

The Magistrates Court can refer a person to the Mental Health Court if the person has been charged with an indictable offence and it believes, on the balance of probabilities, that the person was of unsound mind at the time of offending or is unfit for trial and both:

(i) the nature and circumstance of the offence create an exceptional circumstance in relation to the protection of the community;
(ii) the making of a Forensic Order or treatment support order for the person may be justified.[262]

Mental Health Court

The Mental Health Court considers a range of matters related to serious offences to decide whether a person was of unsound mind at the time an alleged offence occurred and whether they are unfit for trial.[263] The court also hears appeals from decisions made by the Mental Health Review Tribunal (MHRT) (discussed further on p.57).[264]

A criminal case can be referred to the Mental Health Court by:

- the alleged offender or their legal representatives;[265]
- the Director of Public Prosecutions;[266]
- the Chief Psychiatrist/Director of Forensic Disability;[267] or
- the Magistrates Court, District Court or Supreme Court.[268]

A serious offence under the *Mental Health Act* is an indictable offence, other than those offences that must be heard by a Magistrate.[269] Indictable offences under the *Criminal Code* can include offences such as arson, robbery and murder.

[256] *Mental Health Act 2016* (Qld) s 173.
[257] *Mental Health Act 2016* (Qld) s 173(3).
[258] *Mental Health Act 2016* (Qld) s 174.
[259] *Mental Health Act 2016* (Qld) s 174(3).
[260] *Mental Health Act 2016* (Qld) s 177(2).
[261] *Mental Health Act 2016* (Qld) s 177(4).
[262] *Mental Health Act 2016* (Qld) s 175.
[263] *Mental Health Act 2016* (Qld) s 21.
[264] *Mental Health Act 2016* (Qld) ch 13, pt 3.
[265] *Mental Health Act 2016* (Qld) s 110(3).
[266] *Mental Health Act 2016* (Qld) s 110(3).
[267] *Mental Health Act 2016* (Qld) ss 101, 104.
[268] *Mental Health Act 2016* (Qld) ss 175, 183.
[269] *Mental Health Act 2016* (Qld) s 20(3).

The Mental Health Court also has jurisdiction over simple offences if they are accompanied by at least one indictable offence.[270] The Mental Health Court does not have jurisdiction over Commonwealth offences.[271]

Although the Mental Health Court does not conduct a trial, parties can raise issues regarding whether there is a 'substantial dispute' about whether the person committed the offence.[272]

The Mental Health Court can then consider an alternative offence for which there is no substantial dispute and determine whether the person was of unsound mind regarding that offence,[273] or if there is no alternative charge, and the person is fit for trial, the offence can be returned to the criminal courts to be determined.

The Mental Health Court can also determine any substantial dispute regarding material facts that are relied upon in an expert's report (such as a psychiatrist's report) that is before the Mental Health Court concerning the person's unsoundness of mind.[274] Material facts can include issues such as the person's circumstances or events before, during, or after the alleged offending.[275]

Even if the Mental Health Court finds the person was of unsound mind, that person can still elect to return and be tried for the offence in the criminal courts.[276]

Court composition

The Mental Health Court is comprised of a Supreme Court judge assisted by one or two clinicians.[277] Those clinicians do not decide the ultimate issues; instead, they offer advice to the judge on the meaning and significance of clinical evidence and clinical issues relating to the treatment, care and detention needs of a person.[278] It remains the judge's responsibility to decide on the issues.

If the court is assisted by two clinicians, then those clinicians must be:

- two psychiatrists if the hearing is not regarding a person with an intellectual disability; or
- if the hearing is regarding a person with an intellectual disability, one psychiatrist and one person with expertise in the care of persons who have an intellectual disability.[279]

If the court is assisted by one clinician, that clinician must be:

- a psychiatrist if the hearing is not regarding a person with an intellectual disability; or
- if the hearing is regarding a person with an intellectual disability, a psychiatrist or a person with expertise in the care of persons who have an intellectual disability.[280]

Parties to the proceedings

Parties to Mental Health Court proceedings regarding criminal offences are:[281]

- the person charged with the offending (through their lawyer);
- the Director of Public Prosecutions; and
- the Chief Psychiatrist.

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[270] *Mental Health Act 2016* (Qld) s 107, 110(4).
[271] *Mental Health Act 2016* (Qld) s 107, 110(1)(a).
[272] *Mental Health Court 2016* (Qld) s 117.
[273] *Mental Health Act 2016* (Qld) s 117(3).
[274] *Mental Health Act 2016* (Qld) s 117A(1).
[275] *Mental Health Act 2016* (Qld) s 117A(2).
[276] *Mental Health Act 2016* (Qld) s 119(2).
[277] *Mental Health Act 2016* (Qld) s 638.
[278] Queensland Government, *Mental Health Court Annual Report 2023-24*, 2 September 2024, p. 2.
[279] *Mental Health Act 2016* (Qld) s 638(4).
[280] *Mental Health Act 2016* (Qld) s 638(5).
[281] *Mental Health Act 2016* (Qld) s 114(1).

The Director of Forensic Disability can also elect to be a party in the proceedings.[282]

All parties to Mental Health Court proceedings have the right to appear in person and be represented by a lawyer or, with the court's permission, a person who is not a lawyer.[283]

Material that can be considered

The Mental Health Court can inform itself in any way that it considers appropriate.[284]

The normal rules of evidence do not apply to the Mental Health Court, unless it decides it is in the interests of justice to apply such rules.[285] The rules of evidence determine how and when certain types of evidence can be presented to a court, or when evidence cannot be presented to a court, such as the rules around hearsay.

The court can consider information from a wide range of sources, including oral evidence from witnesses, briefs of evidence provided by police, medical reports and records, and written submissions by the parties and victims.[286]

The Mental Health Court decides matters on the balance of probabilities.[287]

Open hearings

Hearings in the Mental Health Court are generally open to the public.[288] However, the court may order a hearing, or parts of it, to be closed to the public in the interests of justice.[289] Hearings involving children are not open to the public.[290]

An appeal of a decision of the MHRT is not open to the public unless the Mental Health Court makes an order allowing others to be present.[291]

Confidentiality

The Mental Health Court can make a confidentiality order that prohibits or restricts the disclosure of any information that the court has received, or the court's reasons for its decisions.[292]

The court can make a confidentiality order only if it is satisfied that the disclosure of the information would cause serious harm to the person before the court or place the safety of another person at serious risk.[293]

Mental Health Court outcomes

In most cases, the Mental Health Court decides that:

- the person was not of unsound mind (and is fit for trial) and refer the matter back to the trial court; or
- the person was of unsound mind;[294] or

[282] *Mental Health Act 2016* (Qld) s 114(2).
[283] *Mental Health Act 2016* (Qld) s 683.
[284] *Mental Health Act 2016* (Qld) s 639(2).
[285] *Mental Health Act 2016* (Qld) s 684(1).
[286] Queensland Courts, What happens in a hearing (31 January 2017) < https://www.courts.qld.gov.au/courts/mental-health-court/hearings-in-the-court/what-happens-in-a-hearing>.
[287] *Mental Health Act 2016* (Qld) s 685.
[288] *Mental Health Act 2016* (Qld) s 693(1).
[289] *Mental Health Act 2016* (Qld) s 693(2).
[290] *Mental Health Act 2016* (Qld) s 695.
[291] *Mental Health Act 2016* (Qld) s 694.
[292] *Mental Health Act 2016* (Qld) s 696(1).
[293] *Mental Health Act 2016* (Qld) s 696(2).
[294] *Mental Health Act 2016* (Qld) s 116(1).

- the person was not of unsound mind at the time the offence was committed but is temporarily or permanently unfit for trial.[295]

If the Mental Health Court determines that the person is temporarily unfit for trial, the court must make either a Treatment Support Order or a Forensic Order.[296]

If the court determines that the defendant was of unsound mind at the time the offence was committed, or that they are permanently unfit for trial, the proceedings against the person are discontinued (dismissed) and the court may make:

- a Forensic Order,
- a Treatment Support Order, or
- no order.[297]

When making a decision in relation to an order, the Mental Health Court must have regard to:

- The circumstances of the person;
- The nature of the alleged offending and the time that has since passed;
- Any victim impact statement produced to the court.[298]

Treatment Support Order

As noted above, a Treatment Support Order can be made by the Mental Health Court following a finding that the person was of unsound mind at the time of an alleged offence or is unfit for trial. A person under a Treatment Support Order is under the responsibility of an AMHS.[299]

Treatment Support Orders generally involve less oversight than Forensic Orders,[300] as the person is to be treated in the community on a Treatment Support Order unless it is otherwise necessary,[301] as opposed to a Forensic Order where the person can be an inpatient.[302]

The *Mental Health Act* specifically states that a Forensic Order operates in a way that is more restrictive of a person's rights than a Treatment Support Order.[303]

The Mental Health Court can make a Treatment Support Order if the court considers that a Treatment Support Order, but not a Forensic Order, is necessary to protect the safety of the community due to the person's mental condition.[304]

If the Mental Health Court makes a Treatment Support Order, it may impose conditions it considers appropriate.[305] The court must also decide whether the category of the order is to be inpatient or community.[306] A Treatment Support Order must be in the community category, unless it is necessary for the person to be an inpatient as a result of their treatment and care needs or to protect the safety of the person or others.[307]

A Treatment Support Order may also be made by the Mental Health Review Tribunal when it revokes a patient's Forensic Order (Mental Health).[308]

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[295] *Mental Health Act 2016* (Qld) s 118.
[296] *Mental Health Act 2016* (Qld) s 132.
[297] *Mental Health Act 2016* (Qld) s 131.
[298] *Mental Health Act 2016* (Qld) s 133(1).
299 *Mental Health Act 2016* (Qld) s 146(1).
[300] Queensland Health, *Treatment Support Orders Factsheet,* 1 July 2022, p. 1.
[301] *Mental Health Act 2016* (Qld) s 145(2).
[302] *Mental Health Act 2016* (Qld) s 138(2).
[303] *Mental Health Act 2016* (Qld) s 130(2).
[304] *Mental Health Act 2016* (Qld) s 143(1).
[305] *Mental Health Act 2016* (Qld) s 144.
[306] *Mental Health Act 2016* (Qld) s 145(1)
[307] *Mental Health Act 2016* (Qld) s 145(2)
[308] *Mental Health Act 2016* (Qld) s 450.

Forensic Order

The Mental Health Court must make a Forensic Order if it considers such an order is necessary to protect the safety of the community, due to the person's mental condition.[309]

The types of Forensic Orders the Court can make are described in further detail below.

The court may also impose the conditions it considers appropriate for a person under a Forensic Order, including conditions where the person is not to contact certain people. However, a condition cannot include requiring the person to take any particular medication.[310]

At the same time, the Mental Health Court can make recommendations that the court considers appropriate regarding intervention programs that an AMHS or the Forensic Disability Service (FDS) should provide for the person.[311]

A Forensic Order will generally continue until it is revoked on review by the MHRT (further details below).[312] However, the Mental Health Court can impose a non-revocation period on a Forensic Order for certain offences. This non-revocation period can be up to 10 years, where the court is to have regard to the protection of the community. [313] Such orders can be imposed when the person was charged for certain 'prescribed offences', which are serious offences such as murder and manslaughter.[314]

Types of Forensic Order

If the Mental Health Court decides to make a Forensic Order, it must decide which of the two types of Forensic Orders it will make.

A Forensic Order (Mental Health) is made when:

- the person's unsoundness of mind or unfitness for trial was due to a mental condition other than an intellectual disability; or
- the person has a dual disability (a mental illness and an intellectual disability) and requires involuntary treatment and care for the mental illness, as well as care for the intellectual disability.[315]

A Forensic Order (Disability) is made when:

- the person's unsoundness of mind or unfitness for trial was due to an intellectual disability; and
- the person requires care for the intellectual disability but not for any mental illness.[316]

If the Mental Health Court decides to make a Forensic Order, it must also decide whether to make the category of the order inpatient or community.[317] The Mental Health Court can only decide that the category is community if it considers that there is not an unacceptable risk to the safety of the community due to the person's mental condition.[318]

Forensic Order – Inpatient

If the court decides the Forensic Order is to be served by the person as an inpatient, the person will most likely be detained in an AMHS, which will be responsible for the person.[319] The Mental Health Court can make an order detaining a person at the FDS if the person is subject to a Forensic Order

[309] *Mental Health Act 2016* (Qld) s 134(1).
[310] *Mental Health Act 2016* (Qld) s 135.
[311] *Mental Health Act 2016* (Qld) s 136.
[312] *Mental Health Act 2016* (Qld) s 441(1).
[313] *Mental Health Act 2016* (Qld) s 137.
[314] *Mental Health Act 2016* (Qld) sch 3.
[315] *Mental Health Act 2016* (Qld) s 134(3)(b).
[316] *Mental Health Act 2016* (Qld) s 134(3)(a).
[317] *Mental Health Act 2016* (Qld) s 138(1).
[318] *Mental Health Act 2016* (Qld) s 138(2).
[319] *Mental Health Act 2016* (Qld) s 146(1).

(Disability) and the Director of Forensic Disability has provided the Court with a certificate that indicates the facility has the required capacity.[320]

A person subject to a Forensic Order (Disability) who is under the supervision of an AMHS can be transferred to the FDS or vice versa by agreement between the Chief Psychiatrist and the Director of Forensic Disability.[321] In deciding whether to agree to a transfer, the Chief Psychiatrist and the Director of Forensic Disability must have regard to:

- the transfer considerations for the person, and
- the person's intellectual disability and,
- the views, wishes and preferences of the person to the greatest extent practicable.[322]

Limited Community Treatment

The purpose of Limited Community Treatment (LCT) is to support a person's recovery by transitioning them to living in the community with appropriate treatment and care.[323]

If the Mental Health Court decides a Forensic Order is to be served by the person as an inpatient, the court must also decide:

- whether or not the person is to receive LCT and, if so, the extent of the LCT; and
- whether or not an authorised doctor at an AMHS or a senior practitioner of the FDS may change the treatment in the community at a future time, and the extent of the treatment in the community.[324]

A person on LCT is considered to be receiving treatment and care in the community, while on the grounds of an AMHS or FDS (other than as an inpatient), for up to seven days.[325]

Power to order, approve or revoke LCT is vested in the Mental Health Court or MHRT, which also has the discretion to set the conditions attached to the LCT.[326]

The Mental Health Court can only make an order authorising LCT 'if the court is satisfied 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.'[327]

In making a decision on the risk to the community, the court must have regard to the purpose of the LCT and the fact that an authorised doctor of an AMHS or a senior practitioner from the FDS can amend the LCT (discussed in further detail below).[328]

Forensic Order – Community

If the Mental Health Court considers there is not an unacceptable risk to the safety of the community, including the risk of serious harm to other people or property, the court can impose a community category Forensic Order.[329] This permits the person to reside in a place other than an AMHS or FDS.[330]

Most people on Forensic Orders (both Mental Health and Disability) are on 'community' orders.

Those on community category Forensic Orders can live in a range of settings, from a private house or unit, in a community care unit, in supported accommodation, in a hostel or boarding house, or in

[320] *Mental Health Act 2016* (Qld) s 147.
[321] *Mental Health Act 2016* (Qld) s 353.
[322] *Mental Health Act 2016* (Qld) s 353(3).
[323] *Mental Health Act 2016* (Qld) s 16.
[324] *Mental Health Act 2016* (Qld) s 139.
[325] *Mental Health Act 2016* (Qld) sch 3.
[326] *Mental Health Act 2016* (Qld) s 139(1)(c), 445(1)(c).
[327] *Mental Health Act 2016* (Qld) s 139(2)
[328] *Mental Health Act 2016* (Qld) s 139(3)
[329] *Mental Health Act 2016* (Qld) s 138(2)
[330] *Mental Health Act 2016* (Qld) sch 3.

accommodation support and respite services provided by DFSDSCS, or they can be homeless, or even in prison.

According to the annual report of the Chief Psychiatrist:

> As at 30 June 2024, there were:
>
> - 729 open forensic orders in Queensland
> - The majority (608) were forensic order (mental health), of which 70 per cent were community category.
> - The remaining open orders (121) were forensic order (disability), of which 90 per cent were community category.[331]

Conditions imposed on people on a Forensic Order (community) can include compliance with treatment and medication, attendance at appointments with psychiatrists, case managers and other clinicians, and a return to hospital if directed by the psychiatrist.

Conditions may also restrict a person's freedom of movement, requiring them to be supervised by a staff member or responsible adult when outside (and sometimes even inside) the home, restricting travel to certain areas, or at certain times of the day, or for particular purposes. Use of certain devices, such as phones, computers, and devices capable of connecting to the internet, and other items, can also be restricted or prohibited.

If the Mental Health Court decides that the Forensic Order is to be in the community category, the Mental Health Court also decides whether an authorised doctor under the Act or a senior practitioner under the *Forensic Disability Act* can amend the Forensic Order so that the category is changed to inpatient, or whether changes can be made to the nature or extent of the treatment in the community.[332]

An authorised doctor can also amend the category of an order from community to inpatient for patients under a Forensic Order contrary to a decision of the Mental Health Court or the Mental Health Review Tribunal (MHRT),[333] if:

- there has been a material change in the patient's mental state, and
- the patient requires urgent treatment as an inpatient in an AMHS.[334]

This decision must then be referred to the MHRT for review within 21 days of receiving the notice of the amendment from the relevant AMHS.[335]

Other orders available under the Mental Health Act

Diminished responsibility

The Mental Health Court can also determine whether a person was of 'diminished responsibility'.[336]

Diminished responsibility is a partial defence to the charge of murder where, if proven, the person is guilty of manslaughter instead. The key provision of the Criminal Code provides that:

> When a person who unlawfully kills another under circumstances which, but for the provisions of this section, would constitute murder, is at the time of doing the act or making the omission which causes death in such a state of abnormality of mind (whether arising from a condition of arrested or retarded development of mind or inherent causes or induced by disease or injury) as substantially to impair the person's capacity to understand what the person is doing, or the person's capacity to control the person's actions, or the person's capacity to know that the person ought not to do the act or make the omission, the person is guilty of manslaughter only.[337]

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[331] Queensland Government, *Chief Psychiatrist Annual Report 2023-2024*, 2 September 2024, p.42.
[332] *Mental Health Act 2016* (Qld) s 140.
[333] *Mental Health Act 2016* (Qld) s 213(2).
[334] *Mental Health Act 2016* (Qld) s 213.
[335] *Mental Health Act 2016* (Qld) s 433(4).
[336] *Mental Health Act 2016* (Qld) s 21(1).
[337] *Criminal Code* (Qld) s 304A.

The person can be referred to the Mental Health Court by the person themselves, their lawyer or the Director of Public Prosecutions.[338] The Mental Health Court can then decide whether the person was of unsound mind or whether the person was of diminished responsibility.[339] The same provisions regarding substantial dispute about key facts as discussed above also apply to this decision.[340]

If the Mental Health Court decides that the person was of diminished responsibility, the charge of murder is to be discontinued.[341]

Forensic Order (Criminal Code)

Although the purpose of the *Mental Health Act* is to create a specialised court that is equipped to hear and deal with people who may have a mental illness and/or intellectual disability and their liability in criminal offending, this does not preclude defendants from raising the same issues in a mainstream court as a defence in a trial.

For example, the defence of 'insanity' remains a complete defence to any criminal charge.[342] In the District and Supreme Court, the jury can be tasked with determining a person's culpability when issues of mental illness and/or intellectual disability are raised.[343]

Specifically, three provisions exist in the *Criminal Code* in relation to this issue:

- Section 613 – Want of understanding of accused person;
- Section 645 – Accused person insane during trial; and
- Section 647 – Acquittal on ground of insanity.

Section 613 reflects the process for finding whether a person is fit for trial in the criminal courts. It states that a jury of 12 persons is to be empanelled to find whether the person can understand the proceedings, and if the jury finds that the person is not capable, the court can then order that the accused person be discharged or order the person to be admitted to an AMHS under the *Mental Health Act*.

Section 645 deals with the question of whether the accused person is of unsound mind during the trial. The section states that if the jury for the trial finds that the defendant is not of sound mind during the trial, the court is then required to order the person to be admitted to an AMHS under the *Mental Health Act*.

Section 647 applies when the accused person was of unsound mind during the time of offending. The jury is to decide whether the person is not guilty due to the defendant being of unsound mind when the offending took place and, if that occurs, the court is to order the person to be admitted to an AMHS under the *Mental Health Act*.

Under the *Mental Health Act*, if the District or Supreme Court makes orders that a person be admitted to an AMHS under any of the above sections, these orders are considered to be a Forensic Order (Criminal Code).[344]

Within 21 days of a Forensic Order (Criminal Code), noted above, being made, the MHRT must conduct a hearing for the purpose of changing this order to a Forensic Order (Mental Health) or Forensic Order (Disability).[345]

[338] *Mental Health Act 2016* (Qld) s 110.
[339] *Mental Health Act 2016* (Qld) s 116(1).
[340] *Mental Health Act 2016* (Qld) s 116(2).
[341] *Mental Health Act 2016* (Qld) s 120.
[342] *Criminal Code* (Qld) s 27(1).
[343] *Criminal Code* (Qld) ss 613, 645, 647.
[344] *Mental Health Act 2016* (Qld) sch 3.
[345] *Mental Health Act 2016* (Qld) s 459.

Inpatient Orders

The section below describes the two services in which people on inpatient Forensic Orders reside.

The Forensic Disability Service (described below) caters for eligible people under a Forensic Order (Disability). Those on Forensic Orders (Mental Health) or Forensic Orders (Disability) can reside in an AMHS while under an inpatient order.

Authorised Mental Health Service

An AMHS is a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service under the *Mental Health Act*.[346] An AMHS is usually a public psychiatric hospital or the psychiatric ward of a public hospital. Private hospitals also have wards that have been gazetted as an AMHS.[347]

As of 30 June 2024, under the supervision of an AMHS, there were:

- 729 people on Forensic Orders
    - Most of these were on Forensic Orders (Mental Health) – 608
        - 70% (approximately 426) of those on a Forensic Order (Mental Health) were on community orders (meaning that they could live in the community) while 30% (approximately 182) were inpatients at an AMHS.
    - The remaining 121 people were on a Forensic Order (Disability)
        - 90% (approximately 109) of those on a Forensic Order (Disability) were on community orders (meaning that they could live in the community) while 10% (approximately 12) were inpatients at an AMHS.[348]

Limited Community Treatment (LCT)

As noted, limited community treatment is available to those under Forensic Orders (mental health or disability) who are inpatients at an AMHS.

An authorised doctor of an AMHS can amend the LCT of a person's Forensic Order if permitted by the Mental Health Court or the Mental Health Review Tribunal.[349] The doctor can only amend the order to increase the extent of treatment in the community if they are satisfied that there is not an unacceptable risk to the safety of the community due to the person's mental condition.[350]

When making this decision, the doctor must have regard to the person's circumstances, the purpose of LCT, the nature of the unlawful act that they were alleged to have committed, and the time that has passed since the act.[351]

The doctor must inform the patient of any proposed changes to the Forensic Order and explain those changes to them.[352]

According to the Chief Psychiatrist's policies, if LCT is authorised or amended, the authorised doctor must state:

- the type of LCT i.e. on grounds, off grounds or overnight, and whether the patient is to be escorted or supervised,
- the conditions of LCT,
- the actions to be taken if the patient does not comply with conditions,
- the duration of the LCT …, and

[346] *Mental Health Act 2016* (Qld) s 329.
[347] Queensland Health, *Schedule of authorised mental health services and administrators*, Updated 2 July 2024, pp. 20-21.
[348] Queensland Government, *Chief Psychiatrist Annual Report 2023-24*, 2 September 2024, p. 42.
[349] *Mental Health Act 2016* (Qld) s 212(2).
[350] *Mental Health Act 2016* (Qld) s 212(3).
[351] *Mental Health Act 2016* (Qld) s 212(4).
[352] *Mental Health Act 2016* (Qld) s 212(5).

- the duration of the authorisation.[353]

Restrictive practices

For involuntary patients being treated in an AMHS, which includes all people on a Forensic Order, the *Mental Health Act* has specific provisions under which restrictive practices can or cannot be used.

Seclusion

Seclusion is defined as 'the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.'[354]

But seclusion does *not* include:

> (a) confinement of a person in a high security unit, or in another authorised mental health service approved by the chief psychiatrist for the purposes of this part, if the confinement is—
>
> i. for a period, approved by the administrator of the service, of not more than 10 hours between 8p.m. and 8a.m.; and
> ii. for security purposes; or
>
> (b) confinement that is authorised under a law other than this part.[355]

An authorised doctor can authorise seclusion of a person only if they are satisfied that:

- there is no other reasonably practicable way to protect people from physical harm, including the patient;
- the seclusion complies with a written direction, if one exists, from the Chief Psychiatrist regarding seclusion;
- the seclusion complies with the policy from the Chief Psychiatrist; and
- if there is a reduction and elimination plan in place, the seclusion complies with this plan.[356]

The seclusion must not be undertaken with any more force than is reasonable and necessary, and while being kept in seclusion, the person must be observed continuously, or at intervals of not more than 15 minutes.[357]

Generally, each authorisation must not be for a period of more than three hours.[358] Further authorisation for seclusion cannot be given if the total period of seclusion is to exceed nine hours in a 24-hour period if there is no reduction and elimination plan.[359] However, there are limited circumstances where an authorised doctor can extend the period in which the person can be kept in seclusion for up to 12 more hours without a reduction and elimination plan.[360]

A health practitioner who is not an authorised doctor can authorise emergency seclusion in certain circumstances.[361] This seclusion cannot be for a period longer than one hour, and must involve continuous observation, and an authorised doctor must be informed as soon as possible.[362]

Seclusion and mechanical restraint may be used only if there is no other reasonably practicable way to protect the patient or others from physical harm.[363]

Mechanical restraint

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[353] Queensland Health, *Chief Psychiatrist Policy, Forensic Orders and Treatment Support Orders, Amending category, conditions and limited community treatment* p 7.
[354] *Mental Health Act 2016* (Qld) s 254.
[355] *Mental Health Act 2016* (Qld) s 254(2).
[356] *Mental Health Act 2016* (Qld) s 258(1).
[357] *Mental Health Act 2016* (Qld) s 256(1)(e), (f).
[358] *Mental Health Act 2016* (Qld) s 258(2).
[359] *Mental Health Act 2016* (Qld) s 258(4).
[360] *Mental Health Act 2016* (Qld) s 259(2).
[361] *Mental Health Act 2016* (Qld) s 263.
[362] *Mental Health Act 2016* (Qld) s 263(1).
[363] *Mental Health Act 2016* (Qld) s 24.

Mechanical restraint is defined as 'the restraint of a person by the application of a device to the person's body, or a limb of the person, to restrict the person's movement.'[364]

Mechanical restraint does not include the appropriate use of a medical or surgical appliance for the person's treatment, or restraint of a person that is otherwise authorised or permitted under law.[365]

Mechanical restraint can only be used in a high security unit or another AMHS that has been approved by the Chief Psychiatrist to use mechanical restraint.[366]

Further requirements under the *Mental Health Act* for mechanical restraint include:

- authorisation by an authorised doctor;[367]
- there is no other reasonably practicable way to protect the person or others from physical harm;[368]
- the device itself must be approved by the Chief Psychiatrist;[369]
- the Chief Psychiatrist has given approval for the use of the restraint on the patient;[370]
- the use of the restraint complies with the Chief Psychiatrist's policy;[371]
- compliance with a reduction and elimination plan if there is one in place;[372]
- the use of the restraint is completed with no more force than is necessary and reasonable;[373] and
- the person is observed continuously while restrained.[374]

An authorisation for mechanical restraint cannot be longer than three hours at a time.[375] If there is no reduction and elimination plan, an authorisation may not be given if the total period for which mechanical restraint has been used on the patient will be more than nine hours in a 24 hour period.[376]

Reduction and elimination plan

A reduction and elimination plan is a written plan that provides for the reduction and elimination of mechanical restraint and/or seclusion of an involuntary patient that is developed by an authorised doctor.[377]

A reduction and elimination plan must contain information regarding the use of mechanical restraint or seclusion on the patient, as well as the strategies that have been used to reduce the use of those practices, the effectiveness of those strategies in the past, and what strategies will be used in the future.[378]

The Chief Psychiatrist can then approve the plan if the strategies proposed for the future are appropriate for the person. The Chief Psychiatrist can also include any further conditions that they feel are necessary.[379]

[364] *Mental Health Act 2016* (Qld) s 244(1).
[365] *Mental Health Act 2016* (Qld) s 244(2).
[366] *Mental Health Act 2016* (Qld) s 246(2)(a).
[367] *Mental Health Act 2016* (Qld) s 246(2).
[368] *Mental Health Act 2016* (Qld) s 250(1)(a).
[369] *Mental Health Act 2016* (Qld) s 246(2)(b).
[370] *Mental Health Act 2016* (Qld) s 246(2)(c).
[371] *Mental Health Act 2016* (Qld) s 246(2)(e).
[372] *Mental Health Act 2016* (Qld) s 246(2)(f).
[373] *Mental Health Act 2016* (Qld) s 246(2)(g).
[374] *Mental Health Act 2016* (Qld) s 246(2)(h).
[375] *Mental Health Act 2016* (Qld) s 250(2)(a)
[376] *Mental Health Act 2016* (Qld) s 250(4).
[377] *Mental Health Act 2016* (Qld) s 264.
[378] *Mental Health Act 2016* (Qld) s 265.
[379] *Mental Health Act 2016* (Qld) s 267.

Physical restraint

Physical restraint is the use by a person of their body to restrict a patient's movement but does not include physical support or assistance that is reasonably necessary to assist the patient.[380]

An authorised doctor or a health practitioner in charge of a unit within an AMHS can authorise the use of physical restraint on a patient if there is no other reasonably practicable way to:

- Protect people (including the person being restrained) from physical harm;
- Provide treatment and/or care to the person;
- Prevent the person from causing serious damage; or
- Prevent the person from leaving an AMHS if they are detained there.[381]

Chemical restraint

Medication (which includes sedation) can only be administered to a person if it is clinically necessary for the treatment and care of a medical condition.[382] However, treatment and care of a medical condition does include preventing imminent serious harm to the person or others.[383]

Forensic Disability Service

The Forensic Disability Service (FDS) is a purpose-built medium secure 10-bed facility situated at Wacol, Brisbane, for the involuntary detention of people found unfit for trial as a result of an intellectual or cognitive disability, and who require secure care.[384]

This service response was prompted by reports prepared by The Honourable Justice William Carter QC, *Challenging Behaviour and Disability: A Targeted Response* (2006), and His Honour Judge Brendan Butler AM SC, Review of the *Queensland Mental Health Act 2000, Promoting Balance in the Forensic Mental Health System* (2006).

Recommendation 5.1 of the Butler Report provided that:

> … a review of the provisions of the *Mental Health Act 2000* affecting people with an intellectual disability be conducted as part of any reform to provide secure care for people with an intellectual or cognitive disability who exhibit severely challenging behaviour.[385]

The Carter Report specifically addressed the issue of alternative detention options for people with an intellectual disability on a Forensic Order, recommending that:

> consideration be given to the amendment of the Mental Health Act in relation to the Mental Health Court's power in making a Forensic Order in respect of a person with intellectual disability to order that the person be detained other than in a mental health service.[386]

The stated purpose of the FDS is to 'provide for the involuntary detention, and the care and support and protection, of forensic disability clients'.[387] This is to be achieved in several ways, including by providing a 'multidisciplinary model of care and support for clients that is designed to promote their continual development, independence and quality of life.'[388]

The Director of Forensic Disability has several responsibilities regarding the FDS and its clients. The Director's functions include protecting the rights of FDS clients, ensuring that FDS clients are treated

[380] *Mental Health Act 2016* (Qld) s 268.
[381] *Mental Health Act 2016* (Qld) s 270.
[382] *Mental Health Act 2016* (Qld) s 272.
[383] *Mental Health Act 2016* (Qld) s 272(3).
[384] Department of Families, Seniors, Disability Services and Child Safety, *Forensic Disability Service* <https://www.dcssds.qld.gov.au/our-work/disability-services/forensic-disability-service>, published 10 February 2025.
[385] Explanatory Notes, *Forensic Disability Bill 2011* (Qld) p 2.
[386] Explanatory Notes, *Forensic Disability Bill 2011* (Qld) p 3.
[387] *Forensic Disability Act 2011*(Qld) s 3.
[388] *Forensic Disability Act 2011* (Qld) s 4(c).

in compliance with the *Forensic Disability Act*, as well as monitoring and auditing compliance with the Act generally.[389]

The Director can also issue policies and procedures about FDS clients.[390] Such policies include processes for the referral and admission of a person into the FDS. To determine suitability for admission, a range of factors are to be considered, including:

- the physical capacity to accommodate the referred person;
- the person's requirement for a medium secure environment;
- the person has significant criminogenic needs that can be addressed through rehabilitative programs delivered at the FDS;
- the person's intellectual functioning/cognitive capacity and adaptive functioning is at a level where they will (with reasonable adaptations) be able to successfully participate in, and benefit from, evidence-based rehabilitative programs;
- the person does not have mental health needs that are likely to impact on their ability to participate effectively in the Model of Care provided at the FDS;
- the person's cultural needs can be supported;
- the person is likely to be able to co-tenant with other forensic disability clients and cohabit with the current cohort of clients at the FDS;
- the person is likely to benefit from supports and programs such that there will be a viable transition pathway from the FDS to the community; and
- the views of the client and/or guardian, family members and advocate (where relevant).[391]

Individual Development Plan

Each client of the FDS has an Individual Development Plan (IDP) prepared for them, which is regularly reviewed. [392] The IDP is designed to:

(a) promote the client's development, habilitation and rehabilitation;
(b) provide for the client's care and support; and
(c) when appropriate, support the client's reintegration into the community.[393]

Restrictive practices

Under the *Forensic Disability Act*, restrictive practices, referred to as 'regulated behaviour controls', can include behaviour control medication, the use of physical restraints and the use of seclusion.[394]

Regulated behaviour controls are only to be used when necessary:

- in the least restrictive way to protect people's health and safety;
- having regard for the client's human rights;
- with the aim to reduce or eliminate their use; and
- with transparency and accountability.[395]

The FDS is required to maintain a register of the use of regulated behaviour controls.[396]

Seclusion

Seclusion is defined as the confinement of a client at any time in a room or area where the client's free exit is prevented.[397] An FDS client may only be placed in seclusion if a senior practitioner is reasonably satisfied that seclusion is necessary to protect the person detained or other people from

[389] *Forensic Disability Act 2011* (Qld) s 87(1).
[390] *Forensic Disability Act 2011* (Qld) s 91(1).
[391] Director of Forensic Disability, *Director of Forensic Disability Policy*: *Referral and Admission to the Forensic Disability Service*, 9 January 2023, p 2.
[392] *Forensic Disability Act 2011* (Qld) ss 14, 15.
[393] *Forensic Disability Act 2011* (Qld) s 13(1).
[394] *Forensic Disability Act 2011* (Qld) ch 6.
[395] *Forensic Disability Act 2011* (Qld) s 42.
[396] *Forensic Disability Act 2011* (Qld) s 74.
[397] *Forensic Disability Act 2011* (Qld) s 46.

imminent physical harm, and there is no less restrictive way to protect the client's health and safety or to protect others.[398]

An authorised practitioner, rather than a senior practitioner, can place a person in seclusion only with the authorisation of a senior practitioner or in urgent circumstances.[399]

Restraint

Restraint is defined as the use of an approved mechanical appliance to prevent the free movement of part of a client's body.[400] Any restraint appliances must be approved by the Director of Forensic Disability and stated in a policy or procedure made by the Director.[401]

The Director can authorise the use of a restraint on a client if they are satisfied that it is the least restrictive way to protect the client's health and safety or to protect others.[402]

In authorising the restraint, the Director must have regard to the client's individual development plan and must authorise the restraint to be applied for only the minimum period or periods possible.[403] The authorisation is then given by written order to a senior practitioner or authorised practitioner, who can use the restraint as authorised by the Director.[404]

Behaviour control medication

Behaviour control medication is the use of medication for which the main purpose is controlling a client's behaviour.[405] A senior practitioner may decide to administer behaviour control medication if the senior practitioner is a doctor or a registered nurse, and if a psychiatrist prescribes the medication for behavioural control.[406]

A senior practitioner must regularly review the need and appropriateness of medication at least every three months.[407]

Limited Community Treatment

The senior practitioner may authorise LCT only if –

a) the tribunal or Mental Health Court has ordered or approved the community treatment; and
b) the senior practitioner is satisfied, having regard to the matters stated in subsection (3), there is not an unacceptable risk to the safety of the community, because of the client's intellectual or cognitive disability, including the risk of serious harm to other persons or property.[408]

The relevant matters that the senior practitioner must consider under subsection (3) are:[409]

a) for limited community treatment—the fact that the purpose of limited community treatment is to support the client's rehabilitation by transitioning the client to living in the community with appropriate care and support;
b) the client's current mental state and intellectual disability;
c) the client's social circumstances, including, for example, family and social support;
d) the client's response to care and support including, if relevant, the client's response to care and support in the community;
e) the client's willingness to continue to receive appropriate care and support;
f) the nature of the unlawful act that led to the making of the applicable Forensic Order and the amount of time that has passed since the act occurred.

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[398] *Forensic Disability Act 2011* (Qld) s 61(2).
[399] *Forensic Disability Act 2011* (Qld) s 61(1).
[400] *Forensic Disability Act 2011* (Qld) s 45 (1).
[401] *Forensic Disability Act 2011* (Qld) s 55.
[402] *Forensic Disability Act 2011* (Qld) s 56(1).
[403] *Forensic Disability Act 2011* (Qld) s 56(2).
[404] *Forensic Disability Act 2011* (Qld) ss 56(3), 57.
[405] *Forensic Disability Act 2011* (Qld) s 44(1).
[406] *Forensic Disability Act 2011* (Qld) s 50.
[407] *Forensic Disability Act 2011* (Qld) s 52.
[408] *Forensic Disability Act 2011* (Qld) s 20(2).
[409] *Forensic Disability Act 2011* (Qld) s 20(3).

The Senior Practitioner must have regard to these same matters in deciding the nature and conditions of the LCT.[410]

5-year review of client

Where a person has been detained at the FDS for a continuous period of five years, the Director of Forensic Disability must conduct a review of the person's detention to determine if they will continue to benefit from the care and support provided by the FDS.[411]

'Benefit' refers to a 'benefit by way of individual development and opportunities for quality of life and participation and inclusion in the community.'[412]

Mental Health Review Tribunal

The Mental Health Review Tribunal (MHRT) is an independent decision-making body under the *Mental Health Act 2016* (Qld).[413]

The MHRT has several functions including the review of:

- various involuntary treatment orders such as Treatment Support Orders and Forensic Orders; and,
- a person's fitness for trial after the Mental Health Court has decided that their unfitness is not permanent.[414]

Decisions to make any changes to a Forensic Order can also be made by the MHRT. Changes to orders can include:

- confirming or revoking an order;
- changing the category of an order from inpatient to community; and,
- authorising Limited Community Treatment.[415]

Tribunal composition

For reviews of involuntary treatment orders and fitness for trial, the MHRT must include at least three, and up to five members.[416] There must be at least one member who is a lawyer, one psychiatrist or another doctor, and one person who is not a lawyer or doctor.[417]

Parties to the proceeding

As described below, any person who is entitled to be given notice of a hearing can be a party to the proceedings.[418]

For a review of a Treatment Support Order, those given notice include the person subject to the order, the person who applied for the review, the administrator of the AMHS and the Chief Psychiatrist.

For Forensic Orders, the Attorney-General of Queensland is also entitled to receive a notice of hearing.[419] In addition, the same people as for Treatment Support Orders are entitled to be given notices of hearing if the person is under the responsibility of an AMHS. If they are under the

[410] *Forensic Disability Act 2011* (Qld) s 20(4).
[411] *Forensic Disability Act 2011* (Qld) s 141.
[412] *Forensic Disability Act 2011* (Qld) s 141(6).
[413] *Mental Health Act 2016* (Qld) s 705(2).
[414] *Mental Health Act 2016* (Qld) s 28.
[415] *Mental Health Act 2016* (Qld) s 705(1).
[416] *Mental Health Act 2016* (Qld) s 716(2).
[417] *Mental Health Act 2016* (Qld) s 716(2).
[418] *Mental Health Act 2016* (Qld) ss 703, 736(1).
[419] *Mental Health Act 2016* (Qld) s 439.

responsibility of the FDS, instead of the administrator of the AMHS and the Chief Psychiatrist, the administrator of the FDS and the Director of Forensic Disability are to receive notices of hearing.[420]

For a review of fitness for trial, the same people as for reviews of Forensic Orders are entitled to be provided with a notice of hearing.[421]

Material that can be considered

The MHRT can inform itself in any way that it considers appropriate and is not bound by the rules of evidence.[422] The tribunal is to act quickly with as little formality and technicality as possible while being fair and properly considering the matters before it.[423]

Hearings and confidentiality

MHRT hearings are generally not open to the public, but the tribunal can order hearings to be open, unless the hearing involves children.[424]

The MHRT can also make confidentiality orders that can restrict the disclosure of any information the tribunal has, or the reasons for its decision.[425]

The person subject to an MHRT hearing can be represented by a nominated support person, a lawyer or another person.[426] The person can also be accompanied by a member of the person's support network or, with the tribunal's leave, more than one member of their support network.[427] If the person is not represented by a lawyer or another person, the tribunal can appoint a lawyer or another person to represent the person if it is in the best interests of the person to be represented at the hearing.[428]

A Forensic Order will be reviewed by the MHRT in the following circumstances:[429]

- Periodic review: Forensic Orders are reviewed within six months of an order being made and at least every six months thereafter;[430]
- Applicant review: An applicant, or an interested person for them, can apply for review of an order at any time;[431]
- Tribunal review: The MHRT can review an order at its own initiative;[432]
- Under notice: When there has been a material change in the patient's mental state requiring a change in category from community to inpatient;[433] or
- The Attorney-General, Chief Psychiatrist or the Director of Forensic Disability has requested a review at their own initiative.[434]

Similarly, a Treatment Support Order also has the same criteria for periodic, applicant, tribunal and notice reviews. However, the Attorney-General, Chief Psychiatrist or the Director of Forensic Disability cannot apply for a review of a Treatment Support Order.[435]

Specifically, the MHRT decides:

- whether to confirm or revoke a Forensic Order or Treatment Support Order;

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[420] *Mental Health Act 2016* (Qld) s 439(1).
[421] *Mental Health Act 2016* (Qld) s 487.
[422] *Mental Health Act 2016* (Qld) s 733(3).
[423] *Mental Health Act 2016* (Qld) s 733(3).
[424] *Mental Health Act 2016* (Qld) s 741.
[425] *Mental Health Act 2016* (Qld) s 722.
[426] *Mental Health Act 2016* (Qld) s 739(1).
[427] *Mental Health Act 2016* (Qld) s 739(2).
[428] *Mental Health Act 2016* (Qld) s 740.
[429] *Mental Health Act 2016* (Qld) s 433.
[430] *Mental Health Act 2016* (Qld) s 433(1).
[431] *Mental Health Act 2016* (Qld) ss 433(2)(a) and (b).
[432] *Mental Health Act 2016* (Qld) s 433(3).
[433] *Mental Health Act 2016* (Qld) s 433(4).
[434] *Mental Health Act 2016* (Qld) ss 433(2)(d) and (e).
[435] *Mental Health Act 2016* (Qld) s 465.

- the category of the order (inpatient or community);
- whether the person is to receive any treatment in the community; and,
- whether any other relevant conditions should be included or removed from the person's Forensic Order.[436]

When reviewing a Forensic Order or Treatment Support Order, the MHRT must have regard to:

- the circumstances of the person;
- the nature of the 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 Mental Health Court.[437]

The MHRT must confirm an order if it considers that it is necessary because of the person's mental condition and/or to protect the safety of the community, including from the risk of serious harm to people or property.[438]

Reviews associated with fitness for trial are conducted at least every three months for the first year, and then at least every six months thereafter.[439] Reviews can also be conducted on application by the person, an interested individual for the person, the Chief Psychiatrist, or the Director of Forensic Disability.[440]

In deciding fitness for trial, the MHRT must consider the person's mental state.[441] If the tribunal decides that the person is unfit for trial, the Director of Public Prosecutions must make a decision as to whether the criminal proceedings against the person should be discontinued.[442] If the Director of Public Prosecutions does not decide to discontinue the proceedings, then the proceedings are automatically discontinued after seven years for offences with a maximum penalty of life imprisonment, or three years for all other offences, from the date the initial finding of unfitness for trial was made.[443]

For reviews of Forensic Orders (Criminal Code), the person themselves, the Attorney-General, the Chief Psychiatrist, the Director of Forensic Disability, and the administrator of the AMHS are entitled to be given notice of the hearing.[444] The MHRT will decide at the hearing whether the Forensic Order is to be changed into a Forensic Order (Mental Health), unless the person has only an intellectual disability without a mental illness, or has both but does not require treatment and care for the mental illness, in which case a Forensic Order (Disability) may be made.[445]

[436] *Mental Health Act 2016* (Qld) ss 441, 444, 445, 446, 447, 472, 475, 476, 477, 478.
[437] *Mental Health Act 2016* (Qld) ss 432, 464.
[438] *Mental Health Act 2016* (Qld) ss 442(1), 473(1).
[439] *Mental Health Act 2016* (Qld) s 486(1).
[440] *Mental Health Act 2016* (Qld) s 486(2).
[441] *Mental Health Act 2016* (Qld) s 488.
[442] *Mental Health Act 2016* (Qld) s 490.
[443] *Mental Health Act 2016* (Qld) s 491.
[444] *Mental Health Act 2016* (Qld) s 460.
[445] *Mental Health Act 2016* (Qld) s 462.