



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.

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