NSW Council for Intellectual Disability

www.nswcid.org.au

People with intellectual disability and contact with the justice system, at risk lifestyles or mental disorders

Submission to Productivity Commission on Disability Care and Support – Draft Report

Focus of this submission

We have looked at the draft report with a particular focus on some issues in which we have considerable experience and on which there may not be a substantial number of other submissions. These are issues that arise for people with intellectual disability who:

- come into contact with the criminal law and/or
- lead superficially independent but at risk lifestyles and/or
- have a dual diagnosis with a mental disorder.

Our experience includes our coproduction with the Intellectual Disability Rights Service of *The Framework Report – appropriate community services in NSW for offenders with intellectual disability and those at risk of offending* (2001). This report is available at www.idrs.org.au The report provides a detailed analysis of the service needs of its target group who often have risky lifestyles, mental disorders and problems with drugs and alcohol. Since we wrote that report, we have been very active in advocating for action on it; significant progress has occurred but the NSW service system remains a very long way from properly meeting the needs of offenders with intellectual disability. Most other states and territories are probably further behind.

The complex interplay of disabilities and diagnoses of offenders with intellectual disability has been confirmed by current research led by Professor Eileen Baldry at UNSW (and in which we have been a partner investigator). See attached powerpoints slides. The Commission may find it very valuable to consult Professor Baldry, whose details can be provided upon request.

Eligibility

Group 3d (people with disabilities and "large identifiable benefits from support that would otherwise not be realised") needs to cover people with a **borderline** intellectual disability who have high support needs flowing from the intellectual disability and factors such as those in the above dot points. For example, there is a significant number of such people who have borderline intellectual disability, mental disorders such as a personality disorder and problems with alcohol and other drugs. Some also have an acquired brain injury as well as a pre-existing borderline intellectual disability.

See the Baldry data and *The Framework Report* (section 2.1 and 2.2 and the case studies of Sean and Tony at pages 18 and 30).

Engagement
The Commission has rightly identified the need for homeless outreach services to be provided by the NDIS. However, the need for these services is part of a broader problem of assisting people who are isolated from services to see the value of accepting services.

There are many people who, at least initially, will not see the benefit of support services. The NDIS should recognise the need for a skilled worker proactively to spend a lot of time engaging with such people and help them develop their understanding of their needs and willingness to accept help. (In many cases this would be needed in addition to advocacy). Sometimes, if voluntary engagement cannot be achieved, guardianship might be needed, with the guardian then to pursue services on behalf of the person; however, this should be the backstop rather than the norm.

At least in the period in which engagement is occurring and a person is becoming used to accepting services, any copayment would be counter-productive to engagement.

Will individual needs be covered?
People in the above groups often have complex support needs that are very different to what disability services are used to. Care is needed to ensure that these support needs will be covered by both the needs assessment tool and the range of supports to be funded.

People will often need assistance in dealing with mainstream services which are reluctant to assist them or lack the skills or time to provide assistance that the person understands and otherwise meets the person's needs. This is a consistent message that we hear from users of our information service ASK CID.

Practical examples of services that people covered by this submission may need include:

- Mentoring services – A key problem is commonly the lack of positive role models in a person's life from whom the person can gradually learn by experience and example qualities such as reliability and integrity in relationships.
- Support to re-establish and maintain fractured relationships with family.
- Support in dealing with the criminal justice system, including when dealing with the police and court system as an alleged offender or a victim of crime. Note the existing role of the Criminal Justice Support Network at the Intellectual Disability Rights Service; the CJSN currently facilitates this support in some parts of NSW.
- Support to obtain appropriate health services and follow through on advice from health services in relation to healthy lifestyles and treatment of particular conditions. For example, drug services tend to be reluctant to accept people with intellectual disability and to lack the expertise and time to provide adequate programs. A person may then need strong disability support to obtain drug services, encourage and assist a person to attend appointments, facilitate communication between the person and the drug professional and assist the person to retain what is learnt in a counselling session and apply it in the person's everyday life.
- Support in dealing with the public housing system so as to obtain a tenancy, meet tenancy obligations and deal with problems that may arise dealing with neighbours and the public housing authority.

Also, some people's needs fluctuate greatly and unpredictably with mental state, personal crises etc; the NDIS needs to be structured to respond quickly and flexibly to these fluctuations.

People will often need crisis support in a situation in which the person's behaviour deteriorates and he or she is at risk of trouble with the law or self neglect or self harm. This may include having a suitable support worker available after hours if the person is feeling very anxious about something. It may include access to short-term emergency housing if the person's accommodation suddenly has broken down.

The NDIS needs to be responsive to the racial and cultural backgrounds of individuals. Many Indigenous people have the problems focused on by this submission. The NDIS then needs to be responsive to factors such as the reluctance to label people as having a disability in Indigenous communities and the need to look at an individual's needs within a broad community context. See Simpson and Sotiri (2004), *Criminal Justice and Indigenous People with Cognitive Disabilities,* at http://www.beyondbars.org.au/links.htm

Needs assessment tools

The needs of the people covered by this submission do not tend to be well identified by common assessment tools. For example, the SNAP is grossly inadequate for this purpose. We are not aware of any assessment tool that we could recommend for these groups. An adequate assessment may often require a combination of tools or, at least, the "least inappropriate" tool to be complemented by input from the person and their family/advocate and professional judgement by the assessor.

Given the Commission's welcome proposal that people with intellectual disability would be inherently eligible for services under the NDIS, there may need to be a recognised test of adaptive functioning to accompany a test of intellectual functioning to show that a person has an intellectual disability. Adaptive functioning tests such as the ABAS-II would also provide valuable information in relation to a person's support needs.

In relation to needs assessment of people who have contact with the justice system, the Commission could valuably consult the Community Justice Program of Ageing Disability and Home Care in the Department of Family and Community Services NSW - Natalie Marmone, Manager and the similar program in Victoria. (Contact details can be provided upon request).

Demarcation with mental health services

The needs of people with intellectual disability will often be very much increased by a coexisting mental disorder, including psychoses and mood disorders, personality disorders and substance use disorders. There are major impediments to people with intellectual disability accessing appropriate mental health services; see the accompanying paper, *The Place of People with Intellectual Disability in Mental Health Reform*. Similar difficulties arise in relation to access to alcohol and other drug services. For people with personality disorders, there is minimal coverage by mental health services for people with or without an intellectual disability.

Whilst some needs can be identified as clearly health needs, for example access to assessment and treatment by a psychiatrist, many other needs of people with a dual diagnosis cannot neatly be defined as mental health needs as opposed to intellectual disability needs. Many needs arise from the interplay of the impact of the intellectual disability and the mental disorder or disorders.

In view of the above factors, the NDIS needs to cover all of the needs of a person with intellectual disability except for those which are clearly needs for clinical health services.

Workforce issues

We are very sceptical about whether the market will lead to adequate training of staff to work with people who have challenging needs, in particular the groups covered by this submission. The NDIS needs to include a workforce development strategy with a particular focus on the current gaps in workforce skills. There are currently very limited workforce skills in working with the groups subject of this submission.

See The Framework Report section 4.19 for the kind of skills required to work with offenders with intellectual disability.

For any further information regarding this submission please contact Jim Simpson or Aine Healy.

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National & NSW Councils for Intellectual Disability

Australian Association of Developmental Disability Medicine

THE PLACE OF PEOPLE WITH INTELLECTUAL DISABILITY IN MENTAL HEALTH REFORM

As amended, March 2011

OUR PROPOSITION

People who have both an intellectual disability and a mental illness need to be included from the start in mental health reform. They currently have very poor access to appropriate mental health services.

Government needs to address this problem, in particular by funding specialised intellectual disability mental health psychiatrists and nurses who can act as a consultancy, training and research adjunct to mainstream mental health services.

Since the last week of February 2011, this proposition has been endorsed by numerous leading individuals and organisations in the mental health sector and peak disability groups. See the list starting on page 6. The endorsers include:

Patrick McGorry AO

Meg Smith OAM
President, Mental Health Association NSW

Tony Fowke AM
President, World Federation for Mental Health & Mental Health Carers Arafmi Australia

Philip Mitchell AM
Head of Psychiatry, UNSW

Monsignor David Cappo
Commissioner for Social Inclusion, SA

Anne Deveson AO
Advocate & co-founder SANE Australia

Australasian Society for Psychiatric Research executive committee

Australian Association of Social Workers

Australian College of Mental Health Nurses

Australian Council of Social Service

Australian Infant, Child, Adolescent and Family Mental Health Association

Mental Health Foundation Australia

Royal Australian & New Zealand College of Psychiatrists

The Public Guardians/Advocates of Victoria, NSW, Queensland, South Australia & Tasmania

THE CASE FOR THE PROPOSITION

> **"There is an urgent need for academic research, increased clinical expertise and substantial increased resources in the much neglected area of dual disability" [mental illness and intellectual disability].**
> **Burdekin 1993**

The need

Little has changed since the Burdekin report.

There are over 300,000 people with intellectual disability in Australia. While an intellectual disability is not itself a mental disorder, people with intellectual disability have very high rates of mental disorders. (Einfeld & Tonge 1996a and 1996b; Cooper & others 2007; Morgan & others 2008)

Diagnosis is very challenging. Many people with intellectual disability have limited verbal communication and experience an atypical profile and presentation of mental disorders. It can be very difficult to distinguish to what degree a person's challenging behaviour relates to a mental disorder as opposed to factors such as communication impairments and problems in the person's environment.

The current situation

The mental health needs of people with intellectual disability are poorly met. Australian research shows:

- Very poor access to mental health services for people with intellectual disability and a mental illness. In a ten year period, only 10% of adults with intellectual disability and a mental disorder had received mental health intervention (Einfeld & Tonge 1996b; Einfeld & others 2006). By contrast, Slade & others (2009) found that 34.9% of the overall community with mental disorders had received treatment in a twelve month period.
- Psychiatrists and GPs see themselves as inadequately trained to treat mental disorders in people with intellectual disability. Psychiatrists see people with intellectual disability as receiving a poor standard of care. (Cook and Lennox 2000;Lennox and Chaplin 1995; Lennox and Chaplin 1996; Lennox, Diggens and Ugoni 1997;Phillips, Morrison & Davis 2004; Edwards, Lennox & White 2007; Jess & others 2008)

Peter has a mild intellectual disability and lives independently with drop in support. He was referred to the local mental health service by his outreach worker after he stopped attending work and was found in a self neglected state, refusing to get out of bed. The diagnosis given by the mental health service was "behavioural". Peter was deeply depressed.

Psychiatric disorders in people with intellectual disability are frequently not recognised or are misdiagnosed and inappropriately treated. (Reiss 1990; Torr 1999) Specifically, in a Melbourne study, only 20% of people with depression or bipolar disorder were receiving anti-depressants or mood stabilisers while 80% of this group were receiving antipsychotic medication. (Torr 1999)

In Australia, there are only isolated pockets of expertise in intellectual disability mental health. There is not one staff specialist position devoted to this need. There is one recently established chair at the University of NSW. A number of advanced traineeships are available through the NSW Institute of Psychiatry, but, with the lack of a career path, it has proved difficult to recruit trainees.

By contrast, in England, there is a well developed specialty in intellectual disability mental health.

Maria was middle aged and living in a disability services group home. She had previously lived an isolated existence with her mother.

Over six months, Maria had increasingly agitated and disturbed behaviour, delusional thoughts and weight loss of 20 kg. Residential workers took her to the local emergency department on a number of occasions but no mental disorder was diagnosed. Finally, she saw a psychiatrist with expertise in intellectual disability mental health, who diagnosed psychotic depression.

Maria was then an inpatient of a mental health unit for three months. A registrar decided her diagnosis was autism spectrum disorder and she was treated with high dose benzodiazepines and a low dose atypical antipsychotic. Outpatient follow up was promised but did not occur.

A month after discharge, group home staff took Maria to the local emergency department. She was dehydrated and no longer passing urine. She received intravenous rehydration and the plan was for discharge back to the group home. Her carers refused to take her home. She was then readmitted to the psychiatric inpatient unit, finally properly treated and recovered.

The current situation results in great human and financial cost to people with intellectual disability and their families, as well as considerable financial cost to the health, social security and disability service systems.

What people with intellectual disability need

- People with intellectual disability and a mental disorder need holistic support from mental health, disability and other relevant human services.
- Where there are grounds to think that a person with intellectual disability needs psychiatric treatment, the person needs access to health professionals with the skills required for accurate diagnosis and optimal treatment.

What we seek from government in mental health reform

Our priorities for action in mental health reform are:

1. Specific government funding for a network of specialist intellectual disability mental health psychiatrists, nurses, psychologists and other professionals. These professionals would act as a consultancy, training and research adjunct to mainstream mental health services. This would include clinical services in local areas and education centres of excellence linked to universities.

2. Enhanced joint planning by disability services and mental health services including development of a mandated shared case coordination capacity where intellectual disability and mental disorder co-exist. The psychologists, social workers and other professionals in disability services have a key role in working with mental health professionals to ensure a holistic response to mental disorders.

3. Mandated training in intellectual disability mental health to minimum standards for front-line and other professional staff in disability services and mental health services.

Funding of specialist intellectual disability mental health professionals is vital to the success of the joint planning and training of mental health and disability staff.

Action on the above priorities would result in:

- Improved access to mental health care for people with intellectual disability,
- Improved mental health treatment and holistic support of people with intellectual disability and a mental disorder,
- Improved health and quality of life for people with intellectual disability and a mental disorder, and
- More appropriate use of psychotropic medication with people with intellectual disability.

We now seek from the Commonwealth leadership of national action on the mental health of people with intellectual disability, in particular the funding of specialist intellectual disability mental health psychiatrists and nurses. This is the standout current gap in the health and disability professionals needed for intellectual disability mental health.

The focus of this paper is on mental health reform, rather than disability support needs such as supported accommodation and support with community participation and skills development. Disability support needs are the responsibility of the disability service system. People with intellectual disability and mental disorders also need to be squarely included in the movement towards ongoing expansion and reform of that system.

Nick is aged 14 and has a severe intellectual disability, autism and cyclic mood disorder. He needs 1:1 care which is provided by his family. He easily becomes distressed and then is aggressive and self injurious. His father often has to sleep with him and gets minimal sleep. The family is under ongoing stress but determined to provide the support their son needs. Nick and his family have considerable support from disability services and an intellectual disability health team including a psychiatrist who regularly reviews Nick's mental health and medication. Without this support, it is likely the family would not be able to cope with Nick's very high and complex needs.

The context of "stark health inequalities"

The National Health and Hospitals Reform Commission reported in 2009 that people with intellectual disability face "stark health inequalities". This is the case for both physical and mental health. In 2009, we wrote our *Position Statement on the Health of People with Intellectual Disability*. That position statement calls for

1. All health care planning to include specific consideration of how it will meet the needs of people with intellectual disability.
2. The funding of a national network of health services specialising in the health care of people with intellectual disability. These services would be a consultancy and training resource to the mainstream health system.

Our position statement has been endorsed by

- 36 national organisations including numerous leading groups across the disability and health sectors.
- 165 state and local organisations
- 130 eminent individuals.

The position statement and list of endorsers is at
http://www.nswcid.org.au/standard-english/se-pages/health.html

We have now moved to seeking endorsements of our specific proposition on the mental health needs of people with intellectual disability. This proposition is in line with the National Disability Strategy:

The National Disability Strategy

Australia took a major role in the development of the UN Convention on the Rights of Persons with Disabilities which was finalised in 2006. Article 25 of the Convention states that people with disabilities have a right to "the highest attainable standard of health", including equal access to mainstream health services and provision of specialised disability health services where needed.

On 14 February 2011, the Council of Australian Governments adopted the National Disability Strategy which commits all government to six key outcomes, one of which is:

> People with disability attain highest possible health and wellbeing outcomes throughout their lives.

To give effect to this outcome, **COAG has specified policy directions and action areas including that expansion of national action on mental health should "explicitly meet the needs of people with disability".**

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Julian Trollor, Chair in Intellectual Disability Mental Health, UNSW
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ENDORSERS OF OUR PROPOSITION

Individuals

Patrick McGorry AO
Australian of the Year 2010 & Director, Orygen Youth Health

Maria Tomasic
President, Royal Australian and New Zealand College of Psychiatrists &
Consultant Psychiatrist, Centre for Disability Health, Adelaide

Meg Smith OAM
President, Mental Health Association NSW &
Associate Professor, Adjunct, Social Justice & Social Change Centre
University of Western Sydney

Tony Fowke AM
President, World Federation for Mental Health & Mental Health Carers Arafmi Australia

Monsignor David Cappo
Commissioner for Social Inclusion, SA

Gordon Parker AO
Executive Director, Black Dog Institute

Terry Carney
Professor of Law, University of Sydney &
President 2005-2007, International Academy of Law and Mental Health

Anne Deveson AO
Advocate & co-founder SANE Australia & Schizophrenia Fellowship NSW

Ian Hickie AM
Executive Director, Brain and Mind Research Institute, University of Sydney

Bruce Tonge
Professor & former Head of Psychology, Psychiatry and Psychological Medicine, Monash University

Ian Everall
Professor & Head of Psychiatry, University of Melbourne

Philip Mitchell AM
Professor & Head, School of Psychiatry, University of New South Wales

Bernhard Baune
Professor & Head of Psychiatry, University of Adelaide

Helen Christensen,
Professor & Director, Centre for Mental Health Research, ANU

Allan Fels AO

John Mendoza
Director, Connetica & Adjunct Professor, Health Science

Jill Gordon
President, Australian College of Psychological Medicine

Toby Hall
Chief Executive Officer, Mission Australia

Sally Sinclair
CEO, National Employment Services Association

Andrew Fuller
Clinical Psychologist & Fellow, Departments of Psychiatry and Learning and Educational Development, University of Melbourne

Alan Robinson
Parent advocate, WA

Eileen Baldry
Professor of Criminology, University of New South Wales

Duncan Chappell
Professor of Criminology, University of Sydney &
Former President, Mental Health Review Tribunal NSW

John Brayley
Public Advocate, South Australia

Colleen Pearce
Public Advocate Victoria

Graeme Smith
Public Guardian NSW

Lisa Warner
Public Guardian Tasmania

Dianne Pendergast
Adult Guardian Queensland

Martin Laverty
CEO, Catholic Health Australia &
Chair, Lorna Hodgkinson Sunshine Home

Ros Montague
Director, NSW Institute of Psychiatry

James Ogloff
Director, Centre for Forensic Behavioural Science, Monash University

Kaarin Anstey
Director, Ageing Research Unit, ANU

Keith McVilly
Associate Professor in psychology
Deakin University

Sharon Naismith
Director, Clinical Research Unit, Brain and Mind Research Institute, University of Sydney

Stan Alchin OAM
Former Director of Nursing, Rozelle and Gladesville Hospitals &
Former President, Aftercare

Stewart Einfeld
Professor of Mental Health, University of Sydney

Greg O'Brien
Emeritus Professor of Developmental Psychiatry, Northumbria University, former Associate Dean, Royal College of Psychiatrists

Jenny Torr
Chair of the RANZCP Special Interest Group in Intellectual Disability & Director of Mental Health, Centre for Developmental Disability Health Victoria

Jenny Curran
Senior Consultant Psychiatrist in Child & Youth Intellectual Disability Psychiatry, Disability Services, South Australia

Bill Glaser
Consultant Psychiatrist to the Statewide Forensic Services, Disability Services, Victoria

Julian Trollor
Chair in Intellectual Disability Mental Health, UNSW

David Dossetor
Director for Mental Health, Sydney Children's Hospital Network & Child Psychiatrist with a special interest in intellectual disability and Autism

National organisations

Australasian Society for Intellectual Disability (formerly Australasian Society for the Study of Intellectual Disability)

Australasian Society for Psychiatric Research executive committee

Australian Association of Social Workers

Australian College of Mental Health Nurses

Australian Council of Social Service

Australian Infant, Child, Adolescent and Family Mental Health Association

Australian Medical Association

Carers Australia

Community Collaboration Committee, Royal Australian & New Zealand College of Psychiatrists

Mental Health Carers Arafmi Australia

Mental Health Foundation Australia

Mission Australia

Multicultural Mental Health Australia

National Disability Services

National Rural Health Alliance

Neami

Professional Association of Nurses in Developmental Disability Australia

Royal Australian & New Zealand College of Psychiatrists

SANE Australia

Other organisations

ACT Mental Health Consumer Network

Aftercare NSW

Arafmi Mental Health Carers and Friends Association (WA)

Council of Social Service of NSW NCOSS

Mental Health Association NSW

Mental Health Council of Tasmania

NSW Consumer Advisory Group – Mental Health

List of endorsers as at 18 May 2011

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MHDCD in the CJS
Current Developments

Presenter: Associate Professor Eileen Baldry

Research Team: Eileen Baldry, Melissa Clarence, Leanne Dowse and Phillip Snoyman

ARC Linkage Project

Presentation Outline

- Background to MHDCD in CJS
- Project Cohort
- Findings
- Conclusions

Background

- People with MHDCD over-represented in CJS
- Post-release high rates of homelessness, unemployment, low levels of family support and more likely to return to prison quickly.
- Interventions hampered by lack of overall and longitudinal system impacts
- Need for pathway understanding
- Study designed to integrate criminal justice and human service data.

The Study

- Create criminal justice life course histories, highlighting points of agency interactions, diversion and support
- Identify gaps in policy, protocols and service delivery and areas of improvement for Criminal Justice and Human Service agencies
- Describe individual and group experiences
- Investigate worker beliefs about & attitudes towards people with MHD&CD

The Study - a new approach

- **Method:**
  - Cohort:Prisoner Health Survey & DCS Disability database
  - Data drawn from:
    - The Centre for Health Research in CJS Health NSW
    - NSW Department of Corrective Services
    - BOCSAR
    - NSW Police
    - Juvenile Justice
    - Housing NSW
    - ADHC
    - Legal Aid NSW
    - NSW Health (mortality, pharma., admissions) (on way)
    - Community Services (on way)

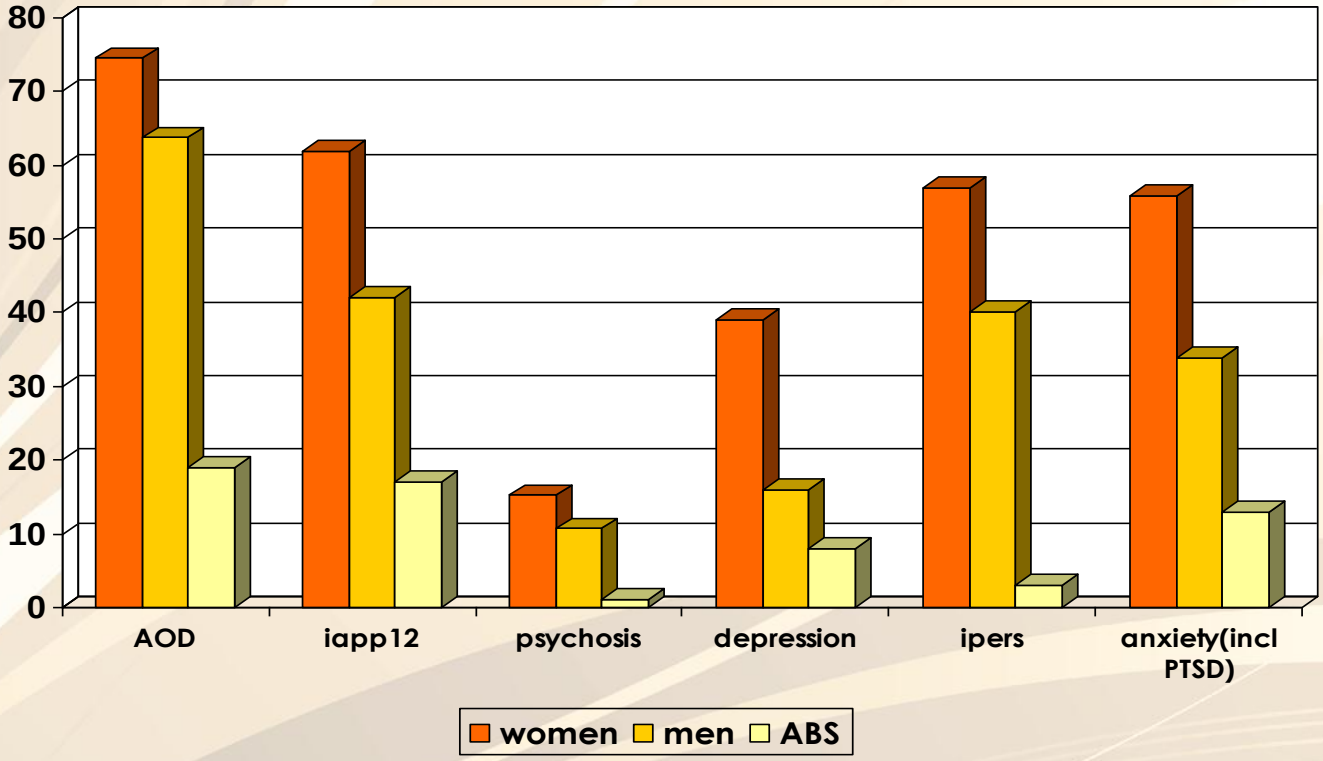
Creating the Dataset

- Problem of aliases & different data gathering & entry forms
- All datasets from all agencies matched then uploaded onto SQL server
- Allows relational merging of information

The problem

The Mental State Of Women And Men In NSW Prisons

(adapted by McComish from Butler & Alnutt 2003)



NB 2009 NSW Inmate Health Survey shows significant increase over1998, 2001 & 2009 surveys

MHD 2009 Survey

- Inmates ever been assessed or treated by doctor or psychiatrist for a MH problem increased from 39% in 1996 to 43% in 2001 to 49% in 2009. Due to men's increasing MH problems: 35% in 1996 to 41% in 2001 to 47%; proportion of women remained steady at around 54%.

- Increasing proportion of participants reported ever having been admitted to a psychiatric unit from 13% in 1996 to 14% in 2001 to 16% in 2009. A higher proportion of women (20%) than men (15%) in 2009.
- Source: 2009 NSW Inmate Health Survey: Key Findings Report p:17

Cognitive disability in CJS

- DJJ NSW: sig over-representation of young people with ID; 74% below av. range of intellectual functioning V 25% standardised sample
- Small ID over-rep in Vic & NSW prisons, but larger BID over-rep in NSW prisons
- But UK appears much higher ~1/5 in ID range; av IQ 84 (Hayes et al 2007)

Study Findings to date:

The cohort

Cohort - Summary

- Full Cohort N=2,731
- Intellectual disability N=680
- Borderline cognitive disability N=783
- Mental health N=965
- No MHCD diagnosis N=339
- Substance abuse disorder = 1276
- Women = 11%
- Indigenous Australians = 25%

Cohort cont.

- Mental Health complex – 863
- Cognitive Disability Complex – 982
- Mental Health Only – 102
- Cognitive Disability only – 481
- Personality Disorder/AOD only – 392
- No diagnosis - 339

MHDCD Study: Cohort - detail

- **Intellectual Disability** - IQ in the ID range less than 70
- **Borderline Intellectual Disability** - IQ in the ID range between 70 & 80
- **Mental Health** - any anxiety disorder, affective disorder or psychosis in the previous 12 months
- **Dual diagnosis (a)** -history of mental health problems and an intellectual disability
- **Dual diagnosis (b)** -history of mental health problems and a borderline intellectual disability

MHDCD Study: Cohort - detail

- **Co - occurring disorder (a)** -mental health disorder and a history of substance use
- **Co - occurring disorder (b)** - an intellectual disability and a history of substance use
- **Co - occurring disorder (c)** - borderline intellectual disability and a history of substance use
- **AOD/PD -** any personality disorder or substance use disorder in the previous 12 months and an absence of other category
- **No diagnosis** - no Mental Health or Cognitive disability diagnosis

Cognitive Disability

- **1463 people in the CD cohort (All CD)**
- **680 (46%) in the ID range includes ABI (<70 IQ)**
  - **465 (68%) have multiple diagnoses (Complex)**
  - **215 (32%) have no co-morbidity**
- **783 (54%) in the BID range**
  - **517 (66%) have multiple diagnoses (Complex)**
  - **266 (34%) have no co-morbidity**
- **So ~ 2/3rd of CD group have complex diagnoses**

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Pathways into, through, around, out of and back into CJS

MHDCD Study: Education

- Although prison population in general has low levels of education, diagnosed groups have even lower levels
- Those with some form of CD have the worst levels of education with by far the majority not finishing year 9 school.
- **Clear points of early intervention to prevent contact with the CJS**

MHDCD Study: ADHC

- Of those 680 persons with <70 IQ only 23% were/are ADHC clients
- Of those 156 ADHC clients, 123 (79%) were first diagnosed in prison. So only 33 / 680 had Disability Services prior to their imprisonment.
- Those who became ADHC clients after diagnosis in prison, reduced offending and contact with the CJS significantly
- **Appropriate disability supported housing and services are very beneficial for offenders with ID.**

MHDCD Study: Housing Assistance

- High application rate (~70-80%) vs non-diagnosed (50%) for housing assistance.
- High rate of housing assistance provision (~80-85%)
- But high tenancy failure/termination – frequent imprisonments, behind in rent, unacceptable behaviour
- **Social Housing vital for offenders with MHDCD but requires support**

Patterns of early police and custody episodes

- Those with any diagnosis have significantly earlier age of first police contact, first custody and first conviction than those without a diagnosis.
- Diagnosed group into custody significantly sooner after first police contact than non diagnosed.
- Those with CD significantly earlier contact with police and into custody significantly sooner after first police contact, than those without a CD.
- **Appropriate disability service intervention / support at first police contact could be very beneficial**

MHDCD contact with DJJ

- Significantly higher rate of being Juvenile Justice clients for those with CD complex diagnoses - between 47% & 58% compared with those without a diagnosis, or with MH at ~ 20%.
- **Those with CD complex identifiable at time of JJ contact – early appropriate disability service intervention and support needed**

Legal Aid Service

- Between 96 & 99% of diagnosed groups ever applied to LA; No diagnosis group significantly lower rate (92%)
- ID only & No diagnosis received sig. lower LA ph. advice than other groups
- No diagnosis group significantly lower rate of ever legal aid case than complex groups
- CJ by far the majority of cases but a reasonable number of civil and family court matters as well
- **LA providing high level of service but CD complex people not staying out of prison**

Section 32

- Very low Sec 32 dismissals. For whole cohort's history as adult offenders only 618 Sec 32 dismissals altogether.
  - MH/ID (17%) & MH/BID (14%); only 9% of ID
- **Sec 32 underused as means to manage offenders with MHD, CD & complex diagnoses in the community**

Finalised Court matters

- Those with CD complex diagnoses have the highest rates of finalised matters overall and higher rates each year.
- **These groups suffer particularly from the 'penal ladder' approach taken in NSW – prison clearly does not deter or rehabilitate these offenders – becomes a way of life very early**

Types of Offences

- Theft and road traffic/motor vehicle regulatory offences most common offences (~20% of all groups)
- Justice Offences next common at ~10% across all groups
- ‘Acts intended to cause injury’ common (approx. 10%)
- But CD complex groups more likely to commit public order offences (approx. 10%).
- **Very high rate of lower level offences – many avoidable if community support / supported housing**

Time in custody

- Those with complex diagnoses have sig. more remand episodes but significantly shorter lengths of stay in remand

And

- Sig. higher rates of sentenced episodes in custody but significantly shorter sentence duration

than single or no diagnosis groups

MHDCD Study: Conclusions

- Those with complex diagnoses have significantly higher offences, contacts with police & JJ, convictions, imprisonments than single and non-diagnosis, both early and ongoing into 40s & 50s
- Persons in these groups seem locked into **cycling around in a liminal, marginalised community/criminal justice space**

Ways forward

- ADHC's Community Justice Program for persistent offenders with ID has good initial outcomes indicating appropriate disability supported accommodation is beneficial
- Clear & Urgent need for range of early school interventions; juvenile and adult disability supported housing & services for those with complex diagnoses. Must have workers trained to work with complex needs persons.

Ways forward

The findings provide strong support for:

- The Public Purpose grant to Legal Aid & IDRS to enhance legal representation for Sec 32 for those with ID. Meets conclusions drawn in this study: eg need for resources, education & links to support workers for lawyers; SWers at LA to assist accessing services.