# PART 1
# INTRODUCTION

## Chapter 1

# The Project

## 1.1 Where does this project come from?

Since *The Missing Services* report of the Wran government in 1985[1], it has been well documented that people with intellectual disabilities do not get the services that they need to help them keep out of trouble with the law.

This was reaffirmed by the Law Reform Commission in its 1996 Report 80, *People with an Intellectual Disability and the Criminal Justice System.* In chapters 10 and 11 of its report, the Commission:

- States that the lack of services to people with intellectual disabilities involved in the criminal justice system has been "a constant theme in earlier reports and in submissions" to the Commission. In particular, submissions and recent reports had pointed out that:
  - There were not enough preventative services.
  - There were not enough programs to address offending behaviour.
  - There was no alternative to prison for people who required secure or supervised accommodation.
  - There was not enough support to enable people with intellectual disabilities to have normal access to bail, parole and non-custodial sentencing options.[2]
- Acknowledges concerns that prisons "fill the gap" caused by the lack of services in the community, contributing to the established over-representation of people with an intellectual disability in prison.[3]
- Notes that the existing "crisis based and ad hoc" approach by government agencies to meeting the needs of people with intellectual disabilities who are in contact with the criminal justice system "results in a violation of the human rights of many people with an intellectual disability".[4]
- Concludes that, if major gaps in services were filled, many people with an intellectual disability would not enter the criminal justice system and many others would not reoffend.[5]
- Recommends the development of a comprehensive interdepartmental policy and procedural framework designed to protect the rights and needs of people with an intellectual disability, including through appropriate service provision. This would include a case management system. The Commission describes these as "key recommendations for the inquiry as a whole".[6]
- Recommends the establishment, with an appropriate legislative base, of secure accommodation options outside prison for some offenders and alleged offenders with an intellectual disability.[7]

1 Departments of Corrective Services and Youth and Community Services *The Missing Services*, Report of the Inter-departmental Committee on Intellectually Handicapped Adult Offenders in NSW (1985).

2 Paras 11.1-11.2.

3 Para 11.1.

4 Para 10.9.

5 Para 11.44.

6 Recommendations 48 and 54, and page 359.

7 Recommendation 57.

- Emphasises that its recommendations are a complementary package, and that, "legislative amendments without the provision of necessary ….services will not overcome the difficulties faced by people with an intellectual disability in the criminal justice system".[8]

Similarly, the Standing Committee on Law and Justice of the NSW Legislative Council recently concluded that people with intellectual disabilities are overrepresented in the criminal justice system. The Committee saw this as flowing from the interplay of the vulnerability of people with intellectual disabilities and the lack of social supports for them.[9] The Committee's chairman, the Hon Ron Dyer, elaborated on this in a journal article. He pointed to the "failure of government agencies to respond to the challenge of supporting people with often difficult behaviour in the community". He saw difficulties in the adequacy of funding, in the support provided to individuals and in coordination between criminal justice and human services agencies.[10]

This project was funded by the Ageing and Disability Department (now Department of Ageing, Disability and Home Care) and the Law and Justice Foundation of NSW to develop a framework for the community services that are needed for this group. The funding was granted to the Intellectual Disability Rights Service and the NSW Council for Intellectual Disability who auspiced the project. These organisations engaged Jim Simpson, Meredith Martin and Jenny Green to carry out the project. The consultants have wideranging experience in intellectual disability and justice system issues.

The consultants were to develop a report setting out a proposed legal, administrative and policy framework for the provision of accommodation, case management, clinical and related services to meet the needs of offenders with an intellectual disability. The project was to include a strong preventative approach aimed at avoiding people becoming offenders or repeat offenders.

The Standing Committee on Law and Justice endorsed the importance of the project[11].

## 1.2 Process of the project

The main steps in the project were:

1. Identification of the existing service system for provision of services that are relevant to the target group. This process included consultation with numerous agencies and studying literature about the existing system.
2. Consultation with a wide range of experienced stakeholders about the characteristics and needs of the target group and barriers to appropriate service provision.
3. An international literature review including existing service provision models.
4. Intensively looking at a sample group of offenders with the assistance of a clinical issues group with diverse experience.
5. Consultation on an options paper. This paper included preliminary conclusions in relation to the needs of the target group, the inadequacies of the existing service framework and options for remedying this situation. Consultation occurred with various key stakeholders, with the clinical issues group and through a forum for community stakeholders.

The methodology used for steps 2-4 above is outlined at Chapter 7.1.

The project had a reference group including representatives of eleven government agencies and four community representatives. This group provided advice on the process of the project and on drafts of documents including the draft report. This approach allowed the accuracy of material to be

8 Para 1.31.
9 *First Report of the Inquiry into Crime Prevention through Social Support* (1999) para 8.4.
10 R Dyer "Disability should not be a sentence" (August/September 2000) *Access* 9.
11 *First Report of the Inquiry into Crime Prevention through Social Support* (1999) para 8.6.2.1.

checked by relevant players. There was a high degree of cohesion in the perspectives of reference group members.

The project was not an empirical research study. However, the above approaches harnessed the knowledge and experience of the various agencies and a range of individuals who have grappled with issues relating the target group over many years. Interstate and international expertise was studied. Looking intensively at a sample group and speaking to members of this group directly gathered the experience and views of members of the target group themselves. Previous studies, in particular Report 80 of the Law Reform Commission, were another valuable reference. The consultants and project managers finally had their own substantial experience with the target group.

The report's conclusions about the needs of the target group, the extent to which those needs are being met, and the action required to remedy this situation flow from the combination of these inputs.

## 1.3 Nexus with government

The project was linked to the NSW Government through its funding from ADD (now DADHC) and through the reference group. The consultants and auspice groups also briefed senior bureaucrats, various relevant ministers and their representatives as the project progressed. Feedback in these briefings was a further valuable input to the project.

The project sought to dovetail with various current initiatives of the Government including:

- The Disability Policy Framework with its aim of ensuring that the services of all government agencies are appropriate for people with disabilities.
- The Disability Reform Directions of 2000. See Chapter 3.3.
- The Families First Program which is focused on early assistance of vulnerable families.
- The Children and Young People (Care and Protection) Act 1998 with its emphases on prevention and early intervention, and cooperation between agencies, to address child protection and related issues.
- The Wards Project of the Departments of Community Services and Juvenile Justice which also calls for prevention and early intervention and cooperation between agencies, plus improvement in casework and assessment by DoCS and Juvenile Justice.
- Initiatives of DoCS disability services and Corrective Services to better meet the needs of offenders with intellectual disabilities.
- The Service Access System of DADHC.

## 1.4 Issues of cost

In Report 80, the Law Reform Commission concluded that the cost to government of properly meeting the needs of the target group would be recovered in the long term because:

- There would be a reduction of recidivism and therefore in expenditure on prisons and on processing people through the legal system.
- There would be less wasteful duplication of services.
- And less money and time would be spent on trying to find services for members of the target group.[12]

See Chapter 8.4 for overseas evidence that appropriate service provision can have a major effect on recidivism.

12 Para 10.19.

Examples of potential savings are:
- The annual cost of imprisonment in 1996-97 ranged from $44,040 to $73,020 per prisoner, with the latter figure being the cost in the special unit for the target group at Long Bay[13].
- The average daily cost to the government of a prosecution in the District or Supreme Court well exceeds $10,000. This includes $5,600 court cost, $3,633 for the Director of Public Prosecutions and $1,268 for the Legal Aid Commission[14].

There are also the costs of police investigations of crimes and attending court, probation and parole, victims' compensation, and duplicative and ineffective responses to the needs of the target group.

The Police Service emphasises the amount of police time that goes into ineffective responses to the target group and other people with disabilities and "at risk" behaviour. For example, police may spend ten hours with a person while they unsuccessfully seek assistance from human services, and this situation may repeat itself "again and again"; this may leave a town with only one police car available for an entire shift. [15]

There are also the human costs to the victims and the intellectually disabled perpetrators of crime. As the Law Reform Commission pointed out, if there was a better service system, community safety would be considerably enhanced, as would the quality of life of many people with an intellectual disability and their families[16].

Savings could be particularly great if there was an effective system of prevention and early intervention.

At the same time, properly meeting the needs of the target group is a very large task and related to the broader issue of unmet need for community services. It is obviously very important that these issues be resolved.

The 2000/2001 NSW State Budget was very positive for people with disabilities. It included a number of major spending initiatives and enhancements. However, there remain very large areas of unmet need which apply both to the target group and broader groups. As the Standing Committee on Social Issues of the Legislative Council recently concluded:

> The evidence to this inquiry has shown that extended investment in disability services must be maintained over a period of years to redress past neglect and to develop an efficient and equitable disability services system. [17]

Areas of unmet need include the following:
- Accommodation and support placements for people with disabilities.
- Services to provide early assistance to families to avoid child abuse and neglect and family breakdown.
- Assessment and programming in schools, child and family services, and disability services.
- Case management/support coordination in child and family services and disability services.
- Advocacy and mentoring programs for children, young people and people with disabilities.
- Inclusive education for people with disabilities in schools.
- Adult education, training, employment and day services for people with disabilities.

---

13 Figures provided by the Department of Corrective Services.

14 Figures obtained respectively from the Attorney-General's Department, annual report of the Director of Public Prosecutions for 1998/99 and Legal Aid Commission Scale of Fees for Assigned Criminal Indictable Matters.

15 Police Service Comments on Frameworks Project pp 2and 5.

16 Report 80, para 11.42.

17 *A Matter of Priority, Report on Disability Services* (2000) at xi.

There are also major issues of service quality that need to be addressed, including:
- The completion of the process of transition of old style services into conformity with the Disability Services Act 1993. In particular, the Government's twelve year plan to close large residential centres needs to be fully implemented. Many older day programs need assistance to provide services that are more individualised and integrated into the community.
- In the placements and support provided to children and young people who are in State care.

In view of these factors and the current budgetary context in NSW, implementation of the recommendations in this report may need to occur over time. The project has sought to build on existing initiatives where this is practicable.

The project has sought to provide recommendations for priority action that is most needed in the first instance. This action requires a budget allocation which is aimed to be feasible. However, it does require a substantial allocation. See Chapter 5 *Priorities for Action.*

It is important to stress that the proposed framework is needed in full. Accepting that its implementation may need to occur over time is a reluctant acceptance of current budgetary realities.

Chapter 2

# The Target Group

## 2.1 Definition

**The target group is people with an intellectual disability (including borderline) who have been in contact with the criminal or juvenile justice systems or are at risk of such contact.**

This definition was developed in consultation with the Reference Group and other project stakeholders. For the purposes of the project, the underlined expressions are defined as follows:

1. Intellectual Disability – Defined on the basis of the 1983 American Association on Mental Retardation (AAMR) Definition of "mental retardation" and include "borderline". That is, there are three components:
   - Significant sub-average intellectual functioning (2 standard deviations below the mean), including borderline level (ie 71-79 I.Q. range).
   - Existing concurrently with limitations in two or more adaptive skill areas. Based on a score at or below the second percentile of people in the same age and cultural group as measured on a standardised adaptive behaviour scale (eg Vineland).
   - Manifesting itself before age 18 years.

2. Contact with the justice system – This arises where a person is charged with an offence or the police initiate another similar legal process (that is a summons, court attendance notice or youth conference).

3. "At risk" of contact with the justice system – This has two ingredients:
   - Behaviour that could found a charge or similar legal process, or clear indications that such behaviour may occur, and
   - The legal process is reasonably likely because of the severity or frequency of the behaviour, or the reaction to the behaviour by those around the person.[1]

## 2.2 Including borderline intellectual disability

From the start, the project has included borderline intellectual disability. However, the above definition makes it clear that, to be in the project target group, a person in the borderline range on IQ scores must also have the same degree of limitations in adaptive skills required for people with lower IQ scores. The project target group is within the target group of the DSA[2].

Many members of the target group who have IQs in the borderline range have other disabilities as well, in particular psychiatric disabilities[3].

---

1 Further work is required on how decisions should be made about whether to invoke the justice system in response to an alleged offence by a person with an intellectual disability. An important factor in this would be the impact of the intellectual disability on the person's understanding of their action.

2 View confirmed in communication with Dr Tim Griffin, Centre for Developmental Disability Studies.

3 Dr W Glaser submission to the Law Reform Commission Report 80 at 30; S C Hayes and G Craddock *Simply Criminal* (2nd ed, Federation Press, Sydney, 1992) at 40; M Moore and J McGillivray "Offending behaviour and substance abuse amongst people with mild intellectual disability", in A Shaddock and others (eds) *Intellectual Disability and the Law; Contemporary Australian Issues* (Australian Society for the Study of Intellectual Disability, 2000) at 86. In their study, Moore and McGillivray found that 60% of offenders with mild intellectual disabilities reported receiving regular psychiatric treatment compared with 6.7% of non-offenders; however, the 60% figure would include two groups, people with a diagnosed psychiatric condition and people being prescribed psychotropic medication to address challenging behaviour.

The traditional "levels" of intellectual disability (borderline to profound) are based on IQ scores. However, there are various criticisms of assessing disability on this basis and there has been a movement away from over reliance on it in recent decades. The issue of the degree of a person's support needs has taken greater prominence.[4]

A specific difficulty with strict reliance on IQ scores is that it does not well cater for some well recognised developmental disabilities, in particular autism. In various United States jurisdictions, the focus for eligibility for services is on developmental disability rather than intellectual disability.[5]

Disability services often do not see people with borderline intellectual disabilities as part of their responsibility. However, at least within the context of the criminal justice system, many people with borderline intellectual disabilities and clear limitations in adaptive skills do need disability services. Their support needs are often high. They might be less likely to get priority of access to disability services than people with lower IQ scores but they should not be ruled out.

People with borderline disabilities certainly need access to generic services. This report includes a major emphasis on those services improving their capacity to assist members of the target group, including those with borderline disabilities.

## 2.3 Prevalence in the justice system

Determining the size of the target group is extremely difficult. Very limited data is collected by the different agencies and the definition of the target group varies between places where information is gathered. Quantifying those who are at risk of justice system involvement would be particularly challenging.

The national and international literature was surveyed in an attempt to understand the extent of the problem.

It is generally accepted that the incidence of intellectual disability in the general population is somewhere between 1 and 3 percent not including borderline disability.

Before giving the results of prevalence studies and other available data, it is important to note that such data can have methodological limitations, for example in depending on people self reporting particular attributes, in sampling processes and in the tests used to indicate intellectual disability. Data also varies on whether it includes borderline disability. However, the data set out here provides the best indication of prevalence that is available.

In the international literature search, prevalence ranged from 2% to 37%. The Law Reform Commission also summarised a wide range of Australian and overseas estimates, which again varied markedly[6].

At any one time, there are approximately 350 young offenders in detention centres in NSW. A 1987 study by the Department of Family and Community Services was based on Ravens IQ assessments on nearly half of the young people who went into detention in one year. The study found that 2.1% of detainees had IQs below 70 and a further 11.3% were in the borderline range. If one cautiously assumed that only half of the latter group had significant adaptive behaviour deficits, the overall incidence was 7.7%.[7]

---

4 X Wen *The Definition and Prevalence of Intellectual Disability in Australia* (Australian Institute of Health and Welfare, 1997) 4-8.

5 Communication with Anne Langford, Clinical Coordinator, Disability Programs, Department of Corrective Services. Ms Langford conducted a study tour of disability offender services in the USA in 2000.

6 Report 80, Table 1.

7 Department of Family and Community Services *Report of the Working Party on Services for Young Persons with Intellectual Disabilities in the Juvenile Justice System* (1987) 22-23.

Ten years later, Professor Susan Hayes reported a higher prevalence amongst juvenile detainees in NSW, 15.1% mild to moderate intellectual disability and 12.2% borderline. This was based on Kaufman Brief Intelligence Test and the Vineland Adaptive Behaviour Test administered to 139 juveniles.[8]

In 1988, Hayes cited 13% of the NSW prison population as having an intellectual disability (Hayes and McIlwain, 1988)[9]. The 1988 figure included 2.4% with a mild or greater disability and 10.5% borderline. This would suggest that, at any one time, approximately 941 prisoners out of a population of approximately 7300 would be in the target group (175 with at least mild disability, 766 borderline). There would also be a considerable number on non-custodial orders.

There is also a Western Australian study by Jones and Coombes[10] where the prevalence rates varied between prisons in that state from 0-10%, including borderline disability.

In 1992 and 1995, Hayes carried out research at 6 local courts, four country and two city[11]. From this study, she concluded that 23.6% of persons before the courts in NSW had an IQ of less than 70 which placed them in at least the mildly intellectually disabled category. In addition there were 14.1% with a borderline intellectual disability. Of the 88 subjects tested in the Bourke and Brewarrina courts, Hayes said 36% were at least mildly intellectually disabled and a further 20.9% were borderline. 73.9% of this latter group were Aboriginal or Torres Strait Islanders.

It is also worth cautiously noting some numbers of target group members who are currently receiving services or at least attention. In October 2000, the proportion of the gaol population who had come to notice as being in the target group was 1.8%. However, the Department of Corrective Services acknowledges that this is not the full prevalence, stating that identification of intellectual disability amongst prison inmates is extremely difficult.[12]

It is also important to note the high proportion of the NSW gaol population who are Aboriginal or from a non English speaking background. As at 30 June 1999, 16.2% were from a NESB. 16.3% of the gaol population (and 13.64% of those identified with an intellectual disability) were Aboriginal or Torres Strait Islanders[13].

A recent survey was carried out in the Departments of Community Services and Corrective Services and the Office of the Public Guardian. This survey revealed 373 people with intellectual disabilities with criminal justice system involvement who were known to at least two of the three agencies (though not including Probation and Parole). This included 175 clients of DoCS disability services[14].

It is interesting to compare these last figures with Victoria where the Department of Human Services has an established role in providing services to offenders with intellectual disabilities and a statutory obligation to assist any person with a mild or greater intellectual disability[15]. The Department has approximately 500 registered clients with intellectual disabilities who have criminal justice system

8 S Hayes *Developing a Screening Test of Intellectual Disability – Findings from a Study of Juvenile Offenders in NSW* (1998) unpublished.

9 S C Hayes & D McIlwain *The prevalence of intellectual disability in the new South Wales prison population: an empirical study* (Criminology Research Council, Canberra, 1988).

10 G P Jones & K Coombes. *The prevalence of intellectual deficit among the Western Australian prisoner population* (Western Australia Department of Corrective Services 1990).

11 S C Hayes, S.C "Prevalence of intellectual disability in local courts" *(1997) Journal of Intellectual and Developmental Disability* 22(2) 71-85.

12 Communications with Anne Langford and Col Rannard, Department of Corrective Services.

13 Communication with Col Rannard, Department of Corrective Services.

14 M Andersen *People with Intellectual Disability and the Criminal Justice System* (1999) unpublished; communication with M. Andersen.

15 Intellectually Disabled Persons Services Act 1986 ss 8-9.

involvement. Of the 500 clients, 237 were identified as having “serious offending behaviour”. The Department’s specialist Statewide Forensic Service reported providing a service to 99 people with an intellectual disability during a two year period (average 90 clients per month). Of these, there were 66% with a mild, 19% with a moderate and 15% with a borderline intellectual disability.[16]

Having surveyed the literature, the Law Reform Commission found people with intellectual disabilities to be over-represented in the criminal justice system[17]. The Standing Committee on Law and Justice of the Legislative Council has taken the same view and noted that Professor Hayes’ research indicates an increase in the over-representation since 1988[18].

It would be desirable to have more precise information about the prevalence of the target group. However, it is clear that the target group is highly represented in the criminal and juvenile justice systems.

With some qualifications, it is possible to give some indication of the number of people most clearly needing intellectual disability services as opposed to just needing better access to generic services. This is on the basis of the Victorian figures set out above. Extrapolating the figure of 500 to NSW on a comparative population basis[19] would give a figure of approximately 690.

This figure of 690 is a useful starting point for estimating the number of members of the target group who most clearly need specific intellectual disability services. However, it does not include people at risk of justice system contact but who have not yet had actual contact. Nor does it generally include[20]:

- Young people in contact with the juvenile justice system.
- People with borderline intellectual disabilities.

## 2.4 Characteristics

**Personal characteristics -** Australian and international studies identify factors which indicate a risk of offending by a person with an intellectual disability. In the current project, the stakeholder consultations and the case studies also considered this issue. There is a general consensus in the factors that emerge from these sources. There are strong similarities with the general population of offenders.

The Standing Committee on Social Issues’ *Inquiry into Juvenile Justice in NSW*[21] noted the following factors associated with juvenile crime participation by young people in general: unstable accommodation or homelessness; family breakdown and abuse; education difficulties; unemployment; and limited leisure facilities and opportunities. Additional risk factors were also identified as: substance abuse; lack of emotional support; carers who are ill-equipped to manage challenging behaviour; poverty/economic inequality; high visibility to police; low socio-economic status; single parent families; crowded dwellings; neglect; and/or being a member of certain racial minorities[22]. These characteristics were cited for all juveniles. Twelve percent of the sample group studied had an intellectual disability and their characteristics did not differ from the broader group.

---

16 J Tomasina, & F Lambrick *A service model for the assessment, treatment and management of intellectually disabled offenders who commit serious offences* (Statewide Forensic Service, Disability Services, Department of Human Services, Victoria 1996).

17 Report 80, paragraphs 2.5-2.9.

18 *First Report of the Inquiry into Crime Prevention Through Social Support* (1999) para 8.2.

19 Based on the 1996 national census as reported by the Australian Bureau of Statistics.

20 Communication with Frank Lambrick, psychologist, Statewide Forensic Service, Department of Human Services, Victoria.

21 The Standing Committee on Social Issues *Inquiry into Juvenile Justice in NSW* (NSW Parliament, 1992) 31-48, as reported in *Just Solutions-Wards and Juvenile Justice* (Community Services Commission, March 1999) at 24.

22 Community Services Commission *Just Solutions-Wards and Juvenile Justice* (March 1999).

## Steven

Steven is 16 and has a mild intellectual disability and an alcohol problem. His most recent charge of attempted armed robbery was dismissed under Section 32 of the Mental Health (Criminal Procedure) Act. However, he remains under the supervision of Juvenile Justice because of a previous parole order. He states that his first offence was when he was eleven and he drove a stolen car while with friends. He has been incarcerated in Juvenile Detention Centres eight times. Steven says he does not mind being in the detention centre, he likes the activities and the friendly staff. He has often been charged within two days of being released.

Steven lived with his father and brother after his mother left when he was three weeks old. His paternal grandmother also assisted in his upbringing. Steven's father is an alcoholic. His mother maintains irregular contact. Steven attended a special class at both primary and high school. He was suspended many times for disruptive behaviour and eventually left in year 9 aged 15. He has also left home on many occasions as a result of arguments with his father.

Steven's charges are increasing in seriousness, including theft, malicious wounding and attempted-armed robbery. They are all committed with "friends", whom he has known since the special class in primary school. Steven's friends are mostly younger than him and he describes himself as the leader. He says his mates are like a family to him. In fact, a number of the friends are from the one family where drugs are a known problem. Steven often lives with this family and gives them money for drugs. The family has a strong negative influence on Steven. However, he says that it is nice to have a supportive family to go to even though he gets into trouble when he is with them.

On one occasion, Steven lived on a farm run by a non government agency. While there he met another boy from a previous stay in a Juvenile Detention Centre and they "took off". Within two weeks at this placement he was rearrested.

Steven admits to an alcohol problem, which started when he was 15. He says that alcohol is always involved when he commits a crime. He occasionally uses marijuana.

Steven states that DoCS has never been involved in his life. Juvenile Justice is the main agency involved in planning and case coordination. He has attended a violent offenders program run in the community by Juvenile Justice. However, he has not seen a drug and alcohol counsellor, as he has not kept appointments.

It is clearly stated in several court reports that Steven should not be near the family which has been involved in many of his crimes. Steven has expressed concerns about the next planned accommodation because it is near his "friends" and he always meets other kids who are a bad influence on him. Steven states that all he needs is "a good place to live and a good family". He says he wants a foster family, some "loving care and cooking".

In the case studies considered in the present project, most of the factors listed above were noted. However, one particular factor, which seemed to be evident very early in the person's life, was difficulties at school either in basic skills or with behaviour and attendance. There was little evidence that any appropriate strategies had been tried to address these problems. In one case, the intellectual disability was not identified until the young man was 15 and could leave school. Five of the eleven individuals in the case studies had been excluded from school due to their behaviour. It was surprising how long this had been a problem, often since pre school. There was a general lack of understanding of the significance of the problem. Youths were not referred for appropriate assessment prior to being excluded.

The issues of suspension and expulsion were also raised strongly in the project's consultation with stakeholders, as were broader issues about the inadequacy of services for early action to address problems of the target group.

In summary, for juveniles, it is the following factors rather than the presence of an intellectual disability which indicated a predisposition to offending behaviour:
- unstable, inappropriate accommodation placements,
- problematic family background,
- high support needs arising from factors such as drug use,
- history of poor educational experience and achievement, and
- unresolved behavioural problems.

In the adult offender population, Hayes and Craddock[23] describe prisoners with an intellectual disability in Australia as follows:

> The average age tends to be in the 20s; unemployment is the norm, and those who are employed have low status jobs; very few received schooling after the age of 16; most are single; Aborigines are over represented; alcohol abuse is prevalent and related to the offence; severe deficits in social and adaptive skills are present, particularly in the area of communication and social interactive skills; there is a high prevalence of multiple problems, such as psychiatric history, behaviour disorder, sensory deficit, or communication problem.

A Danish study[24] concluded that offending behaviour was predicted by a history of early institutionalisation, having disabled or divorced parents of low socio-economic status, and behaviour disorder of the social aggressive type. Offending behaviour was not predicted by factors often associated with an intellectual disability such as epilepsy.

The Developmentally Disabled Offenders Program, New Jersey[25] gives the following social profiles of their clients:
- 20% had graduated from High School.
- 14% were employed.
- 29% had any recreational activities.
- 43% had a close friend.
- 77% had a mild intellectual disability, 17% borderline, and
- 94% were male.

The Law Reform Commission noted some factors which affect and perhaps increase the shift into the criminal justice system of people with an intellectual disability:

> Their background, which often includes alcoholism and an ensuing sense of failure, may make people with intellectual disability particularly susceptible to exploitation and challenging behaviour. The inappropriate behaviour and crime may often be seen as a symptom of a deficit in the knowledge, skills and experience necessary for independent living.[26]

A list of factors common in the backgrounds of child and adolescent sex offenders has been identified by Hudson, Nankervis, Smith and Phillips[27] (1999). However, the authors emphasised that the mere presence of these factors does not mean that the child will become a sex offender. They are "signposts" which should alert families, carers and service providers to the need for early intervention. Some of the notable risk indicators for all sex offenders (that is, those with and without an intellectual disability) included: a background of family dysfunction, including physical, sexual, and emotional abuse; the onset of sex offending behaviour in early childhood, sometimes as young as 4 or 5 years; deficits in social skills and school adjustment; and high levels of parental punishment.

---

23 S C Hayes and G Craddock *Simply Criminal* (2nd ed, Federation Press, Sydney, 1992) at 40.

24 J Lund "Mentally retarded criminal offenders in Denmark" (1990) *British Journal of Psychiatry*, 156 cited in Hayes and Craddock at 40.

25 Developmentally Disabled Offenders Program (DDOP) Arc of New Jersey (S Lustig, Director), http://www.arcnj.org.

26 Report 80 at 31.

27 A Hudson, K Nankervis, D Smith, and A Phillips *Prevention of sexual offending amongst adolescents with an intellectual disability: Identifying the risks*. (Final Report, Department of Psychology and Intellectual Disability Studies, RMIT University 1999).

In the authors' own study, the following characteristics of adolescent sex offenders with an intellectual disability were noted:

- Most were educated in mainstream schools or a combination of mainstream and special schools.
- A significant number had a background of family dysfunction and abuse, with the majority of physical and sexual abuse committed by the natural father.
- The majority committed multiple offences, sexual and non sexual. The sexual offences were predominantly opportunistic in nature.
- The majority had deficits in social skills and limited knowledge of human relations and sex education.
- The majority had a mild intellectual disability.

A Victorian study of all admissions from 1990 to 1994 to the specialist facility for offenders with an intellectual disability (the Victorian Statewide Forensic Service) stated that "intellectual disability is itself merely a marker for an overwhelming array of psychological disadvantages"[28]. Prisoners with an intellectual disability, "even more so then the mainstream prison population, experience unemployment, major educational disadvantages, childhood institutionalisation, disrupted or disturbed families of origin, frequent contact with psychiatric services, alcoholism, drug addiction and poor social skills"[29].

A Swedish study [30] found that the criminal behaviour of over half of the subjects appeared before the age of 18 years. The subjects all had an intellectual disability and had been followed since birth.

In conclusion, it appears clear that the overwhelming majority of offenders with an intellectual disability are male and have a mild or borderline intellectual disability. They have mostly left school early at about 15 years of age, usually with a pattern of non attendance long before that. They have severe deficits in literacy, numeracy and other skills which limits their possibility of employment. Multiple problems are common including psychiatric conditions and alcohol abuse.

The factors most likely to bring people with an intellectual disability into contact with the criminal justice system are related to a number of deficits in life skills due to the lifestyle and the environment in which they grew up, rather than having an intellectual disability itself. In addition, the behaviour which eventually lead to arrest was usually apparent during childhood and yet was not addressed by schools or other services.

The clarity of the factors that indicate a risk of offending is itself a powerful argument for concerted preventative and early action to reduce the risk.

**Types of crimes committed -** Offenders with an intellectual disability tend to commit either relatively minor, but repeated offences, or a major, violent crime with only a low incidence for offences in the middle range of seriousness, which tend to be crimes requiring planning ability[31].

Recent studies and descriptions of a number of intellectual disability/criminal justice programs indicate that people with an intellectual disability are most likely to commit offences involving impulsive or unpremeditated behaviour. That is, offences against property (for example arson, break and enter and car theft), or against persons in general (for example assault and murder)[32], or sexual offences[33]. Crimes which involve planning or foresight (such as drug trafficking, robbery, false pretences and escape) are far less common.

---

28 K Deane and W Glaser *The Characteristics and Prison Experience of Offenders with an Intellectual Disability: An Australian Study* (University of Melbourne, 1994) at 1.

29 Dr W Glaser submission to the Law Reform Commission, Report 80 at 30.

30 S Hodgins "Mental disorder, intellectual deficiency and crime: evidence for a birth cohort" (1992) 49 (6) *Archives of General Psychiatry* 476.

31 Law Reform Commission Report 80 at 32.

32 K Deane and W Glaser *The Characteristics and Prison Experience of Offenders with an Intellectual Disability: An Australian Study* (University of Melbourne, 1994) at 3-4; S Hayes and G Craddock *Simply Criminal* (1992)at 44.

Although sexual offences are prominent amongst offenders with an intellectual disability, the pattern of adolescent sex offenders with an intellectual disability differs from non disabled sex offenders. Those with an intellectual disability are:

- Less likely to commit offences that involve penetration or physical violence.
- More likely to engage in both homosexual and heterosexual activity.
- More likely to engage in opportunistic and impulsive offences.
- Likely to be apprehended for their first offence at a significantly younger age, possibly due to less ability to "cover up".
- More likely to select victims more vulnerable than themselves.
- More likely to have deficits in their knowledge in relation to human relations and sexuality.[34]

The Victorian Statewide Forensic Service[35] deals with people with intellectual disabilities who have committed the most serious offences. The most prevalent offence type for their client group is child sex offences, followed by adult sex offences, physical assault, murder/manslaughter and arson.

**Recidivism -** Research carried out by the Department of Corrective Services shows that prisoners with an intellectual disability have a 78% higher rate of reimprisonment than the total prison population. This jumps to a 139% higher rate for prisoners with no prior conviction.[36] This status quo in NSW contrasts starkly with the low recidivism rates achieved by some of the more successful American programs.

In the USA the national average recidivism rate for inmates is 62%[37]. Studies of specialist intellectual disability offender programs have found recidivism rates as low as 5%. For more detail on these American programs, see Chapter 8 *Literature Review*, especially Chapter 8.4 *Evidence of success.* Like all research studies, these need to be seen in their context and interpreted cautiously. However, they at least indicate that substantial reductions in recidivism are achievable.

---

33 K Deane and W Glaser *The Characteristics and Prison Experience of Offenders with an Intellectual Disability: An Australian Study* (University of Melbourne, 1994) at 4; A Hudson, K Nankervis, D Smith, and A Phillips *Prevention of sexual offending amongst adolescents with an intellectual disability: Identifying the risks.* (Final Report, Department of Psychology and Intellectual Disability Studies, RMIT University 1999)at executive summary.

34 A Hudson, K Nankervis, D Smith, and A Phillips *Prevention of sexual offending amongst adolescents with an intellectual disability: Identifying the risks.* (Final Report, Department of Psychology and Intellectual Disability Studies, RMIT University 1999).

35 *Victorian Disability Services'Criminal Justice Program*, Department of Human Services, Victoria.

36 In the period 1990-1998, 68.3% of identified inmates with intellectual disabilities were reimprisoned within two years of their release, compared with 38.3% for the total prison population. In relation to inmates with no prior convictions, these figures were 59.9% and 25.0% respectively. Department of Corrective Services, *Recidivism and Other Statistics on a Population of Inmates with Intellectual Disability in NSW Correctional Centres* 1.1.1990-31.12.98.

37 S Lusitg *Developmentally Disabled Offenders Program* ARC of New Jersey.

# PART 2
# THE PROPOSED FRAMEWORK

## Chapter 3

## Key Themes and Principles

### 3.1 Key themes

A number of key themes run through the framework recommended in this report. They are encapsulated in the following recommendation.

**Recommendation**

1. The NSW Government should adopt the following as key themes for addressing the needs of the target group:

   a) Providing appropriate services for the target group is a cross agency problem requiring cross agency solutions. All agencies need to be accessible to the target group and provide them with an equitable share of services.

   b) Existing disability services have a role – The risk to an individual flowing from his or her offending behaviour and lifestyle should be recognised as an important component in assessing relative need for disability services under the NSW Disability Services Standards. This applies to both actual offending behaviour and clear indications that such behaviour may occur.

   c) A specialist capacity is needed to do some direct work with the target group and foster an enhanced response from existing generic and disability services.

   d) There need to be clear links between services and the justice system.

   e) A system for cross agency cooperation is needed to address both systemic and individual issues.

   f) All relevant agencies should seek to prevent people with intellectual disabilities from developing behaviours that may bring them into contact with the justice system. Where such behaviours first arise, agencies should assist the person to avoid the behaviours recurring.

   g) Additional budget allocations are needed to fund the provision of appropriate services for the target group

**A cross agency problem -** Recommendation a) emphasises that it is neither feasible nor appropriate for disability services alone to seek to address the needs of the target group. The needs of the target group range across the roles of various agencies including:

- Health services – These include alcohol and other drug, mental health and community health services.

- The Department of Education and Training – Schools are vital places for early identification of members of the target group and for early action to prevent offending behaviour developing. TAFE colleges have a major potential role in development of living skills.
- Child and family services provided or funded by DoCS – Children and young people in state care are vulnerable to developing offending behaviours. Child and family services also have potential to prevent the development of offending behaviour through support for families and children and young people who are in risky situations.

Also, many members of the target group do not identify with disability services. The Government's Disability Policy Framework, which is based on anti-discrimination law and section 9 of the Disability Services Act 1993, emphasises the obligation of all government agencies to make their services accessible to people with disabilities.

**Equity of access to disability services -** Recommendation b) responds to a status quo where services for people with intellectual disabilities tend not to be available to offenders. The former DoCS disability services (now operated by DADHC) have focused on people with more severe intellectual disabilities. The Department has generally not accepted that the risks associated with offending behaviour can give rise to "high support needs" and so has not seen members of the target group as within its priority groupings. The Law Reform Commission did not accept this argument:

> The Commission considers that a person with an intellectual disability, of whatever level of severity, who comes into contact with the criminal justice system, has high support needs which justify access to DoCS services. The consequences of not providing that support are amply documented by this inquiry[1].

Those consequences are equally documented by the case studies in this report.

Similarly, the Legislative Council's Standing Committee on Law and Justice saw the need for a category of "risk of offending", that would enable a person with an intellectual disability to receive appropriate supports (which the Committee felt should be jointly funded by human services and criminal justice agencies)[2].

In fact, DoCS disability services have had a significant role over the years with the target group. DoCS has acknowledged a broad role with former state wards who are in the target group and DoCS offices around the state have not been consistent in declining to assist members of the target group. (See *Department of Community Services former role* in Chapter 6.1.)

Note also the factors that have limited the role of NGO disability services in assisting the target group. (See *Funded non-government organisations* in Chapter 6.1.)

Just as equity of access calls for people with disabilities to have access to generic services, so does it call for the target group to have access to disability services.

Moving to a focus on risk to determine priority of need for services is consistent with the recently introduced DADHC Service Access System. Eligibility for assistance under the SAS is based on the needs of a person not being met and this situation placing the person at significant risk or placing the person's current community support arrangements or level of independence at risk. This formulation appears appropriate for the target group. Offending behaviour and potential imprisonment certainly create risks for the offender as do the lifestyles that members of the target group tend to have.

**A specialist capacity -** The need for a specialist capacity focused on the target group (Recommendation c)) flows from:

1 Report 80 para 1043.

2 *First Report of the Inquiry into Crime Prevention through Social Support* (1999) para 8.8.2.

- the complexity of the task of assessing and meeting the needs of members of the target group,
- the major difference between that task and meeting the needs of other people with disabilities, and
- the current lack of appropriate skills amongst intellectual disability and other professionals.

Recruiting or skilling up some specialists could provide a basis both for some direct work with members of the target group and for training of, and consultancy to, other professionals and workers.

It would be very difficult to achieve a great deal through Recommendations a) and b) unless there was some specialist support available for generic and disability agencies. Those agencies are both highly stretched in their existing responsibilities and lacking in skills and confidence to work with the target group.

There is a variety of options for how such a specialist capacity could be integrated with existing services. The recommended option includes a specialist capacity in disability services comprising:

- A forensic clinical team.
- A network of area based forensic support coordinators and forensic support workers.
- And some accommodation.

This would be linked to existing or proposed specialist capacities in other agencies.
See in particular Chapter 4.19 *A specialist capacity* and Chapter 4.13 *Accommodation.*

**Links with the justice system -** Recommendation d) emphasises the importance of service provision occurring in close liaison with the justice system. This would both allow the justice system to make well informed decisions about issues like bail and parole, and, where appropriate, link non-acceptance of services to sanctions.

This report proposes links including:

- Justice plans developed in cooperation between justice system and disability service personnel and which then link services that will reduce the likelihood of offending to bonds and parole conditions.
- A specialist capacity in probation and parole and Juvenile Justice community based services.

See Chapter 4.20 *Links with the justice system.*

**Cross agency cooperation -** Given the range of agencies that have roles if the needs of the target group are to be met, cross agency cooperation is obviously essential (Recommendation e). This report proposes a system based on:

- High level commitment to the system.
- Involvement of all relevant agencies and interests.
- Cross agency protocols with clear accountability measures.
- Leadership by a relevant agency or agencies.

See Chapter 4.21 *Coordination between agencies.*

**Prevention and early action -** Recommendation f) reflects the importance of intervening early before offending behaviour becomes entrenched and therefore much harder to change. Early action may be more effective and avoid considerable monetary and human cost to society. See Chapter 1.4 *Issues of cost.*

This report includes many recommendations directed wholly or partly at prevention and early action. In particular, these include those focused on Child and Family Services in DoCS and the Department of Education and Training. Prevention and early action would be a priority of the proposed specialist forensic capacity in disability services. Equally, the target group needs to be included in the early intervention focus of DADHC.

## Sean

Sean is a 17 year old youth with a borderline intellectual disability. He also acquired a brain injury at thirteen. He lived at home with his parents until he was 16 when he moved out of the family home due to physically and emotionally damaging family dynamics. Sean has an older sister who left home early in her adolescence because of physical abuse. Since leaving home, he has lived in a refuge, a hotel and then a flat. The latter two were organised by the head injury team.

Sean attended a mainstream school and had very definite problems before his head injury, including poor concentration, organisation and planning, and severe learning difficulties. However, after the injury there was a further deterioration in Sean's memory, behaviour and relationships. He was suspended for disruptive behaviour several times before and after his head injury. He attended school irregularly and he left when he was 15.

Sean has had contact with a number of services. He was referred to a head injury service after his accident. DoCS have been involved with the family since 1997 on care and protection issues. The Public Guardian and Protective Commissioner were appointed in 1999. Sean received interim funding for community options in 1999, but he was ruled ineligible for DoCS disability services. Despite the number of services that assisted Sean, there was no case coordination. The Public Guardian called a meeting to address this problem. DoCS agreed to provide a small amount of short term support.

The head injury unit said they could not provide case management as Sean's needs are complicated because of his intellectual disability, his drug and alcohol problems and his adolescence. He was referred to another head injury agency for case management but was refused because his injury occurred prior to age 15.

By February 2000, Sean had been referred to a drug and alcohol counsellor but was still receiving no case management because of "policy criteria and resource implications". He continued to receive three hours per week community options support although he did not meet the criteria for this.

In April 2000, Sean was charged with 3 "break and enters" all occurring in the past couple of months. However, he was suspected of about 30 other break and enter offences. They all involve entering older people's houses and stealing small amounts of money or objects. The magistrate noted the lack of resources and lack of case management.

Subsequently, DoCS offered case management. However, due to staff limitations, there was a three months delay. A local community housing organisation could offer accommodation support for disadvantaged youth but Sean was not seen as a priority.

However, this report needs to be seen in a broader context of the kinds of strategies that are needed to promote lawful behaviour by, and constructive lives for, all children and young people. For example, two recent reports have focused on state wards and the juvenile justice system:

- Department of Juvenile Justice and Department of Community Services, *The Wards Project – Final Report* (1999).
- Community Services Commission, *Just Solutions – Wards and Juvenile Justice* (1999).

These reports include many recommended strategies to reduce offending behaviour by state wards. The Community Services Commission report outlines literature showing that early childhood support can be effective in preventing later criminal behaviour. In one American study, young children were provided with two years of pre-school and weekly home visits by the teachers. The arrest rate at age 19 was 40% lower than for a control group. The program participants were also

more likely to have finished school and be employed and less likely to have substance abuse problems. Similar crime prevention results were achieved by a national program providing comprehensive developmental services for low income families with pre school children; about 13% of children in this study had disabilities.[3]

Programs such as the NSW Government's Families First Program have obvious potential to reduce offending behaviour. The focus on prevention and early action in the new Children and Young Persons (Care and Protection) Act is another positive initiative. It is very important that these initiatives are implemented in a way that is sensitive to the needs of the target group. Through this report, various recommendations are aimed at ensuring that generic child and family services are equipped to meet the needs of target group members. These recommendations apply to services funded under the Families First Program, those provided or funded under the Children and Young Persons (Care and Protection) Act and other child and family services.

As a recent report of the Legislative Council Standing Committee on Law and Justice noted:

> Any programs, particularly early childhood intervention, which assist lower socio-economic groups in general are likely to assist in reducing the numbers of intellectually disabled [persons] involved with the criminal justice system[4].

**Additional budget allocations -** There is scope to improve the situation of the target group through existing services providing more equitable and skilled assistance to target group members. Also, funding for disability services received a major increase in the 2000/2001 State budget. This gives some scope to improve the position of the target group along with various other groups in urgent need.

However, the above approaches would have very limited capacity to meet the overall needs of the target group as outlined in this report. Those needs are considerable as are the unmet needs of other groups who use community services. See Chapter 1.4 *Issues of cost.*

Additional budget allocations are needed. At the last meeting of the project reference group, members emphasised the following view:

> There needs to be a clear and prominent statement recognising that the target group is one that has not traditionally received services or funding and that the starting point for a framework is one of addressing a deficit rather than developing an existing service. Any meaningful intervention requires a specific funding allocation.[5]

## 3.2 Guiding principles for service provision

**Recommendation**

2. The following principles should apply to service provision for the target group:
   a) The prevention or reduction of offending behaviour is very important both for the protection of the community and to meet the needs of members of the target group.
   b) The objects, principles and applications of principles in the Disability Services Act 1993 should apply to services for the target group.
   c) Restrictions on the freedom of members of the target group should only occur through due process of the criminal or juvenile justice system, or under the authority of an order of the Guardianship Tribunal.

3 Pages 32-33.

4 *First Report of the Inquiry into Crime Prevention through Social Support* (1999) para 8.12.

5 Minutes of reference group meeting 14 November 2000.

Recommendation a) speaks for itself.

Before arriving at Recommendation b), consideration was given to whether any variation was needed to the objects, principles and applications of principles in the DSA to make them appropriate for the target group. No variation was needed. Issues such as choice, integration, individual needs, protection and recognition of ethnic origin or Aboriginality apply similarly to the target group as for other people with disabilities. There is flexibility to apply the DSA rules to an individual's circumstances. No other group of people with disabilities has different rules applying to it.

The needs of people who are Aboriginal or from a non-English speaking background are one important issue covered by the principles and applications in the DSA. This report includes recommendations that emphasise some specific action that is required to make the proposed framework appropriate for these groups. However, the needs of these groups should be taken into account in implementing all aspects of the proposed framework.

In some circumstances, quite restrictive services may be required to address an individual's needs, and this might be thought to sit oddly with the principle of "least restriction" in principle (g). However, that principle does not say "no restriction". What is the least restriction is a matter of individual circumstances and can involve a high level of restriction for some individuals whether or not they are members of the target group.

Similarly, if the objects, principles and applications were amended as recommended by the Law Reform Commission in its review of the DSA, the amendments would be equally appropriate for the target group as for other people with disabilities. The proposed amendments relating to children would support the prevention and early action thrust in this report.[6]

Recommendation c) reflects the view that members of the target should not have their freedom of movement restricted except through normal processes of the justice system or under the authority of an order of the Guardianship Tribunal. The Tribunal and any appointed guardian is required to treat the individual's interests as paramount; however, this is not necessarily inconsistent with restrictions to prevent offending behaviour. See Chapter 4.14 *Restrictions on freedom of movement*. See also Chapter 4.15 *Transfer from prison/detention centre* for one situation where it would be appropriate for issues of community safety to override the DSA, namely if a prisoner was to be transferred to secure accommodation run by community services during his or her sentence.

## 3.3 Consistency with the Disability Reform Directions

The Government has recently approved a set of Disability Reform Directions, which are guiding current initiatives of DADHC. Below are these directions and a brief statement of how this report responds to them.

- *Managing demand for services to ensure that existing and new resources are provided to people with the greatest need.*
  This report proposes equitable access to existing disability services for the target group and strategies to achieve this. The Service Access System can also be a vehicle for ensuring that target group members with greatest need obtain individual funding allocations. The report proposes development of services to meet common needs of the target group in recognition of the lack of equitable access to disability services to date for the target group.

6 Law Reform Commission *Review of the Disability Services Act 1993 (NSW)* Report 91 (1999) chapters 2 and 8.

- *Reducing crisis in demand for services so that in future needs can be addressed in a planned and systematic way.*
  This report recommends a comprehensive framework that would avoid the ongoing crisis in demand for services for target group members. The report also places a high emphasis on well informed assessment of individual needs and planning to meet those needs.

- *Strengthening informal supports within families and communities by ensuring that demand management maximises opportunities for the inclusion of people with disabilities in their local communities.*
  The report includes emphases on support for families and existing social networks and enhancement of these through advocacy and mentoring programmes.

  The report also acknowledges that members of the target group often have very limited or dysfunctional informal support networks. This dysfunction may be very entrenched. Also, it is difficult to recruit volunteer advocates and mentors for offenders. These factors increase the importance of formal support systems for members of the target group. However, formal supports have an important role in seeking to develop positive informal supports for target group members.

- *Emphasising prevention, early intervention and family and community based supports by developing a broader, more flexible range of formal support and accommodation options.*
  Prevention and early action is a major emphasis in the report, including the roles that schools and child and family services could play in this. The report stresses the need for flexible options around individual needs.

- *Increasing the involvement of the non-government sector in order to grow the capacity and responsiveness and thereby the cost effectiveness of the formal support system.*
  The report does not take a particular stance on the appropriate balance between DoCS and non-government services. However, the report does note factors that have limited the role of NGOs with the target group. If that role is to be enhanced, particular attention is needed to building an appropriate skill base in, and specialist support for, NGOs who are assisting target group members. Without this capacity building, NGOs are very likely to say that they are not equipped to assist offenders; and there will be considerable justification for this stance.

  Any increase in the role of the non-government sector should be aimed at improving the overall service system, not at saving costs. A significant investment will be required from government if the capacity of the non-government sector to assist the target group is to be substantially increased.

# Chapter 4

# The Framework in Detail

The framework needs to address the issues below. Under each issue, there is an assessment of the current situation, discussion and recommendations. To a large degree, what is said flows from the information and research set out elsewhere in the report. However, some further information is introduced and referenced.

## 4.1 Identification

There is no systematic or reliable system for identifying members of the target group to provide a basis for considering their support needs. The Law Reform Commission commented, "The failure of agencies to identify people with an intellectual disability [is] a major issue of concern"[1].

Identification relates to the existence of an intellectual disability and risk factors indicating the likelihood of contact with the justice system. These problems are particularly relevant in:

- Schools, health services and child and family services in relation to children and young people at risk of contact with the justice system.
- The Police Service, courts and the services of the Departments of Corrective Services and Juvenile Justice.
- Disability services in relation to risk factors for contact with the justice system.

A first step for various generic agencies would be the use of a screening process appropriate to the circumstances of the agency. Such a process would indicate the possibility of an intellectual disability. Further investigation or assessment would then be needed. This may mean enquiring whether psychological assessments have been done in the past. It may mean carrying out assessments of intelligence and adaptive functioning.

Screening instruments and assessments need to take account of cultural and linguistic issues.

Associate Professor Susan Hayes has developed the HASI screening index. The Department of Juvenile Justice is trialing the use of the HASI by trained staff, including counsellors and psychologists, as a first response where there are concerns that a person may have an intellectual disability. Various other agencies have also expressed interest in using the HASI[2].

The Police Service sees a difficulty for its officers in distinguishing different disabilities. The Service has a Code of Practice that includes guidelines for identifying people with "impaired intellectual functioning"[3]. However, this kind of broad screening tool could be complemented by information and training about how to distinguish different kinds of disability[4].

In relation to risk factors, see Chapter 2.4 *Characteristics.* The factors outlined there could be used as a basis for training of staff in a wide range of agencies.

1 Report 80 para 10.27.

2 S Hayes *Early Intervention or Early Incarceration?* (2000) Paper presented at Congress of the International Association for the Scientific Study of Intellectual Disabilities.

3 NSW Police Service Comments on Framework Project.

4 See for example Attorney General's Department *Access Link – Guide to Flexible Service Delivery* draft.

**Recommendations**

3. The Departments of Corrective Services and Juvenile Justice, the Legal Aid Commission and the Police Service should each adopt and/or develop a screening process:
   a) For use by lawyers, and community based and custodial officers of Corrective Services and Juvenile Justice as a basis for identifying people who might have an intellectual disability or need support in court processes. Further investigation or psychological assessment should then be considered.
   b) For use by police to identify people who may need support in police interviews.

4. Relevant agencies should increase the skills of professional staff in identifying an intellectual disability and risk factors for contact with the justice system. This should occur through enhancing skills and access to expert consultancy, redirecting priorities or increasing resources in schools, TAFE, health services, child and family services, youth services, disability services, the Legal Aid Commission and the Departments of Juvenile Justice and Corrective Services.

## 4.2 A fair process with police and courts

An intellectual disability makes it harder for a person to understand, and protect his or her interests, in dealings with police and courts. In particular, the reliance on verbal communication in police interviews and court processes severely disadvantages members of the target group who tend to have major deficits in communication skills. In fact, they tend to have a proportionately greater deficit in communication than in other functional abilities[5]. Thus, even if police and courts identify that a person has an intellectual disability, they may still overestimate the person's communication abilities. This can lead to the person's communication needs not being met or the person being seen as uncooperative.

Safeguards are needed to avoid these communication problems leading to members of the target group being treated unfairly. Failure to meet the communication needs of the target group jeopardises members' right to silence and right to legal advice as well as their ability to defend charges in court. It also makes unreliable the information they provide during investigation and trial processes.

One safeguard for which there is already a precedent is the use of support people in police interviews and in courts. The law requires that a support person be present when a suspect with an intellectual disability is being questioned by the police and allows for support people to be used in courts. However, support people are not readily available. See *Advocacy and support with police and courts* in Chapter 6.1.

**Support people in police interviews -** A review of the Illawarra Disability Trust's program for the provision of support people in police stations ("IDEAL") revealed that the program was appreciated by clients but under-utilised by police[6]. The review did not measure objective outcomes, and so provides no information on the impact of a support person on a suspect's tendency to exercise his or her rights.

In Victoria, it is mandatory for police to involve an "independent third person" (ITP) when questioning a suspect with an intellectual disability. The scheme establishes panels of specially trained volunteer support people. An unofficial but independent review of the scheme conducted in

5 S Hayes *Good Behaviour? A comparison of cognitive and adaptive behaviour impairments in offender populations* paper presented at the 1999 ASSID 35th Annual National Conference at 4.

6 A Shaddock, and A Shaddock *Illawarra Disability Trust: review of the criminal justice project* (1998) 16-17.

1992 raised serious concerns that the use of the third person in fact tended to encourage the suspect to dispense with his or her rights and created a false impression of a fair and voluntary interview. The author was concerned that the presence of the third person so relaxed the suspect that he or she failed to exercise appropriate caution. She concluded that, “ITPs in such circumstances have failed to provide intended protection and have in fact become de facto members of the police force.” [7]

The disastrous consequences of ineffective support in a police interview were realised in the Victorian case of Dominic Simm. The court ruled inadmissible a confession made to police by Mr Simm on the basis that it was not voluntary or fair. As the defence put it, Mr Simm would have been “better represented by a poodle”[8].

Since then, the system has been improved but the role of the independent third person remains contentious.

In 1995 an official and independent evaluation recommended:

- That the role of the ITP be to ensure the person understands his or her rights and to play an active role in facilitating communication rather than being a passive observer.
- That the ITP should be clearly attending for the benefit of the interviewee and not the police.
- That consideration be given to monitoring the rate of convictions sustained following interviews where ITPs are present. [9]

There is no more recent public report on the implementation of these recommendations or on current successes and limitations of the scheme.

The NSW Police Service has expressed reservation about support people playing too active a role and, in particular, advocating for the suspect. It is true that it is not the place of the support person to take on the role of a solicitor, nor to speak for a person in an interview.

However, the experience of the Victorian scheme makes it clear that the role of the support person should involve active promotion of the suspect’s rights. To this end, support people need to be specially trained and their role must include the tasks specified in the recommendation below. Unless the support person has this pro-active role, the risk that his or her presence may actually undermine the suspect’s rights would not be outweighed by the emotional comfort the support person would provide. The suspect would be better off with no support.

The role of a support person should also not be confused with that of an interpreter. If an individual was from a non English speaking background, then a support person and an interpreter would be needed.

**Support people and other disabilities -** While the focus of this report is people with intellectual disabilities, police work with people with other disabilities and conditions that affect communication and require special measures to safeguard rights. For this reason, legislative and practice regulations used by the Police Service are more broadly targeted to “vulnerable persons” including people with “impaired intellectual functioning”[10]. It is sensible for support systems to be designed on the basis of need rather than on clinical definitions of disability. Any system of support for people with disabilities should be part of a broader support system for vulnerable people generally.

7 K Deane *Sitting on a See-Saw: an evaluation of the independent third person program* (1992) 62 .

8 K Deane "Better Represented by a Poodle: the case of Dominic Simm" *Socio-Legal Bulletin* No 15 Summer 1994 at 50.

9 Lampshire &Rolfe *The Independent Third Person Program, Evaluation* (Department of Health and Community Services 1995) v-x.

10 Crimes (Detention After Arrest) Regulation cl3 and 5; *CRIME: Code of Practice for Custody, Rights, Investigation, Management and Evidence* (NSW Police Service 1998).

Nonetheless, different disabilities and "vulnerabilities" have very different effects on communication and support needs. For example, short, narrow questioning may be suitable for a person with an acquired brain injury, who may have trouble with concentration. Such questioning may be entirely inappropriate for a person with an intellectual disability, who is likely to be more suggestible. Police officers cannot be expected to make diagnoses of disability at point of contact. However, it is important that they and any support people can broadly recognise the impact of different disabilities on communication and identify strategies to accommodate the person's communication needs. Failure to do so would compromise the quality of an interview and its admissibility.

The NSW Police Service has expressed considerable reserve about involving its officers in any kind of assessment of the specific, disability related needs of suspects. It is true that police officers cannot be expected to become de facto clinicians. They do not have the expertise, nor is the police station environment conducive to proper assessment. Nonetheless, like all involved in public service, police can and should be expected to acquire a working knowledge of disability sufficient to discharge their duties equally to people with disabilities. Many police officers already have this level of skill.

There are some good examples of efforts to bring a working, practical understanding of disability to people working with the public. For example, the NSWAttorney General's Department has recently developed a *Guide to Flexible Service Delivery* for its frontline staff. This guide includes an outline of the major features of different disability types and strategies for assisting clients with those disabilities. The guide is practical and geared towards people without any sort of clinical background. Another good example is the training provided to police as part of the Freemantle Police Diversion Pilot Project, 1996.

In Canberra an indigenous support persons program is operating through the Aboriginal Legal Service. It offers a model that could be extended to other areas for Aboriginal members of the target group.

**Support people in courts -** People with intellectual disabilities may need a support person in court for a range of reasons. These include for encouraging and assisting attendance, helping to find the right court room, explaining what is happening in court and explaining the outcome. This sort of support is uncontroversial.

More controversial is support while an accused person is giving evidence. Legislative backing for such support is already in place in other states[11], and in NSW for children[12]. The accused may benefit from a support person sitting nearby, or even in the witness box, as they give evidence. However, there are concerns that this may convey an impression of innocence to the jury and that the support person may attempt to influence the evidence of the accused.

In considering this question, the Attorney General's Committee on Intellectual Disability and the Criminal Justice System recommended that adult accuseds with intellectual disabilities should have the right to this kind of support. The support person should not be permitted to influence the accused's evidence directly or indirectly. His or her role should be limited to the provision of emotional support and the promotion of effective communication.

The Committee made specific recommendations which are repeated and endorsed below.[13]

11 s37C(3)(c) Evidence Act 1958 (Vic), s21A(2)(d) Evidence Act 1977 (Qld), s13(2)(c) Evidence Act 1929 (SA), s21A(2)(c) Evidence Act 1939 (NT), s106R(4)(a) Evidence Act 1906 (WA).

12 s27 Evidence (Children) Act 1997.

13 Committee on Intellectual Disability in the Criminal Justice System *Procedures for Giving Evidence in Court by People with Intellectual Disability* Discussion Paper (Attorney General's Department, 2000).

**Interplay of support people with general advocacy -** More general individual advocacy is needed to complement the role of support people. Support people will assist through one process many individuals who have ongoing needs for things like appropriate services. More general advocacy then needs to be available to assist the individual with these broader needs. If police and court support has an appropriate rights base, it could be logical for the support organisation to also provide broader advocacy.

**Training for lawyers -** The project's consultation with stakeholders highlighted the need for lawyers and judicial officers to be made more aware of the nature and effect of an intellectual disability.

In relation to broader issues of how the court system needs to better accommodate people with disabilities, see the report of the Disability Council of NSW, *A Question of Justice – Access and Participation for People with a Disability in Contact with the Justice System*[14].

**Recommendations**

5. The Government should fund a statewide network of trained support people to assist people with intellectual disabilities in police interviews and in court. The network might be based on volunteers but with paid workers to recruit, train, advise and monitor them. Also, support people should be paid in some situations where a major time commitment is required.

6. The auspice or auspices of any support person program should be required to have a clear rights basis in its carrying out of its functions.

7. The role of support people in police interviews should be defined (in the Crimes (Detention after Arrest) Regulation or otherwise) as follows:
   a) The role of support people is to:
      - Provide emotional support to the suspect.
      - Explain their role to the suspect and, in particular, stress that they are not able to provide legal advice.
      - Assist the suspect to understand: the right to remain silent; that any information the suspect provides to police can be used in evidence against the suspect; and the significance of giving up the right to silence.
      - Assist the suspect to understand the right to and importance of legal advice and, where possible, to assist the suspect to obtain it.
      - Assist the suspect to work with his or her solicitor (if there is one).
      - Advise police or the suspect's solicitor if they think the suspect does not understand the right to silence or the right to legal advice.
      - Immediately advise the solicitor or the police if the suspect appears not to understand something or if information provided by the suspect appears to be misinterpreted.
      - Advise the solicitor and police if the suspect needs a break from the interview.
      - Assist the suspect to understand each stage of the charge process, including questions by the independent officer, bail and bail conditions.
      - Maintain and be seen to maintain their independence from the police.

   b) Support people must not:
      - Ask the suspect questions about the alleged offence before, during or after the interview process.
      - Pending implementation of recommendation 9 below, allow the suspect to talk to them about the alleged offence before, during or after the interview process.

14 Publication pending.

**Recommendations (cont'd)**

- Put questions relating to the alleged offence to the suspect on behalf of police.
- Encourage the suspect to answer police questions regarding the alleged offence.

c) The responsibilities of the support person do not in any way reduce the responsibilities of the police to ensure the fairness of the investigative process.
d) When the support person arrives at the police station, police should advise him or her the reason the suspect is at the police station and any charge that has been laid.
e) When the support person arrives at the police station, the police should provide written guidance as to her or his role.
f) The police custody manager should ensure that the support person is not connected with the victim or the alleged offence.

8. The role of a support person in court should be defined as follows:
   a) To inform the court if the witness does not understand a question.
   b) To inform the court if the witness needs assistance because she or he has become tired, confused or needs a break from proceedings.
   c) To inform the court of any other difficulty the witness is experiencing in understanding the proceedings.
   d) And not to make physical contact with the witness without leave of the court.

9. The Evidence Act 1995 (NSW) should be amended to make support people competent but not compellable witnesses in respect of the content or conduct of the interview.

10. The Evidence Act 1995 (NSW) should be amended to give a right to the use of support people for all witnesses (including defendants) with intellectual disability.

11. The Attorney-General's Department and the Law Society should promote better training of lawyers and judicial officers about intellectual disability and issues relevant to their dealings with people with intellectual disabilities.

## 4.3 Assessment of support needs

Members of the target group need to have their support and supervision needs assessed by suitably qualified persons. In most cases, multiple assessments are needed. If the individual's needs are complex, he or she may need an assessment by a multidisciplinary team.

Whenever there are multiple assessments, this process needs to be well coordinated. This includes ensuring that each assessor has necessary and consistent information including access to other relevant assessments. Otherwise, assessors may make illbased or unnecessarily inconsistent recommendations.

At present, adequate assessments seldom occur. In some cases, multiple, poorly coordinated assessments occur. In some cases, some limited consideration of needs occurs in the context of a pre sentence report by Probation and Parole or Juvenile Justice Officers.

All relevant agencies need to improve their capacity to assess members of the target group. At the same time, it is acknowledged that this is often a specialised task and there is currently little such specialist skill in NSW. This skill base needs to be developed and to be available as a training and consultancy resource to other professionals. Hence, the proposal for a specialist clinical capacity such as a forensic clinical team; this is discussed in detail in Chapter 4.19 *A specialist capacity.*

Two particular aspects of assessment that need development are:
- Assessment of risk of further offending behaviour. See Chapter 8.3.
- Taking account of cultural and linguistic factors in assessment processes. See Chapter 4.16 *People from a non-English speaking background*.

Appropriate assessment is very important if the needs of a member of the target group are to be identified and met. However, a note of caution is needed. People with disabilities can be subjected to assessments that are unnecessary, duplicative or designed to exclude them from services, rather than assist them. Assessments should be focused on meeting the person's needs and only occur where they are really needed.

**Recommendations**

12. The functions of the proposed specialist clinical capacity should include:
    a) Assessment of an individual's needs in some priority cases, and being a training and consultancy resource to other services.
    b) Developing skills in assessment of risk of offending behaviour.
    c) And developing skills in taking account of cultural and linguistic factors in assessment processes.

13. Generic agencies should enhance the skills and priority or resources of their staff to assess the needs of members of the target group. These agencies include:
    a) Schools and TAFE.
    b) Child and family services.
    c) Health services, including alcohol and other drug, and mental health services.
    d) Corrective Services, both in custodial services and probation and parole.
    e) Juvenile Justice, in both custodial and non custodial services.
    f) Ethnic community agencies.

14. Existing disability agencies should enhance the skills and priority or resources of their staff to assess the needs of members of the target group. These agencies include disability services provided or funded by DADHC.

15. DADHC should ensure that assessors employed under the Service Access System include individuals skilled in assessing the needs of the target group.

## 4.4 Meeting individual needs

Once a person's needs have been assessed, a plan needs to be developed and implemented to seek to meet those needs. At present, this seldom happens in any thorough manner. It may happen in a limited and generally ad hoc way through one or more agencies that are involved with the person.

Members of the target group seldom have a case manager or the like with clear responsibility for coordinating individual planning and implementation of the plan. Where someone does have this responsibility, the problem is accessing appropriate services.

A recent project of DoCS disability services and the Department of Corrective Services meant that there was a temporary position of an officer focused on post release planning for target group members. This officer only assisted seven members of the target group in one year. This very small caseload flowed from it being very difficult to find appropriate supports and services[15]. An evaluation of this project is currently occurring.

15 Communication with Ann Langford, Clinical Coordinator, Disability Programs, Department of Corrective Services.

## Tony

Tony is 24 years old and has a borderline/mild intellectual disability with moderate deficits in adaptive behaviour. He lived with his mother until he was about thirteen. After some arguments with his mother, Tony set fire to the home. The Children's Court placed him on probation. He was made a state ward and lived at the Minali institution for a while. Tony met Mike who was also a ward. Mike invited Tony to come and live with his mother Dot in western Sydney. Tony has stayed with Mike and his mother Dot in western Sydney on and off for about ten years and sees Dot as a foster mother.

However, until he was about 22, Tony led a very itinerant lifestyle. He spent a lot of time in youth refuges. He was convicted of many minor offences and did a number of very short periods in prison. On the other hand, he also worked from time to time.

In 1995, when Tony was seventeen, a youth service actively sought to address his needs. He had limited living skills and could be aggressive. He liked to belong to a peer group and so was easily led. A DoCS psychologists assessed Tony. She felt that, with appropriate training, he could live independently with drop in support. However, he had an itinerant lifestyle and DoCS disability services were not willing to take case management responsibility because of the level of his disability. DoCS did offer some more limited assistance.

In recent years, Tony has had regular support from his solicitor and a citizen advocate. He values these relationships. Through 1998, things seemed a lot more settled for Tony. He avoided the inner city which he saw as trouble. He stayed at Dot's house rather than moving around. He got a job doing building work. He was more likely to keep appointments.

However, in early 1999, the police charged Tony with malicious wounding. A man had teased him. Tony had gone and got a knife, and stabbed the man. Tony pleaded guilty.

A psychologist wrote a court report. She said that Tony appeared oblivious to the seriousness of the situation. He showed a rote learning approach to life rather than a reasoned understanding. This left Tony unprepared for novel or stressful situations. He was impulsive and acknowledged a short temper. He lacked attachment figures and role models. On the other hand, he responded very well to positive input. When things are going well, he is a very likeable person.

DoCS paid for some therapy by the psychologist. She focused on exploring the divergence between Tony's personal belief system and societal expectations and she taught him some anger management techniques. Tony learnt all this well but the challenge remained to put it into daily practice.

Tony was sent to prison for a year. He was victimised in a mainstream prison but was fairly happy in a special disability unit. In prison, Tony acknowledged major problems with cannabis and gambling.

**Focuses for individual planning -** Planning needs to focus on issues such as:

- Maintenance and enhancement of existing support networks.
- Taking account of ethnicity and Aboriginality. For example, the importance of community bonds in Aboriginal communities need to be capitalised on.
- Accommodation and related support.
- Education and training.
- Employment.
- Recreation.
- Social skills.

- Health including mental health, neurological issues, nutrition and problems with alcohol and other drugs.
- Maintaining and building on existing positive skills and interests.
- Income security and assistance with budgeting. (In some cases, this might extend to the appointment of the Protective Commissioner to manage a person's money.)
- Specific offence related interventions.

Individual planning needs to address barriers to the person accessing both generic and disability supports. Support needs to be flexible and imaginative, including taking into account from whom the person is willing to accept services. Skilled and imaginative approaches may be needed to engage the person and promote acceptance of assistance. A person may need ongoing support to access appropriate assistance.

Whilst much may be achieved by innovative and flexible use of available supports and services, specific funding may also be needed to allow a person's needs to be met or to develop services needed to meet common needs.

**Case management and support coordination -** Someone needs to coordinate the development and implementation of the individual plan. This has usually been seen as the role of a case manager. Recently, support coordination has been developed as a kind of independent case management where coordination between a number of agencies is required and the support coordinator has access to discretionary funding to assist in meeting the needs of the individual. Support coordination is usually a short term intensive role whereas case management is more of an ongoing role. A member of the target group may well need both a support coordinator and a case manager.[16]

In 1999, the Minister for Disability Services approved the phased implementation of support coordination across the state.[17]

DADHC is currently piloting local support coordination in a number of parts of NSW. This is mainly in rural areas. As well as assisting individuals, local support coordinators will have roles in community development, fostering the roles of local generic agencies and service development.

A role similar to support coordination is also found in the support planner role in the DADHC Service Access System.

**Service access system**[18] **-** This new system appears to provide a suitable framework to identify and meet the needs of some members of the target group whose needs cannot be met from existing services and supports and whose behaviour is placing the person or others at risk.

However, the SAS also appears to have a number of serious limitations on, or doubts about, its capacity to assist the target group. These are:

- The SAS is a new system with a limited budget that already has many demands being placed upon it from many quarters. Whilst the SAS has a budget of $22.4M in 2000/2001, this includes the allocations for new supported accommodation announced in the 2000/2001 State Budget.[19] And, as the Legislative Standing Committee on Social Issues has recently emphasised,

16 Ageing and Disability Department *What is Support Coordination?* (1999) and communication with Wendy Williamson, ADD.

17 Ageing and Disability Department *What is Support Coordination?* (1999).

18 The discussion of the SAS here is drawn from communications with Warwick Neilley, adviser to the Minister for Disability Services and Peter Reid, ADD (now DADHC), and the following ADD publications:

- *Developing a Formal Service Access System for People with Disabilities in NSW*, directions paper (2000).
- Service Access System Information Forum notes (2000).
- *Service Access System – Adult Request for Support Form* (2000).

Also, there was discussion of the SAS at a project reference group meeting and comments provided by ADD on the draft project report. However, the opinions expressed about the SAS are those of the consultants.

19 Communication with Anna Edwards, ADD, April 2001.

> extended investment in disability services must be maintained over a period of years to redress past neglect and to develop an efficient and equitable disability services system.[20]

In relation to supported accommodation alone, the Committee recommended a growth target of 200 new placements a year for the next five years.[21] In relation to areas of unmet need, see further Chapter 1.4 *Issues of cost.*

The extent to which members of the project target group will become priority consumers of the SAS is unclear at this stage.

- The starting point for seeking SAS assistance is an application from the person and/or their family or carer. Target group members and their families often do not seek out assistance from service agencies. They may not see the need or they be suspicious of service agencies. Where they are connected to service agencies, they tend not to be disability services that would be familiar with the SAS. Many target group members lack involved families.
- Similar difficulties would arise with another key phase of the SAS, when the support planner was meeting with the individual to identify his or her support needs. The individual and his or her family may have great difficulty seeing needs in any clear and consistent way.
- It is assumed in the SAS that there is a disability service system for consumers to access directly. This is not presently the case for the project target group. In the absence of such a system:
  - The SAS may improve the situation of some members of the target group while most continue to receive very inadequate support.
  - It may be very difficult to find a suitable service to buy for a person who has funding available under the SAS. DADHC comment, "There are many specialist supports that need to be tailored, reshaped and even built to get appropriate supports around some individuals" who are supported under the SAS[22]. However, this may be very difficult in the absence of a substantial skill base in working with the target group.
  - There may be considerable resources expended in making similar applications to the SAS for a number of individuals who need a similar service.
- The SAS includes an emphasis on building around a person's existing supports. A high proportion of the target group lack any substantial supports or have supports that are negative influences on the individual. However, DADHC emphasise, "Support planners would take this into account and the plan would be aimed at creating the supports"[23].
- The importance of a preventative approach is acknowledged in the SAS. However, the degree to which the system's resources will be able to extend to a preventative approach for the project target group is at least uncertain.

To meet these limitations, a number of things are needed. First, DADHC should devise a plan to make the SAS accessible for the target group. This plan needs to address the following issues:

- Promoting the SAS amongst agencies that have regular contact with target group members such as Probation and Parole, the Department of Juvenile Justice and legal aid lawyers.
- Otherwise encouraging target group members to seek appropriate assistance. Strategies are needed to address the difficulty individuals and their families may have in seeing the need for assistance.
- Ensuring that SAS support planners and assessors who are working with target group members:
  - Are be skilled in this task.
  - Have the time to build a relationship of trust with the individual and/or persons who have the individual's trust, for example an advocate.
  - Involve in the planning process persons able to assist in identifying needs of the individual.

The proposed specialist forensic support coordinators and workers would be able to considerably assist these processes. See Chapter 4.19 *A specialist capacity*. The support coordinators could fulfil the support planning role.

---

20 *A Matter of Priority, Report on Disability Services* (2000) at xi.

21 Page xii.

22 Email from Anna Edwards, ADD, to Georgina Connelly, IDRS, dated circa 22 February 2001.

23 Emailed memo from Anna Edwards, ADD, to Georgina Connelly, IDRS, dated 23 February 2001.

Second, the SAS should be given a budget supplement focused specifically on the project target group. Without this, there can be no reasonable degree of confidence that the SAS will assist a substantial proportion of the target group.

Third, the use of the SAS and individualised funding to meet the needs of the target group should be balanced with the development of services aimed at meeting common needs. This would be in line with the thinking underlying the SAS that investment in the SAS should interlink with the current service system capacity and future investment in it. Examples of common needs for which local or regional services might be funded are:
- recreation,
- counselling/therapy, especially focused on offending behaviours,
- general and offence related skills development,
- mentors, and
- family support.

The services to be developed might be focused on a range of consumers including members of the target group. Some services might be focused on the target group alone. In either case, it would be important that there was some degree of specific focus of the service on the target group. Otherwise, it would be unlikely that the service would have the necessary skills to work with the target group.

Another issue is the time required to obtain emergency funding. For members of the target group, very quick responses may be needed to avoid a crisis turning into a further crime. Responses within a matter of hours may be required. In Victoria, such a capacity exists through Regional Self Sufficiency Funding which is a targeted allocation of money to each Community Services Area. This money is only to be used for short term and usually emergency needs of members of the target group. An Area Manager makes spending decisions. Examples of use of this money include emergency accommodation, money for transport, an assessment from a private agency and short term counselling. DADHC states that the SAS has a similar capacity to respond within hours and that this does happen.

**Broader action -** As in relation to assessment, all relevant agencies need to enhance their capacities to meet the needs of members of the target group. This is so whether their responsibility is specific, such as an alcohol and other drug service, or general, such as the role of DoCS in relation to a state ward, or the role of a case manager in the former DoCS disability services.

At the same time, establishing a trusting relationship with and meeting the needs of members of the target group is often a specialised and complex task and there is currently little of such specialist skills in NSW. This skill base needs to be developed and to be available as a training and consultancy resource to other local workers. Hence, the proposal for specialist support coordinators and workers which is discussed in detail in Chapter 4.19 *A specialist capacity* below.

The Law Reform Commission saw case management as an "absolutely critical" element in preventing a person reoffending. The Commission strongly recommended that DoCS should provide an ongoing case manager for each member of the target group.[24] Without detracting from the critical nature of this role, it would be too inflexible to always place it in the former DoCS disability services (now operated by DADHC). Some members of the target group are very antipathetic towards DoCS because of their experiences in the child protection system. Some may obtain appropriate case management from other agencies with which they are connected. Also, the development of support coordination and the Service Access System have made the former DoCS services much less of the dominant player in individual planning.

24 Report 80 Recommendation 54 and paras 10.38-10.50. Note the equally strong view of the Community Services Commission in relation to young people in care: *Inquiry into the Practice and Provision of Substitute Care in NSW* (2000) at 77.

However, if a person does not have appropriate mechanisms in place to coordinate the development and implementation of an individual plan, there needs to be an agency that can be relied upon to do this. In view of their statewide structure, the former DoCS services may well be the most appropriate for this.

The DADHC Regional Planning Framework has an important role in the development and improvement of the disability services system. To date, the needs of the target group have not been highlighted in that process. This raises issues about whether people who are involved with the target group have inputed to the planning process. People such a legal aid lawyers and Probation and Parole officers could provide valuable input. So could the proposed specialist forensic support coordinators.

**Recommendations**

16. A specialist capacity in meeting the needs of target group members should be established. This capacity should directly assist some members of the target group and be a local expert resource and referral point to others who are seeking to assist members of the target group. See Recommendations 100-108.

17. Generic agencies should enhance their skills and priority or resources to develop and implement individual plans for members of the target group. These agencies include:
    a) Schools and TAFE
    b) Child and family services
    c) Youth services
    d) Corrective Services, in both custodial services and Probation and Parole
    e) Juvenile Justice, in both custodial and non custodial services
    f) Mental health services
    g) Drug and alcohol services
    h) General health services
    i) Ethnic specific and multicultural services

18. Existing disability services should enhance their skills and priority or resources to develop and implement individual plans for members of the target group. This includes disability services provided or funded by DADHC.

19. DADHC disability services (formerly operated by DoCS) should be enabled to provide a case manager for each member of the target group who needs one and does not have appropriate case management from another source.

20. Where existing services cannot meet a person's needs, planning to meet those needs should occur through the DADHC Service Access System (SAS). There should be an enhancement of the funding to the System, earmarked for the target group. This funding should be available for both immediate crises and planned ongoing support of target group members.

21. DADHC should devise a strategy to make the SAS accessible for the target group. This strategy needs to address the following issues:
    a) Promotion of the SAS amongst agencies that have regular contact with target group members.
    b) Otherwise seeking to ensure that target group members are encouraged to seek appropriate assistance in a way that addresses difficulty individuals and their family may have in seeing the need for assistance.
    c) Ensuring that SAS support planners and assessors working with the target group:
        - Are skilled in this task.
        - Have the time to build a relationship of trust with the individual and/or persons who have the individual's trust, for example an advocate.
        - Involve in the planning process persons able to assist in identifying needs of the individual.

22. DADHC should fund services to meet common needs of a substantial number of members of the target group (as part or all of the focus of the service).

23. DADHC should review the processes used in its Regional Planning Framework to improve its capacity to be well informed about the needs of members of the target group.

## Matthew

Matthew is twenty one years of age. His parents separated when he was six and his mother remarried. Matthew attended a regular school and enjoyed primary school. He was identified as a bit slow and recommended for remedial classes, but he did not attend. In secondary school, inappropriate and aggressive behaviour brought him to the notice of teachers. He was suspended a couple of times and towards the end of year 10 he was assessed by the local district guidance officer and identified with a borderline/mild intellectual disability. It was recommended that Matthew leave school and seek support, training and employment.

The local supported employment service would not accept him because they were concerned about his volatile nature and a propensity for stealing. Matthew started to sleep all day and watch TV all night. He started regularly smoking marijuana and he was diagnosed with depression. Matthew's mother sought help from DoCS and the local supported accommodation service for people with intellectual disabilities. Both services said Matthew fell outside their target groups. He joined two recreation programs for people with disabilities but stopped attending because his behaviour attracted negative attention from the staff and other participants. He started a car-detailing course with TAFE for people with special needs but he stopped attending because he thought the other students were 'spasos'.

Around this time, Matthew started to get into trouble for petty theft. He was used and abused by a group of unemployed youth who included him in crimes and stole his money and possessions. Tensions at home increased with Matthew assaulting his stepfather and being aggressive towards his sisters.

He moved out of home and into a flat. He received meals on wheels and the community health nurses assisted him with his medication. His cannabis dependency increased and he started to use inhalants such as butane and glue. His encounters with the police escalated with charges of larceny, assault, stealing, possessing house breaking implements and cruelty to animals. The Department of Housing refused to accept Matthew because there was no 'workable case management plan' in place. The Public Guardian was appointed and the Protective Commissioner as financial manager.

Finally there was a violent incident with some of the local youths. Matthew stabbed a man who attempted to break up the fight. He was convicted of malicious wounding and assaulting and resisting police. He was sent to the Developmental Disability Unit at Long Bay Prison for three months with six months parole.

At Long Bay, Matthew was identified as having autism. The Autism Association and DoCS agreed to support Matthew. However, nothing was set up and so Matthew stayed in prison for the duration of his parole. He was then released from prison and went to Rydalmere Centre to live until something more appropriate could be worked out. He has lived at Rydalmere for over a year and lost considerable skills.

## 4.5 Family and social networks

Members of the target group need positive relationships with a network of family and friends. They commonly lack such relationships. In many cases, family and friends are negative role models.

Offending behaviour can also place great pressure on relationships. Family and friends often need support and advice. This is both to support their relationship with a target group member and to help them to help the person. This is particularly important in the early stages of offending behaviour when early action may prevent an escalation of the behaviour.

The Community Services Commission has emphasised the need for enhanced family support to decrease the need for children with disabilities to be placed in out of home care[25].

For Aboriginal members of the target group, there needs to be a focus on encouraging the role of their communities. The potential for families from a non English speaking background to be socially and culturally isolated also needs recognition.

**Recommendations**

24. Individual planning for members of the target group should include consideration of what assistance is needed to maintain and enhance a person's existing support and social networks and/or to link the person to alternative networks. This might include approaches such as:
    a) Facilitating a family conference.
    b) Training for an individual in social and friendship skills.
    c) Supporting family members so that they can better support their member of the target group.
    d) Fostering the links of an Aboriginal person with his or her community.

25. The Department of Community Services and Cabinet Office should consider how they could enhance the capacity of family support and other child and family services to support important relationships of members of the target group. This should include taking into account the isolation often experienced by families from a non English speaking background.

26. DADHC should give specific attention to the needs of the target group and their families in the development of the Flexible Family Support program.

27. DADHC or the proposed forensic support coordinators should explore local options for promoting support of families of a member of the target group, for example through encouraging the establishment of a group attended by parents of offenders.

# 4.6 Advocacy/mentoring

**Individual advocacy and mentoring -** Members of the target group seldom have a family member or friend willing and able to act as an advocate. Advocates tend to need skills in grappling doggedly with complex service systems. The fact that so many agencies are often involved, and each has different systems of operation, makes advocating for a person in the target group even more complex.

Members of the target group often also lack positive role models. They need a positive role model with whom they can develop an ongoing and trusting relationship. They need someone who is readily available to listen and provide advice. They often need someone who can introduce them to new activities and social networks.

An advocate and/or mentor can fulfil these needs.

For Aboriginal people and those from a non English speaking background, advocates/mentors from their own communities can be very valuable.

Community disability advocacy groups provide advocates for some members of the target group. This includes citizen advocacy groups that match a volunteer advocate with a particular person with a disability, usually aimed at a long term relationship but sometimes to assist with a crisis. These

25 *Inquiry into the Practice and Provision of Substitute Care in NSW* (2000) at 109.

groups aim to cover a wide range of different needs in a local community and so are limited in the focus they can provide to the target group.

The Public Guardian is guardian for some members of the target group and presses service providers and others to meet their needs.

In the youth sector, there is a small number of mentoring schemes which may also be useful to some of the target group. Evaluations of these schemes support their usefulness.[26]

However, the existing programs that depend on volunteer advocates or mentors find it very difficult to recruit volunteers for offenders especially if this involves an ongoing relationship. It is also difficult to find volunteers equipped to grapple with complex service systems.

The role of advocacy and mentoring needs to be further developed with the target group, with consideration to the following factors:
- It may not be realistic to expect a volunteer to commit at the outset to a long-term relationship with a member of the target group.
- Rather than only recruiting volunteers who already have all of the qualities needed, it may be preferable to recruit a wider pool of people with appropriate aptitude and then develop skills through training.
- Rigorous processes are required to recruit, screen, train, match and support volunteers.
- Advocacy and mentoring programs may need to be open to identifying people needing their assistance through methods including approaches from justice system personnel and service providers.
- Salaried advocacy may be required to assist members of the target group to obtain assistance from complex service systems. However, salaried advocacy is not well suited to meeting ongoing relationship needs.
- Many members of the target group will not be comfortable with being identified as having an intellectual disability or accepting assistance from a program that is overtly focused on people with disabilities.

A substantial budget is required if a scheme based on volunteer advocates or mentors is to work effectively. Also, the number of matches between volunteers and people with disabilities will be quite limited if the quality of the matches is to be maintained. For example, the Young Offenders Mentoring Project of the Big Sister/ Big Brother Program budgeted to achieve 35 matches per annum with 2.5 staff but found this target very difficult to achieve.[27] Citizen Advocacy Eastside supports about 30 ongoing relationships and aims to achieve about 15 new matches each year. This is with about 1.5 staff.[28]

Note the interplay between the issues under this heading and in Chapter 4.2 *A fair process with police and courts* above. It may that the one local organisation could deal with both issues.

**Systemic advocacy -** For the last fifteen years, a number of advocacy groups have been active in highlighting the systemic issues that make it difficult for target group members to have their needs met. Systemic advocacy is a very important complement to individual advocacy for a disadvantaged group such as the target group. Individual advocacy for a number of individuals provides valuable information and ideas about ways in which systems such as the legal system and service systems could better meet the needs of people with disabilities. Systemic advocacy can ensure that this information is gathered and ideas developed.

26 Evaluation of the Big Brother/Big Sister program in the USA found that the program had a major impact on drug use, school absenteeism and violent behaviour: Big Sister/Big Brother Program *Submission to Attorney General's Department for Young Offenders Mentoring Project* 23. See also K Orth *Friends Evaluation* (Uniting Care, Burnside, 2000).

27 Big Sister/Big Brother Program *Submission to Attorney General's Department for Young Offenders Mentoring Project* 8 and 28, and communication with Shauna McIntyre, Big Sister/Big Brother Program.

28 Communication with Kate Milner, Coordinator, Citizen Advocacy Eastside.

Systemic advocacy is also important in representing group views and needs of people with disabilities and their families. In the absence of universal availability of individual advocacy, this is a very important way to give groups of people a voice with governments and other community institutions.

**Recommendations**

28. The NSW Government should fund pilot advocacy and/or mentoring projects specifically focused on the target group, including projects closely linked to Aboriginal and NESB communities.
29. DADHC and/or the proposed forensic support coordinators should work with existing disability advocacy groups to develop their roles in providing advocates to members of the target group.
30. The funding bodies of existing mentoring schemes and/or the proposed forensic support coordinators should work with existing mentoring schemes for young people to develop their roles with members of the target group.
31. In developing generic and disability specific housing options for members of the target group, consideration should be given to options involving co-tenancy with a person able to act as a mentor and positive role model.

## 4.7 Addressing the offending behaviour – behaviour intervention and support

Many members of the target group need interventions focused on their offending behaviour. At present, appropriate responses very seldom occur.

**The kind of interventions needed -** See Chapter 8.3 *Interventions to address offending behaviour* for a summary of the international literature on this issue.

DADHC's *The Positive Approach to Challenging Behaviour* is a general guide to good practice for addressing challenging behaviour of people with intellectual disabilities. However, that practice has been largely based on working with people with moderate to severe intellectual disabilities. While a similar process for assessing and analysing behaviour applies to the target group, their needs are often more complex because of the interplay of their social, cultural, medical, educational and psychological histories. Also, the DADHC guide does not include approaches specifically focused on offending behaviour.

Members of the project target group also tend to have mild to borderline intellectual disabilities and this has major implications for program design and implementation. For example, there is a greater scope to use verbally based approaches such as cognitive-behaviour therapy and counselling than with other people with intellectual disabilities. Members of the target group tend to lead fairly unstructured lives which raises difficulties for embedding a program in a person's day to day life.

Interventions with target group members squarely need to address the offending behaviour. Intervention approaches must include offence specific approaches, which directly address the individual's particular offences. Offence specific interventions are provided in a therapeutic setting and may include both one to one counselling and small group sessions. This kind of intervention is usually provided over a long period by a skilled counsellor, clinical psychologist, psychiatrist or other appropriately trained and experienced professional.

In addition to offence specific interventions, most of the target group also need training in offence related areas. These include areas such as problem solving, anger management, sexuality and legal issues. This training also can be offered in either group or individual sessions. They need to be tailored to the individual's needs. Training is more effective if it continues until the person has acquired the desired skill outcomes and shown they can use them over time and in generalised settings.

Where a person has involved family, it is generally important to work with them, including addressing issues in their lives that might impede their capacity to work consistently with behaviour programs.

**A major gap in expertise -** There is very limited availability, expertise and experience in NSW in meeting the particular behaviour intervention and support needs of the target group. Intellectual disability professionals have expertise with and a focus on people with more severe intellectual disabilities, and rarely with offence specific interventions. Professionals with generic agencies lack expertise in intellectual disability and find it difficult to provide the greater time commitment that an offender with an intellectual disability may need. There is also very limited networking and cross fertilisation of knowledge and experience between these groups of professionals. Even where the expertise does exist, it is very isolated and difficult to access.

Some agencies offer generic courses in some offence related areas but these seldom meet the needs to the target group. The content of the courses tends not to be appropriate. The courses are often time limited and lack the necessary follow up and support to ensure that skills are generalised into the settings where they are needed.

**Bridging the gap -** Later in this report, there are recommendations aimed at bringing together and developing a specialist clinical capacity focused on the target group. The recommended option for this is a forensic clinical team in disability services linked to specialist initiatives elsewhere. The team would do some direct assessment and programming work with target group members and act as a training and consultancy resource to other services. See Chapter 4.19 *A specialist capacity*. The specialist capacity would develop some offence specific and offence related training courses which could be then implemented by it or other disability or generic services.

The specialist capacity would build a bridge between existing skill bases in working with offenders generally, and in working with challenging behaviour of people with disabilities.

The Departments of Juvenile Justice and Corrective Services have some particular experience doing offence specific programs with offenders generally. For example, Juvenile Justice has a sex offenders program for convicted young offenders. This is complemented by two programs funded by the Department of Health for young people who have not been convicted. Corrective Services also has some programs for sex offenders. Although the programs are not specifically for offenders with intellectual disabilities, Corrective Services have provided training to DoCS staff in this area of expertise.

The target group needs to benefit from this existing expertise in offence specific work. This requires a pooling of disability and offence specific expertise so that offence specific programs are implemented in a way that takes account of a person's intellectual disability.

One encouraging development in a generic agency is enthusiasm in the Department of Education and Training to better address the challenging behaviour of members of the target group. The Department has a Challenging Behaviour Positive Intervention Team focused on students with intellectual disabilities. There may be scope to expand this team so as to allow it to focus specifically on members of the project target group. The Department of Education and Training team could also be linked with the forensic clinical team proposed in this report.

**The role of guardianship -** Where a program involves restrictive elements, there are important roles for departmental mechanisms, the Guardianship Tribunal and guardians in the approval and monitoring of the program. These roles are made more challenging by the currently very limited skill base in NSW for design and implementation of behaviour programs for members of the target group. When a restrictive element is proposed as part of a program for a person with a severe intellectual disability, there are well established standards of good practice against which the program can be measured. In the absence of such standards in relation to the target group, monitoring and consent authorities need to proceed with greater caution. This is the more so given the possibility that restrictive practices could be proposed for reasons of community protection. Guardianship authorities must regard the interests of the person with the disability as paramount.

**Focuses for action -** The following recommendations are aimed at ensuring appropriate behaviour intervention and support for members of the target group through:

- Building a specialist skill base that can be used directly to assist some members of the target group and to be a training and consultancy resource for other generic and disability professionals.
- Cross fertilisation of existing knowledge amongst existing disability and generic professionals.
- Enhancement of the capacity of professionals in existing agencies to work with the target group.
- Ensuring that the adult guardianship system acts as an adequate safeguard on the appropriateness of restrictive practices used with members of the target group.

**Recommendations**

32. The proposed specialist clinical capacity in disability services should have a function of design and implementation of behaviour intervention and support programs for some members of the target group and be a training and consultancy resource on these issues to other agencies.

33. The proposed specialist clinical capacity in disability services should have clearly established links with the Departments of Corrective Services and Juvenile Justice and funded agencies that have expertise in offence specific work. These links should be aimed at cross fertilisation of knowledge and determining who is best placed to carry out offence specific work in different circumstances. A professional network for clinicians and agencies working in this area should be established.

34. The proposed specialist clinical capacity should develop some specialised offence specific and offence related training courses and conduct some such training and encourage other generic and disability services to do so also. Where appropriate, the specialist clinical capacity should do these things jointly with agencies that have expertise in offence specific work and agencies that have expertise in culturally appropriate behaviour intervention strategies.

35. Generic agencies should enhance their skills and priority or resources to develop and implement programs to address the challenging behaviour of members of the target group. These agencies include schools, child and family services, Corrective Services, Juvenile Justice, general health services and mental health services.

36. Existing disability services should enhance their skills and priority or resources to develop and implement intervention and support programs for members of the target group. These includes services provided or funded by DADHC.

37. The Department of Education and Training should expand its Challenging Behaviour Positive Intervention Team so as to allow it to focus specifically on members of the target group and to link the team with the proposed specialist clinical capacity in disability services.

38. The Guardianship Tribunal and Public Guardian should review their roles, policies and procedures in relation to restrictive practices used with the target group, including considering whether further safeguards need to be built into this system. This would include addressing issues of:

a) Whether there are adequate safeguards to ensure that a restrictive practice is appropriate in the interests of the individual.
b) Ensuring an adequate focus on outcomes for the individual.
c) Appropriate restrictions on the breadth of discretions given to guardians and service providers.
d) Regular reviews of orders and consents.
e) Ensuring that Tribunals hearing cases involving a member of the target group have specific skills in relation to the target group.
f) Providing an accessible, multi member and expert appeal mechanism against decisions of the Tribunal and Public Guardian.
g) Training of Tribunal and Public Guardian personnel.

## 4.8 Education and training

Education and training is often part of the professional approaches that are needed to address offending behaviour. However, it is worth also treating it separately here so as to acknowledge the role of schools, TAFE colleges and other education and training services.

Members of the target group commonly need general skills development as well as the offence specific and offence related interventions noted in the previous section. General skills development covers issues such as such as literacy, numeracy, social, recreation, daily living, communication and vocational skills.

These kinds of teaching can be provided on a one to one basis in the person's home. Alternatively, they can be provided in small groups by organisations including schools, correctional centres, TAFE colleges, community health centres and FPA Health.

However, there is very limited such teaching available that is suited to the needs of the project target group. While courses in some relevant areas do exist in the generic services, they are either targeted to people with more severe intellectual disabilities or to people without disabilities. Thus, these courses are either too difficult, or the target group will not attend as they do not identify with having a disability.

Also, course organisers often do not recognise the support needed by target group members if they are to access and benefit from these courses. Target group members are often labelled as unreliable and unmotivated when the problem may be one of no money to travel to the course or not being able to tell the time so as to arrive on time. Target group members are often very good at hiding their disability. Though they may seem to have good language skills, they may have very poor comprehension. Flexibility and support are needed.

Another important limitation to TAFE is that its focus is confined to vocational and prevocational training. The latter does include subjects like literacy and numeracy but not various other kinds of general skills development. Other agencies, including funded disability services, need to cover non-vocational subjects.

The school system should have a central role in prevention of the development of offending behaviours. In fact, a person's disability may not be identified, the more so if the person is from a non English speaking background or Aboriginal. Early intervention to address challenging behaviour commonly does not occur. Members of the target group often have numerous changes of school, suspensions and expulsions, with no follow up. Where a person's needs are recognised and action taken to address the needs, this knowledge may be lost when the student moves from primary to secondary school or leaves school.

## Chuan

Chuan is 28. He has a mild intellectual disability and epilepsy. He was born in China and has an older sister Lim. In China, both his parents worked and a nanny raised Chuan. The family migrated to Australia in 1980 and his parents ran a restaurant in Sydney. They worked long hours. Chuan's mother does not speak English. In 1985 Chuan's parents separated. His mother got work as a "live in" housekeeper with another Chinese family. Chuan and Lim were left to cope without the presence of an adult. He was 13.

Chuan and Lim attended the local public school. Lim had no difficulty learning English and did well at school. Consequently, the school did not realise that Chuan had an intellectual disability and assumed his poor performance was instead a conduct disorder. He had great difficulty learning English. He was bullied and bashed by other boys and his behaviour deteriorated. He left school under suspension before his school certificate. His school reports had implied that he was a normal and adequate student. He never saw a school counsellor or specialist staff member.

Both Chuan and Lim worked for their father in his restaurant. It appears to have been an unsatisfactory and exploitative experience. When Chuan was 16, Lim went away to university. He was left at home by himself six days of the week. Chuan was keen to work and got a number of jobs. However, he lost the jobs quickly because of his very low levels of literacy and numeracy and his limited concentration and comprehension. His mother had no knowledge of the Social Security benefits available and continued to work six days and nights a week. Chuan drank heavily, smoked cigarettes and cannabis and mixed with "criminal" associates.

When Chuan was 19, he was convicted of break, enter and steal. He was placed on an 18 month unsupervised recognisance. A year later, he forged his sister's signature to her bank account and tried to steal money. He was given community service. At 20, Chuan was convicted of sexual assault of a seven-year-old girl and sentenced to three years' imprisonment.

While at Long Bay, Chuan was assaulted and nearly strangled to death by other inmates. The effects on Chuan were severe and he was diagnosed as suffering post-traumatic stress disorder. On release from prison, he stayed at an accommodation service for people with an intellectual disability for a year and apparently did well there. He then returned to live with his sister and mother. Lim has a professional occupation and now supports her mother who stays at home. According to Lim the atmosphere at home is very unhappy. Lim has unsuccessfully tried to find Chuan a job in a sheltered workshop. In 1997 Chuan suffered serious epileptic seizures and had to be hospitalised.

Currently Chuan is appealing two convictions of sexual assault of a woman with an intellectual disability. The forensic psychologist's reports describe Chuan's sexual offences as "characterised by his ability to assess suitably vulnerable and defenceless female victims on an opportunistic basis".

Schools could valuably offer courses focused on the law and how to deal with the legal system.

Families, especially those from cultural or racial minorities, often lack confidence in dealing with the school system.

**Recommendations**

39. Primary, secondary, special education and TAFE teacher training courses should include training about the target group. This could be included in the mandatory training on students with special needs that is required for NSW teacher registration.

40. The Department of Education and Training should include as an essential requirement in teacher promotion, a working knowledge of issues relating to the target group and otherwise managing diversity in a mixed ability environment.

41. The Department of Education and Training should enhance the capacity of schools to identify members of the target group and take early action to avoid the development of offending behaviours. This should include promoting an understanding of the ethnic and racial factors that may impact on these processes. This recommendation could be implemented by providing staff development and support material in relation to the target group. An initial pilot could establish effective training procedures and identification and support mechanisms.

42. The Challenging Behaviour Positive Intervention Team of the Department of Education and Training's should provide support to schools to assist in developing supports for the target group. This could include staff development and staff support.

43. Schools should enhance their transition procedures to ensure that knowledge gained about the needs of a member of the target group accompany the student when he or she moves through transition points such as changing schools or leaving school. The pilot mentoring program for children at risk of difficult transition from primary to secondary school could be a useful model to explore and use.

44. The Department of Education and Training should develop strategies to raise the capacity of TAFE Institutes to provide courses suited to the needs of the target group and support to enable target group members to access courses.

45. As one initial strategy, the Department of Education and Training should dedicate resources for a pilot support program to operate in a TAFE Institute and be administered by the disability teacher/consultant. The teacher/consultant would be part of post release planning processes and support target group members in selected education and training options. The teacher/consultant would provide staff training about the target group, including cultural competence, and provide support to the teachers working with target group members.

46. Individual planning should address the support needs of individuals so that they can attend education and training courses, for example through travel training, budgeting for fares or provision of a support person.

47. The Department of Education and Training should identify district contact officers to provide support for interagency cooperation around members of the target group.

48. The Department of Education and Training should include the strategies developed from the above recommendations in its Disability Strategic Plan so that there is regular monitoring and reporting at a senior departmental level.

## 4.9 Mental health services

Many members of the target group have psychiatric disorders as well as intellectual disabilities. Many are prescribed psychoactive medication. There needs to be close cooperation between mental health services and others assisting members of the target group. This cooperation is often hard to achieve.

Mental health services are often reluctant to accept even partial responsibility for a person with a dual diagnosis. Mental health services and disability services may each claim that a person is the other's responsibility, based on arguments about what is a person's "primary disability".[29]

Where mental health services do become involved, they tend to be focused on dealing with crises rather than ongoing assistance. A more integrated and ongoing approach to service provision is needed. For example, the mental health service might at least monitor a person's mental health each three months and participate in individual plan reviews.[30]

Mental health professionals are often ill informed about intellectual disability and the disability services system and so can have quite unrealistic expectations of it. Likewise, intellectual disability professional are often ill informed about mental illness and mental health services.[31]

There is a dual diagnosis protocol between the former DoCS disability services and the Department of Health. This protocol has not worked well. The problem was not so much in what was in the protocol as in getting it to happen in practice. The protocol was being reviewed but there do not appear to have been any outcomes of the review.

One particular problem relates to personality disorders. Better understanding is needed of when it is appropriate to use this diagnosis with a member of the target group. There is also inadequate understanding and availability of the ongoing services needed for people given this diagnosis.

Especially with the difficulty accessing specialist mental health services, general practitioners can have an important role in mental health treatment. Recent changes in Medicare rules means that GPs can be paid to attend case conferences relating to a patient. Whilst a GP may have a useful role, this should always be complemented by periodic consultations with a psychiatrist.

Mental health professionals need to be conscious of the potential for some medications to have different effects on people from different ethnic origins.

One positive development in recent years has been the formation of a Psychiatrists in Developmental Disability group which meets regularly.

See Chapter 4.21 *Coordination between agencies* for discussion and recommendations in relation to achieving a more integrated cross agency approach to meeting the needs of the target group. The recommendations there apply to mental health services. However, some further and more specific recommendations can be made.

29 Report 80 para 10.2.

30 Consultation with clinical issues group on options paper.

31 Consultation with clinical issues group on options paper.

**Recommendations**

49. Cooperation between mental health services and disability services should be promoted through implementation of Recommendation 112 below.

50. Professional training and development should be used to enhance the knowledge and skills of psychiatrists, other mental health professionals and general practitioners about treating members of the target group and about the disability service system.

51. Professional training and development should be used to enhance the knowledge and skills of intellectual disability professionals about mental illness and about the mental health service system.

52. Through the Psychiatrists in Developmental Disability group, the specialist knowledge of psychiatrists who have a particular interest in the target group should be enhanced.

53. Through the Psychiatrists in the Transcultural Mental Health Services, the specialist knowledge of psychiatrists who have a particular interest in the target group should be enhanced with information and strategies for working with people form a non English speaking background.

54. The proposed specialist clinical capacity in disability services should have consultant psychiatrists available for advice to it and other psychiatrists, and to participate in assessments and program design.

55. Research should occur to provide better understanding about when it is appropriate to diagnose a person with an intellectual disability as having a personality disorder and about the ongoing management options for a person with this diagnosis.

## 4.10 Brain injury

Some members of the target group have acquired brain injuries that have caused or added to their disabilities. The lifestyle of many members of the target group leaves them vulnerable to brain damage from substance abuse or an accident.

This may have important implications for behaviour intervention, management and training options.

A neuropsychological assessment would often be valuable in identifying the existence and nature of an acquired brain injury and implications for addressing the person's needs. For example, an assessment may show damage to the frontal lobe of the brain so that the person has major limitations in impulse control. These assessments are hard to get. There are neuropsychologists in brain injury services and public hospitals. However, assessments are generally only available in these services to people with severe brain injuries, or in private centres that are beyond the financial means of most of the target group.[32]

32 Consultation with clinical issues group on options paper.

**Recommendations**

56. The proposed specialist clinical capacity in disability services should have neuropsychologists available to it to participate in assessments of members of the target group and provide advice on intervention options.

57. The Department of Health should ensure that neuropsychologists in public hospitals are available to provide assessments and consultancy where needed for a person with an intellectual disability.

58. The proposed specialist clinical capacity should develop and promote a screening tool to assist disability professionals to be alert to the possibility of an acquired brain injury.

## 4.11 Alcohol and other drug services

Many members of the target group have problems with alcohol and other drugs. These problems may well contribute to their offending[33]. However, it is very difficult to get alcohol and other drug services to assist members of the target group. These services are not well equipped to assist the target group and so tend to be reluctant to do so. The Drug Court is reluctant to accept members of the target group into its diversion program. Also, the recently established Youth Drug Court Program Pilot has suitability criteria which mean that a person with a “serious” intellectual disability may be assessed as unsuitable[34].

The NSW Government has recently finalised a protocol between alcohol and other drug services and mental health services[35]. A major seminar was held on this issue in late 2000. These acknowledgments of the significance of dual diagnosis should be extended to people with intellectual disabilities.

A recent paper by Louisa Degenhardt from the National Drug and Research Centre provides a timely study on appropriate interventions for people with intellectual disabilities who have alcohol problems.[36] Most of the interventions suggested by Degenhardt are consistent with usual best practice for meeting the needs of people with intellectual disabilities. Some need debate about the ethics of their use especially with people who may not be able to give a valid consent. However, the Degenhardt paper shows that there are appropriate interventions available to address alcohol and other drug problems of people with intellectual disabilities. Alcohol and other drug workers need better training so that they can confidently implement these interventions.

Approaches to address substance abuse need to be worked out holistically with other plans to meet a person’s needs. Substance abuse is often associated with factors such as loneliness, and sexual abuse.

Disability workers also need to be better informed about substance abuse. This would enable them to better identify signs of a drug problem and equip them to work with alcohol and other drug services. Disability workers could work with alcohol and other drug workers and the person concerned in deciding what interventions should be used. This would both enhance the confidence of alcohol and other drug workers to work with the target group and allow the disability workers to take a role in program implementation.

---

33 M Moore and J McGillivray "Offending behaviour and substance abuse amongst people with mild intellectual disability" in A Shaddock and others (eds) *Intellectual Disability and the Law; Contemporary Australian Issues* (Australian Society for the Study of Intellectual Disability, 2000) 77-87.

34 K Graham "Piloting a Youth Drug Court" (August 2000) 25(4) *Alt LJ* 185-186.

35 NSW Health *The Management of People with a Co-existing Mental Health and Substance Use Disorder* (2000).

36 L Degenhardt "Interventions for people with alcohol use disorders and an intellectual disability: a review of the literature" (June 2000) *Journal of Intellectual and Developmental Disability* Vol 25 No2 135-146.

If professionals have appropriate training and members of the target group have appropriate support, there is no reason why the target group should not have equitable access to the diversionary programs of the Drug Courts[37].

Meredith Adams, Clinical Nurse Consultant (Drug and Alcohol), was a member of the project's clinical issues group and expressed enthusiasm to follow through on the issues around people with an intellectual disability in Central Sydney health area.

**Recommendations**

59. Cooperation between alcohol and other drug services and disability services should be promoted through implementation of the recommendations in *Coordination between Agencies* below.
60. The Department of Health should organise training to increase the skills of alcohol and other drug services to identify members of the target group and meet their needs.
61. The accessibility for the target group to diversion programs through the Drug Court should be enhanced through training for personnel linked to the Court.
62. Professional development should be used to provide disability workers with skills in identifying problems with alcohol and other drugs, and in working with alcohol and other drug services in addressing those problems.
63. The proposed specialist clinical capacity in disability services should have alcohol and other drug professionals available for advice to it and to participate in assessments and program design.
64. The functions of the proposed specialist clinical capacity in disability services should include being a source of expert consultancy to alcohol and other drug services in design of programs suited to members of the target group.

## 4.12 Employment

Employment is a very important way of reducing the likelihood of a person offending, through providing constructive activities and income. Members of the target group are commonly unemployed. They often lack the skills, motivation and support to find and maintain employment. Many find segregated disability supported employment stigmatising and boring.

Generic employment agencies also find it difficult to meet the needs of the target group. These agencies tend not to understand the problems a person with a disability has in accessing, obtaining and maintaining a job without some support. The support needed is often related to getting to and from the job on time, problem solving and social skills, and is a very individual thing. Disability employment agencies are also limited in this regard.

Community Support Programs are funded through Centrelink to prepare for employment people who have been unemployed for over two years and who face particular barriers to employment. These programs could be useful for members of the target group but they may need specialist staff training and a disability worker to provide support to the person.

Hands on support may also be very important to the person maintaining a job. The person may need support to deal with problems that arise in the workplace. This kind of support might be provided through the DADHC Service Access System or through the role of the proposed forensic support workers. See Chapter 4.4 and 4.19.

The Commonwealth Department of Family and Community Services has recently funded a project to look at barriers to employment for people with intellectual disabilities leaving prison. This project should provide some clear ideas about how to improve this situation.

37 See the outline of the program in K Graham "Piloting a Youth Drug Court" (August 2000) 25(4) *Alt LJ* 185-186.

**Recommendations**

65. The Commonwealth Department of Family and Community Services should develop strategies to enhance the capacity of generic and disability employment agencies to meet the needs of the target group.

66. Individual planning should consider what support a person needs to find and maintain employment.

## 4.13 Accommodation

Members of the target group have diverse accommodation and related support needs. Most have potential to live at least semi-independently in the long term. Some need long-term intensive supervision and support. A wide range of options is needed.

Housing needs of target group members also range from urgent short term accommodation to a long term home.

Apart from being a basic human need, stable accommodation is an extremely important underpinning to programs that can reduce the likelihood of offending behaviour and give people the opportunity to lead more positive lifestyles.

**The status quo -** In fact, members of the target group very often lack appropriate accommodation and associated support and supervision. Many are homeless. These factors can both contribute to offending and be a crucial factor in police and judicial decision making about bail, non custodial sentences and parole. People with intellectual disabilities often miss out on these normal non-custodial options. As the Law Reform Commission put it, "And so a person with an intellectual disability may be denied liberty due to a lack of services"[38].

Some members of the target group are in disability supported accommodation, ranging from inappropriate institutional accommodation to a few people in highly individualised arrangements with individual funding packages. The former DoCS disability services (now operated by DADHC) established a house devoted to providing intensive support, supervision and programming for some offenders who have intellectual disabilities and similar needs.

Some children and young people in the target group are in generic out-of-home care arranged by DoCS or an NGO funded by DoCS under the Children and Young Persons (Care and Protection) Act 1998. These arrangements often do not meet the needs of the person. Some members of the target group stay in youth refuges, which find it very difficult to meet their needs.

Historically, unfunded boarding houses accommodated many members of the target group. Such businesses are not equipped to provide the support needed by members of the target group. The entry screening tool introduced by the Ageing and Disability Department in 1999 should inhibit further admissions to this accommodation by target group members with higher support needs. See *Boarding houses* in Chapter 6.1.

Department of Housing tenancies are often not available to members of the target group for want of the support needed to meet their tenancy obligations and other needs.

The Department of Corrective Services funds transitional accommodation for some prisoners at the end of their sentences. The Department has approved in principle funding some such accommodation to members of the target group.

38 Report 80 para 11.43.

## Hassid

Hassid is thirty years old and has a moderate intellectual disability and epilepsy. He comes from a Lebanese background and lives in Sydney. He has a supportive and loving family. Problems with challenging behaviour were noted early in Hassid's school history. He attended a school for specific purposes until he assaulted the principal and lost his place when he was ten. He was then placed at a residential school for specific purposes, where he remained for another two years.

Hassid returned home for another four years. During this time he attended respite services. His parents found him increasingly difficult to manage. Consequently, Hassid was placed in an old traditional residential institution for men with intellectual disability on the outskirts of Sydney.

Within four months, Hassid was involved in an incident of a sexual nature that resulted in the death of another resident. Hassid was found unfit to be tried and was placed in a detention centre for a four year term.

In preparation for Hassid's discharge, a psychologist compiled a report in which he indicated that there was still a risk of assaultive behaviour and that it was unlikely that any self control that was learnt in the detention centre would be generalised. There were no suitable options identified for Hassid on his release. However, his parents accepted him home with programming support from the DoCS Special Program Support Service (SPSS). Within two months the placement broke down.

The Public Guardian was appointed as guardian for Hassid. It sought emergency respite care on the basis that there was a "very real danger that Hassid would cause serious physical harm and possibly the death of a member of his family if he were not separated from them."

Hassid was finally admitted for an eight day respite stay at a DoCS disability services institution. He is still there nine years later. A psychiatrist assessed him and noted a nexus in Hassid's mind between sexual behaviour and aggressive behaviour. During his early years at the institution, Hassid worked full-time and was involved in a program with SPSS which relied heavily on the use of response cost or natural consequences for non-performance of activities of daily living. This was extremely effective. He had a one to one worker for three years but funding for this then stopped. Hassid has absconded on a number of occasions, he has stolen keys and knives and he has threatened other residents and staff. Nonetheless, the number of incidents has been decreasing over the years and aggressive behaviour is now the exception rather than the rule.

Throughout Hassid's time in the institution, there has been a constant dialogue between DoCS, the Public Guardian and Hassid's parents to try and meet his needs through placement and programming. In 1996, Hassid started going to local TAFE courses in employment access, numeracy and literacy. In 1998, he started working with a supported employment service, collecting trolleys at the local supermarket.

The Department of Juvenile Justice funds some community-based accommodation. The Department acknowledges that this accommodation may not meet the needs of young people with intellectual disabilities.[39]

**Victoria -** In Victoria there is a range of supported accommodation funded by the Department of Human Services for people in the target group. This includes accommodation for limited term

39 R Beilby, Department of Juvenile Justice, Comments on draft report.

intensive program support and individual flats with drop in support. The Department also runs two "emergency or crisis" houses which offer up to three months accommodation for people on bail or otherwise in need of crisis accommodation. See *Victorian Disability Services Criminal Justice Program* in Chapter 8.1.

**Focuses for action -** A range of strategies is needed in NSW in order to meet the accommodation needs of the target group. Existing service providers such as the children's substitute care system need to raise the quality of what they do.

Existing disability service providers need to provide equitable access to the target group. This in turn requires those providers to develop their skills in working with the target group.

However, DADHC also needs to plan a focused development of accommodation and related support for the target group. This includes ensuring an appropriate system for secure access to real estate, whether through purchase, leasing from the Department of Housing or otherwise. The accommodation and support need to cover a range of needs:

- Urgent short term accommodation.
- For some individuals, limited term accommodation for intensive program support in preparation for a move to a more independent home.
- An ongoing home – For most members of the target group, this would involve the person living alone or with someone else of his or her choice, and with drop in support. For a small proportion, group home accommodation may be appropriate. A very small proportion may need long term intensive support and supervision.
- Transfer of some individuals from prison or a detention centre during the term of a sentence. See Chapter 4.15 *Transfer from prison/detention centre.*

Whilst the capacity of all services to assist the target group should be enhanced, some service providers should be encouraged to develop specific skills in working with the target group. This could be through funding some accommodation/support specifically for members of the target group and in choosing appropriate providers where funding has been approved under the Service Access System.

Preferably, services providing accommodation/support to target group members would also be assisting other people with disabilities. However, a degree of specific focus on the target group would be needed if the service was to develop appropriate skills.

**Urgent short term accommodation -** Members of the target group can need this in a variety of circumstances including:

- If a person has inadequate housing and support and is showing signs that he or she may commit an offence.
- When decisions are being made about whether a person should be charged with an offence, about bail and about bonds.
- At the time of release from correctional settings, although, if the service system was working well, pre release planning should normally be able to identify a longer term option.

For a young person, even a short period in a Juvenile Justice detention centre increases the likelihood of recidivism[40]. There is no reason to think that this would not apply equally to adult offenders.

Short term accommodation should provide the person with some stability, and time to identify and plan to meet the person's needs. Individualised short term placements, for example in a flat with support, will be desirable for some people. However, some placements in group homes are also needed, in particular for people needing a high level of support or supervision. These houses should not just be focused on offenders.

40 Department of Juvenile Justice, quoted in Community Services Commission *Inquiry into the Practice and Provision of Substitute Care* Final Inquiry Report (2000) 76.

**Limited term accommodation for intensive program support -** For most members of the target group, beyond any urgent crisis period, accommodation/support should be focused on provision of an ongoing home suited to the needs of the person. However, a small proportion of the target group need a more intensively supported transitional option.

This kind of option may be the only way to give some individuals the opportunity to develop patterns of stable accommodation and positive lifestyle rather than itinerancy and regular imprisonment, or segregation in an isolated institution. These tend to be people with very unstable lifestyles who are unlikely to remain in accommodation and avoid prompt reoffending without a period of very structured and intensive programs and supervision. They may have just left gaol and face great difficulty with the transition from a highly structured and restricted lifestyle. They may be in a period of crisis where offending and breakdown of their support arrangements is highly likely.

A small number of group homes should be funded for people in these circumstances. Each house would have no more than five residents. The houses would need a high level of staffing and staff skills. Intensive programs would be provided both away from and at the house. Programs would focus on addressing the person's offending behaviour and development of skills needed for a more positive lifestyle. A person's freedom of movement may be restricted to some degree, by conditions on bail, bond or parole, and/or the consent of a guardian.

In view of the combination of the restrictive nature of such houses and the congregation of offenders in them, they are justifiable only where they demonstrably lead promptly to a less restrictive alternative. Structural safeguards need to be in place to ensure they do not become a de facto form of preventative detention. Such safeguards should include, at minimum, that:

- The houses are overseen by a steering committee including independent community representatives.
- Placement in the houses only occurs in the context of a plan for the person to move on to a home suited to his or her needs. This plan would need to address ongoing individual needs for program support and supervision.
- There should be a set maximum period for which any person could be accommodated in such a service. This maximum would apply irrespective of progress in response to programming.

There are competing arguments about what this maximum period should be. From a rights perspective, one year is arguably an appropriate maximum. From a clinical point of view, two years is arguably more appropriate in view of the complexity of the challenge of addressing entrenched patterns of offending behaviour of some individuals. Analogous accommodation is provided in Victoria by the Statewide Forensic Service (SFS) and the Australian Community Support Organisation (ACSO). SFS endeavour to move people through the accommodation within two years and this is mostly adequate. A maximum time limit is seen as a valuable way to ensure prompt action in designing and implementing programs.[41] ACSO has a usual maximum stay of one year but about 20% of people are seen as needing longer[42]. SFS generally deal with the most challenging offenders.

**Community housing schemes -** These have potential as a structure through which some of the kinds of housing discussed above could be set up. The Department of Housing enters partnership arrangements with other agencies which manage the tenancies and provide the supports needed by residents. This can be for long term housing or under the Crisis Accommodation Program. Such arrangements for the target group are within current priorities of the Department of Housing.[43]

**An assessment unit? -** There was some support on the clinical issues group for the idea of a specialised live-in assessment unit. However, if there was a range of accommodation options as discussed above, appropriate assessments should be feasible and may be more valid where the person is. There should be no need for a separate assessment unit.

41 Communication with Frank Lambrick, psychologist, Statewide Forensic Service.

42 Communication with Kathy Arentz, manager, ACSO.

43 Communication with Alison Wannan, Director, Office of Community Housing, Department of Housing.

**Grouping of offenders -** In the limited circumstances where it is appropriate for members of the target group to live in communal accommodation, there should be no rule or presumption that they live together. Grouping of offenders may lead to the household being stigmatised and residents reinforcing each other's negative behaviour. However, in a narrow range of circumstances, grouping may be appropriate. For example, it may make it practicable to meet shared and specialised needs for assessment, supervision and programs. Also, the wishes and existing relationships of the individuals concerned are important, especially if they have already lived together. Two members of the target group may well want to share a flat and similar support services.

**Recommendations**

67. Individual planning needs to consider the accommodation and related support needs of the person.

68. DoCS Child and Family Services should develop a strategy to increase the capacity of its own and funded child and family services to provide appropriate out of home placements to children and young people in the target group. This includes working with youth refuges to increase their skills for working with the target group.

69. DADHC should ensure development of the capacity of disability services generally to provide supported accommodation and accommodation support for the target group, through increasing staff skills and access to specialist support.

70. DADHC should fund appropriate agencies to provide supported accommodation or accommodation support for members of the target group who need this assistance. This should include:
    a) Urgent short-term accommodation and support, including a small number of group homes for crisis accommodation for people with milder levels of intellectual disability, including members of the target group.
    b) Ongoing homes, generally in individualised accommodation but including some group homes.
    c) A small number of group homes providing accommodation for a strictly limited period in conjunction with intensive and expert program support and in the context of a plan for each resident to move to an ongoing home suited to his or her needs. Such homes should be overseen by a steering committee including independent community representatives.

71. The funding and housing stock for the accommodation and support in recommendation above should be provided from:
    a) Funds currently available to DADHC for accommodation and related support.
    b) The Service Access System.
    c) A funding enhancement from Treasury.
    d) And development of the role of community housing schemes through the Department of Housing.

72. Through increased skills, priority or resources, there should be an enhancement of the capacity of generic agencies that provide post release accommodation to offenders to meet the needs of the target group.

73. As part of the transitional accommodation funded by the Department of Corrective Services for people at the end of their sentences, the Department should provide short term options for members of the target group.

74. If the Department of Juvenile Justice continues to fund community-based accommodation, then the Department should ensure that funded services are able to meet the needs of young offenders with intellectual disabilities.

> 75. The starting point should be that members of the target group should not be housed together. However, exceptions to this may be appropriate taking account of the following factors:
>     a) The wishes and compatibility of the residents.
>     b) The number of members of the household and the mix between members of the target group and other residents.
>     c) If the accommodation is for urgent short term purposes and it is the best available option for the person.
>     d) If the members of the household have highly specialised needs in common in terms of intense supervision, programming and location of accommodation (eg people with established patterns of sexual offences).
>     e) If the grouping is for a strictly limited period of intense programs and supervision, with a process in place to ensure that the person then moves on to other accommodation.
>     f) If the accommodation is for people who have been allowed to move to community based accommodation during a prison sentence.

## 4.14 Restrictions on freedom of movement[44]

Court orders that provide alternatives to prison or a detention centre often have conditions attached. This applies to bail, bonds as a sentencing option and parole towards the end of a term in prison. The conditions often require the person to live in a particular place, attend certain programs and the like. An intellectual disability can be an impediment to complying with such normal conditions[45]. These conditions do not empower service providers to force the person to comply. Breach of the conditions can rather lead to the person being sent to a prison or detention centre.

**The role of guardianship -** Guardianship orders from the Guardianship Tribunal can be used to restrict the freedom of movement of individuals with disabilities, including those in the target group, in a range of circumstances. Purposes of restrictions on members of the target group include:

- To keep a person out of trouble with the law.
- To assist a person to comply with bail, bond or parole conditions.
- And/or to provide a period of stability whilst trying to assist the person to develop a more positive lifestyle.

Guardianship may only be used in this way where a person's disability precludes him or her making and implementing a reasonably informed decision about the issue in question, for example, whether to comply with bail conditions. In the case of a person with a borderline or mild intellectual disability, the Tribunal would need to consider this issue very carefully.

Obviously, restrictions on freedom of movement should only be imposed with great care. In making these decisions, the guardianship authorities must comply with the principles in section 4 of the Guardianship Act 1987. These principles include that:

- The interests of the person with the disability are paramount.
- The freedom of decision and freedom of action of the person should be restricted as little as possible.
- The person should be encouraged, as far as possible, to live a normal life in the community.
- The views of the person should be taken into consideration.
- The person should be protected from neglect, abuse and exploitation.

44 For a more detailed discussion of these issues, with references, see J Simpson *Options to Imprisonment, Legal and Related Issue Concerning the Department of Community Services Providing Restrictive Services to Alleged Offenders with Intellectual Disabilities* (1997) unpublished.

45 In the period 1990-1998, 10.1% of identified prison inmates with intellectual disabilities were in prison for breach of parole conditions compared with 5.7% of total inmates. Department of Corrective Services, *Recidivism and Other Statistics on a Population of Inmates with Intellectual Disability in NSW Correctional Centres* 1.1.1990-31.12.98.

These principles govern the Tribunal in making a guardianship order and an appointed guardian in carrying out the order.

Features of the use of guardianship to restrict members of the target group include:

- The degree of restriction involved can vary widely with individual circumstances. It may only be a power to bring the person home if he or she leaves in an agitated state. However, it might be a locked door in more extreme circumstances.
- The degree of restriction can be varied with changing circumstances. For example, a high level of restriction may be needed in an initial period when a person is very unsettled. The degree of restriction then may be gradually relaxed. Increased restriction may be needed again in a time of crisis.
- Restriction should only occur in the context of appropriate positive programs and other service provision to meet the person's needs. The guardian's power to give or refuse consent to the restriction adds clout to the guardian's advocacy for such services. It would be much harder to say that a restriction was in someone's interests if it were not part of an overall positive plan.
- The views of the person are relevant. If the person shows a strong negative reaction to a restriction, it would be much harder to say that the restriction was in the person's interests.

At first reading, such restrictions might be thought to breach the Disability Services Act principle that disability service provision must occur in a manner which results in the "least restriction" on the "rights and opportunities" of people with disabilities[46]. But the issue is what is the <u>least</u> restriction that is consistent with the individual's circumstances, including complying with the other principles and applications in the Act. Similarly, the paramountcy of the interests of the person may require a restrictive option under the Guardianship Act principles.

Restriction can be beneficial in a range of circumstances. For example, some individuals may need a period of restriction to provide a stable base for programs to assist them from a very negative lifestyle, with no stable home and regular imprisonment, to a much more positive and fulfilling lifestyle. A small degree of restriction may be needed to provide an individual with a "normal" opportunity for bail or parole.

However, guardians tend to be confronted with major dilemmas about whether to consent to restrictions. Restrictions may avoid a possibility of imprisonment. However, the degree of this possibility may be difficult to assess and the accommodation and services available to the individual may be poorly equipped to meet the person's needs. If this report is implemented, guardians' decisions may not be so difficult

There is also a danger that using guardianship to restrict members of the target group could confuse the focus of guardianship on the interests of the individual. Guardianship authorities could allow community protection to blur this focus or there could at least be a perception that guardianship was about community protection.

**An alternative approach: civil commitment -** An alternative to guardianship being used to restrict the movement of some offenders would be "civil commitment" or "compulsory care" legislation. This could provide for a court or tribunal to impose restrictions on a person with an intellectual disability who was perceived as a danger to the community. This could occur without the person being charged with an offence. At most, the restrictions could involve indefinite confinement to a locked facility. This approach would provide service providers with a clearer mandate for restrictions than does guardianship where the consent of the guardian is needed and the focus has to be the interests of the individual.

On the other hand, civil commitment legislation could lead to people being heavily restricted rather than receiving an appropriate response to their challenging behaviour. This could apply to both those

46 Disability Services Act 1993 (NSW) Principle (g). Note also Guardianship Act 1987 (NSW) s4.

currently seen as "offenders" and those not so perceived. Also "dangerousness" is both very difficult to predict and tends to be considerably over-predicted. Further, civil commitment legislation could have a negative effect on community perceptions of people with intellectual disabilities. Such legislation does not apply to non-disabled people and so raises major issues about the equal rights of people with disabilities.

These concerns about civil commitment legislation also apply to guardianship but the paramount focus of guardianship on the interests of the individual reduces the concerns.

Overall, civil commitment legislation would be an unjustified move away from the notion of equal rights for people with intellectual disabilities. It was not favoured by the Law Reform Commission[47].

**Conclusion on guardianship -** A continued though cautious use of guardianship is appropriate. It would be valuable to enhance the safeguards in the guardianship system in cases involving restrictions on offenders. The recommendations below are aimed at this.

DoCS disability services have sometimes expressed concerns about whether guardianship could be used to authorise restrictions on the freedom of movement of people with intellectual disabilities.[48] These concerns were perhaps given more weight by the obligation of DoCS services to comply with the objects, principles and applications of principles in the DSA. However, these doubts should have been resolved by the passage of the Guardianship Amendment Act 1997. That Act inserted a new s.21A into the Guardianship Act. That section makes it explicit that the Tribunal may empower a guardian to authorise others (such as disability service workers) to take specified measures (such as restraint or confinement) to ensure that the person under guardianship complies with a decision of the guardian. If there remain any serious doubts on this issue, it could be put beyond question by a small amendment to the DSA. However, this should not be needed.

**Recommendations**

76. Guardianship should continue to be used as a way of providing for restrictions on the freedom of movement of members of the target group where this is required in an individual's interests. The interests of the individual should remain the paramount consideration for the Guardianship Tribunal and appointed guardians.

77. The safeguards in the guardianship system in relation to such cases should be enhanced, through the following measures:
    a) Legal or advocacy representation should be arranged by the Guardianship Tribunal for a member of the target group if it is proposed to give a guardian the power to restrict his or her freedom of movement.
    b) The Tribunal should adopt a policy that guardianship orders that permit a guardian to restrict the freedom of movement of a member of the target group should be made for a maximum of one year at a time.
    c) The Guardianship Tribunal and Public Guardian should cover restrictions on freedom of movement in the review of their roles and procedures in relation to the use of restrictive behaviour intervention strategies proposed in recommendation .

47 Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System; Courts and Sentencing Issues* (Discussion Paper 35, 1994) paras 12.2-12.28 and Report 80 para 6.35.

48 Cf letter from the Crown Solicitor's Office to the Department of Family and Community Services dated 20 May 1991, and advice to the Office of the Protective Commissioner from BHK Donovan QC dated 21 June 1991.

# 4.15 Transfer from prison/detention centre

The options just discussed would not apply to people who have been charged with offences and who are not seen by a court as suitable for bail, a bond or the like. The Law Reform Commission recommended that the then DoCS disability services provide a range of secure accommodation for some such people, as the Department of Health does for some offenders with mental illnesses. This would require specific legislation.

Consumers of such a "secure option" would need to be "detained" at their place of residence. However, "detention" can range from locked doors to a high level of supervision, including appropriate outings, depending on individual circumstances.

For a more detailed discussion of these issues, see J. Simpson, *Options to Imprisonment, Legal and Related Issue Concerning the Department of Community Services Providing Restrictive Services to Alleged Offenders with Intellectual Disabilities*[49]. The recommendations below are based on that paper. However, the detail in that paper should be given further consideration including a process of community consultation if the idea of a "secure option" is to be implemented. Since the paper was written in 1997, there have been substantial changes to the disability service system and this report proposes further changes.

**Recommendations**

78. A secure option to prison should be created for some offenders with intellectual disabilities:
    a) Who are on remand awaiting trial.
    b) Who have been sent to prison after being found "unfit to be tried".
    c) Who have been found not guilty on the grounds of "mental illness" (which in this context can include intellectual disability).
    d) Or who have been given normal prison sentences.

    The secure option should apply similarly for young people in juvenile detention centres.

79. An appropriate tribunal should have a central role in decision making about transfer of a person to the secure option, setting of security arrangements and regularly reviewing the person's circumstances. With appropriate adjustments, this might be the Mental Health Review Tribunal or the Guardianship Tribunal.

80. Decision-makers should take account of community safety in decisions about security levels, leave and release for people accommodated in the secure option.

81. Subject to community protection considerations, the secure option should conform to the principles and applications in the Disability Services Act 1993.

82. The location, appearance and number of residents in accommodation for the secure option should fully conform with the DSA.

83. The accommodation in the secure option should be operated by DADHC.

Recommendation 82 would mean that some individuals could not be catered for. The recommendation reflects a judgment on how far it is appropriate to qualify the principles in the DSA so as to allow a secure option to be established.

49 Unpublished 1997.

The secure option should be operated by DADHC. It would not be appropriate to contract out such a restrictive role. And DADHC is the appropriate government body since it is experienced in providing services within the DSA. In Victoria, intellectual disability services in the Department of Human Services fulfil the role being proposed here – the Intensive Residential Treatment Program runs a small number of group homes, partly for people transferred from prison. See *Victorian Disability Services Criminal Justice Program* in Chapter 8.1.

## 4.16 People from a non English speaking background

Members of the target group from a NESB face particular problems in having their needs met. Apart from communication problems, they face problems including a lack of cultural awareness and cultural stereotyping.

Lack of sensitivity to language and cultural issues can impede identification and assessment of people in the target group from a NESB. Assessment tools, for example IQ tests[50], may not be linguistically or culturally appropriate. Services and families may be inclined to see a problem as flowing from language rather than the possibility of a disability.

For refugees, the impact of trauma and torture may make more complex the task of an accurate assessment.

People who have recently arrived in Australia are particularly likely to be isolated from support networks.

In assisting members of the target group, services need to work with the person's community. Community settlement workers in migrant resource centres are a valuable source of liaison and might be used as paid consultants.

**Recommendations**

84. People working with the target group should receive cultural competency training.
85. Services should ensure a budget for the use of interpreters where needed to ensure adequate communication.
86. Services should promote themselves and provide information in ways that are culturally accessible and in different formats and languages.
87. Disability services should establish a network of culturally specific support workers.

## 4.17 Aboriginal people

Aboriginal people also face particular problems including a lack of cultural awareness and cultural stereotyping. An intellectual disability is often not identified in school. A child's problems at school are perceived as related to his or her Aboriginality and families may not be concerned due to an accepting attitude to diversity in academic achievement and behaviour.

Removal to a correctional centre tends to sever constructive links between an Aboriginal person and his or community and promote a feeling of disenfranchisement and demoralisation.

50 X. Wen *The Definition and Prevalence of Intellectual Disability in Australia* (Australian Institute of Health and Welfare 1997) at 8.

## Careena

Careena is fourteen years old. In primary school, she was diagnosed with a borderline/ mild intellectual disability and Attention Deficit Hyperactivity Disorder (ADHD). She also has a vision impairment.

Careena grew up in a large regional city. Her father is white and her mother is Aboriginal. Her parents lived in a defacto relationship and then separated. Careena has a younger brother. After the separation sole custody was granted to her father and Careena has had very little contact with her mother. Her mother is an addicted drug user. Careena's mother contacted her children every couple of months but the contacts were brief and unsatisfactory. They would often finish when her mother was too intoxicated to attend to the children any longer. Careena's father did not encourage contact because he believed that her mother was not a positive influence on the children and that in her extended family there is a history of substance abuse and criminal behaviour. Nonetheless, Careena reports a positive relationship with her maternal grandmother. She also reports positive relationships with her paternal grandmother and her father's sister. Careena's relationship with her father is positive and important to her. However, she says that her father has hit her "heaps of times". Careena's father formed another relationship and Careena has younger half brothers and sisters.

Careena attended a regular primary school and was placed in a regular class from kindergarten until year 3. In years 4 to 6 she was in a special class. Careena went on to a special education program at the local high school, however she only attended for a month and refused to return. She was 13. While her experiences at primary school were essentially positive, she had begun to experience difficulties at high school and the difficulties were intensifying. She was suspended on several occasions for violent behaviour towards other students. The principal of the school made an application to an adolescent support unit for professional assistance in addressing her school problems and behavioural disturbance. Nothing eventuated. In the interim Careena worked from home with the assistance of the home school liaison officer. Her progress reportedly improved.

Careena then set fire to and burnt down one of the school buildings. This appears to have been her first offence. Whilst awaiting court for the arson charge, and during a visit to her mother, she robbed a liquor store while armed with a broken bottle.

Careena was detained at Yasmar where a number of issues emerged. Careena reports some difficulty in her identification as an Aboriginal. She expresses a wish to become closer to her Aboriginal family and her Aboriginal culture. Careena also identifies as a lesbian. She says that she has been aware of her sexual preference since she was eleven.

The use of custodial sentencing options for Aboriginal people needs to be minimised. The principle that an offender's cultural background is relevant to sentencing is well established at common law[51]. The principle has been used to justify departure from the general sentencing requirement that at least three quarters of a sentence must be served in a correctional setting. This approach can allow Aboriginal offenders to serve a greater percentage of their sentence on parole[52].

The Australian and NSW Law Reform Commissions have independently recommended that the recognition of Aboriginal customary law in sentencing be given legislative backing[53]. At present,

51 *Neal v The Queen* (1982) 149 CLR 305 at 326; *R v Fernando* (1992) 76 A Crim R 58 at 62.

52 *R v King* NSW CCA No 60721/95, 27 November 1996 unreported; *R v Stone* (1995) 84 A Crim R 218.

53 NSW Law Reform Commission *Sentencing: Aboriginal Offenders* Report 96 (2000) Chapter 3; Australian Law Reform Commission *The Recognition of Aboriginal Customary Laws* Report 31 (1986) para 517.

judges and magistrates have a discretion as to whether or not to consider Aboriginal customary law and this discretion is inconsistently applied[54]. A legislative requirement to consider Aboriginal customary law would encourage community development and maintenance of such laws and form a basis for greater involvement of the community in sentencing. This would encourage the use of sentencing to reconcile the offender with his or her community.

While legislative support for culturally positive sentencing is important, it will have little effect unless there is an increase in the availability of community based alternatives to custodial sentences. There must be greater involvement of Aboriginal communities in the development of these alternatives. Aboriginal people are more likely to respond to services provided by their own communities and tend to be wary of services provided by white bureaucracies especially those that handle child protection issues.

The NSW Law Reform Commission has recommended the adoption of the Canadian developed "Circle Sentencing" pre sentence option[55]. Based on the premise that crime affects whole communities, this scheme involves indigenous community members in sentencing decisions. Sentencing plans are developed and community resources are used to put them in place. The scheme is similar to Youth Justice Conferencing. However, it has been used with adults and for serious offences, such as those involving violence. A working party is currently developing a model of the scheme for piloting, based on a proposal by the NSW Aboriginal Justice Advisory Council. The scheme needs legislative backing, adequate funding and judicial and community support. The scheme needs to have regard to the particular needs of Aboriginal offenders with intellectual disabilities.

In correctional settings, Aboriginal people can form close bonds with other Aboriginal inmates. This needs to be taken into account in post release planning.

It would be valuable to link an Aboriginal member of the target group to a mentor in his or her own community. However, people able to take a mentor role tend to be overstretched. Training programs and other supports within communities may increase the availability of mentors.

**Recommendations**

88. Where possible, Aboriginal workers and support people should be included in planning and support for Aboriginal members of the target group.
89. Training on the needs of the target group should be provided to Aboriginal workers and community and family members involved in supporting members of the target group
90. People working with the target group should receive training in issues relevant to working with Aboriginal people.
91. Services for the target group should be developed with and in Aboriginal communities.
92. Liaison should be established with the Aboriginal Education Consultative Group NSW to explore strategies for identifying and supporting Aboriginal members of the target group at school.
93. At a local level, each Aboriginal Education Consultative Group should be involved in individual planning for Aboriginal school students who are members of the target group.

54 NSW Law Reform Commission *Sentencing: Aboriginal Offenders* Report 96 (2000) Chapter 3.
55 Ibid Chapter 4.

94. At a school level, the Aboriginal Education Assistant should be included in planning and support for Aboriginal school students who are members of the target group.

95. Development of options to custodial sentences should be promoted within Aboriginal communities, and Aboriginal customary law and "Circle Sentencing" should guide this process.

96. Evaluation of the proposed pilot of "Circle Sentencing" in NSW should consider the use of the pilot with members of the target group.

97. Post release planning and support should be developed for each Aboriginal member of the target group. It should include liaison with the person's family and community. If the person is not returning to his or her community then, pre release, there should be networks established elsewhere for him or her. Post release planning and support should involve Aboriginal workers. A useful link could be with the local Aboriginal legal service field officers and/or the Aboriginal justice workers in the Attorney General's Department.

## 4.18 Promoting acceptance of services

Members of the target group often find it difficult to regularly attend beneficial programs and comply with expectations that will promote non-offending lifestyles. Services too readily withdraw rather than grapple with these issues.

Service providers sometimes say that their services are voluntary and that the person has rejected the service. These statements tend not to consider:
- How informed the rejection is.
- Whether steps could be taken to promote acceptance of assistance.
- Or to look for more flexible ways of offering the service.

When a person rejects a service, this should be documented along with the efforts taken to address the situation. A flexible and imaginative approach can often avoid or overcome the rejection of assistance.

In some situations, a more coercive approach from external authorities such as the courts or guardianship authorities may be appropriate.

Appropriate strategies can include:
- A case manager or other key worker spending time establishing a positive and trusting relationship with the person.
- Seeking to respect the person's wishes about who their key worker should be.
- Actively involving the person in the choice or development of programs.
- Investigating whether there is any cultural factor relevant to whether the person might accept assistance.
- Flexibility in service delivery, for example a worker regularly attending the person's home at a time when the person is most likely to be there and encouraging the person to participate in some constructive activity.
- Working out with the person what assistance he or she might need to ensure attendance, for example travel training, time telling and time planning, budgeting for fares, provision of a support person.
- Similarly involving any trusted people in the person's life such as an advocate or family.
- Working out strategies for the person and others to use to defuse any overly stressful situations.
- Building in consequences for non-compliance as arise if, for example, attendance at a program is a condition on a bond or parole or the like.
- Guardianship orders.

**Recommendations**

98. Services should train staff in strategies for promoting or requiring the acceptance of assistance by members of the target group. This should include consideration of the circumstances where such strategies are appropriate.

99. Services should record each person in the target group who is in contact with that service, the steps taken to seek to provide access to the service, and the success or otherwise of these steps. The system for coordination between agencies (proposed in Recommendation 112) should include a system to gather data on these issues and use the data to improve the capacity of services to appropriately respond to the target group.

# Joanne

Joanne is thirty six years of age. She has a mild/moderate intellectual disability and an alcohol dependence problem. She has a long history of self-harm. Although Joanne has no diagnosed metal illness, she has been admitted to psychiatric hospitals for assessments on a number of occasions. A report by a psychiatrist said, "She feigns depression imitatively and for secondary gain and is often prescribed anti-depressant drugs".

Joanne lived at home with her parents, a sister and the sister's defacto and two children. Her father, sister and sister's defacto all have alcohol problems but Joanne and her mother did not while she was living at home. Over the years, nine children had been removed from the home due to the father's alcoholism and physical abuse. Joanne was sexually assaulted by her father when she was an adolescent.

Joanne attended a local primary school until year 5 when she went to a special class for two years. She then attended the local high school until she left in Year 9. After school, she worked for "a few months" in a sheltered workshop but has not worked since.

At 31, Joanne left home and moved into a unit in order to be independent. When she left home she says that she was lonely and began to drink heavily. Within a month, she was charged with shop lifting. She was given bail, which she quickly broke and consequently went to prison. She has been to prison approximately 15 times in the past 5 years. Joanne has continued to shoplift and her other offences included malicious damage and assault with intent to rob. A typical pattern is for Joanne to be released from prison and then to reoffend very quickly.

A number of services have been involved in Joanne's life since she has been in contact with the criminal justice system. She received a one off grant of $20,000 from the Department of Community Services (DoCS). This money was used by a non government organisation to provide support, which included: training in living skills and budgeting; 1:1 weekend support for recreation; general drop in support and assistance with visits to doctors appointments and alcohol counselling. Whilst receiving this support, Joanne returned to prison five times for periods ranging from two weeks to four months.

The Public Guardian is Joanne's guardian. They called a case meeting as their role was unclear and there was no agency providing case management. DoCS then agreed to develop a behaviour management plan and to complete an accommodation funding submission. However, four days after the meeting, Joanne reoffended and has remained in custody since then.

## 4.19 A specialist capacity

**Complex but absent skills -** Complex skills are required to assess and meet the needs of members of the target group in relation to behaviour intervention and other clinical issues. Addressing or "nipping in the bud" patterns of offending behaviour of people with intellectual disabilities and generally unstructured and negative lifestyles is no easy task. These skills are in very short supply in the existing service system. As discussed earlier in Chapter 4.7 *Addressing the offending behaviour – behaviour intervention and support,* intellectual disability professionals who work in challenging behaviour tend to be focused on people with more severe intellectual disabilities. They lack experience and skills in working with the target group who generally have mild to borderline disabilities and unstructured lives as well as their offending behaviour. There are some generic professionals skilled in addressing offending behaviour but they lack expertise in intellectual disability.

NSW needs to develop a group of professionals with specialist skills in addressing the offending behaviour of the target group. They could build up this expertise by gathering together existing knowledge amongst disability and generic professionals in Australia and the learning to be found in international literature. They could then apply and further develop these skills by working with the target group in NSW.

One important example of an issue where skills are currently lacking is in assessment of risk of offending behaviour. See Chapter 8.3.

This specialist clinical capacity would need to include professionals from a range of disciplines. The central core would be psychologists and special educators. However, this would be complemented by other disciplines such as psychiatry, communication and alcohol and other drugs.

Similar issues arise in relation to more general assessment of needs, support coordination, case management, delivery of support services and supervision of offenders. There is the same sort of gap in expertise in what is a complex and demanding task – seeking to divert from a pattern of offending people who are often:

- Leading very unstructured lives.
- Difficult to establish and maintain rapport with.
- Unused to engaging in learning and other programs.
- Itinerant or at least unreliable about attending appointments.
- Lacking positive social supports and role models.
- Confronting police and other legal issues.
- Skilled at hiding any deficits.
- Quick to react negatively to stressful situations.
- Quick to quit when the situation is difficult, confronting or confusing.

Again, intellectual disability workers are used to dealing with the very different challenges raised by people with more severe intellectual disabilities. Those who work with people with more mild disabilities generally are working with people with well structured lives and who are readily open to service assistance, for example in accommodation support or employment programs. And again, generic workers, such as those in Probation and Parole or child and family services, lack skills in intellectual disability.

At the last meeting of the project reference group, members strongly confirmed that there is no significant pool of expertise in disability services in relation to the target group. Skills and experience need to be specifically developed.

Thus, a body of expertise needs to be developed amongst psychologists, special educators, other clinicians, support coordinators and other service providers. Those with this expertise could work

directly with some members of the target group and act as a training and consultancy resource to other service providers.

This report includes many recommendations aimed at relevant generic and disability services lifting their capacity (that is, their skills, priorities and/or resources) to assist members of the target group. These recommendations will have very limited efficacy unless a body of expertise in relation to the target group is developed. Services will have nowhere to obtain the skills and guidance that they need if they are to competently and confidently work with the target group.

People with appropriate expertise should be available on a 24 hour basis. Many crises for members of the target group, including those that consume considerable police resources, arise outside business hours.

The issue then becomes where to develop this expertise and how to integrate it with existing and proposed structures and roles in the disability, justice and other generic service systems.

**Options for building a specialist capacity -** There is a wide range of options that could be focused upon for building a specialist capacity. These options would have varying degrees of effectiveness. A package could be put together out of the following options:

- Identifying and fostering people with appropriate aptitude amongst Service Access System support planners and assessors.
- Building expertise amongst local area support coordinators.
- Building expertise amongst DADHC services local case managers and programming teams, and other local disability services.
- Building expertise amongst local health professionals.
- Building expertise amongst local justice system workers.
- Building expertise of other local workers (child and family, education and training, Housing etc).
- Some internal specialisation focused on the target group in applicable options above.
- Establishing a network of local specialist disability behavioural professionals linked to other local clinicians.
- Lifting the capacity of the Training Resource Unit in DADHC to act as a source of expertise in behaviour intervention and support in relation to the target group.
- Establishing a network of interested professionals across the range of disability and generic services. This network might meet for training and information exchange and informally consult each other as needed.
- Establishing a statewide clinical team based in disability services but also including health professionals. See below.
- Establishing a statewide system of forensic support coordinators and workers focused on the target group. See below.
- A statewide forensic group (centrally based or locally with statewide coordination). This group might bring together specialists working in disability services, health services, Education, Corrective Services and Juvenile Justice. It could provide a basis for cooperative action in meeting an individual's needs, mutual development of skills and mutual cooperation in training of personnel in disability and generic services.
- Linking in the above with DADHC structures for regional planning and capacity building.

The potential effectiveness of each of the above options would depend on factors including:

- Their capacity to provide an even statewide service.
- Their status and clout in the overall service system.
- The competing demands placed on personnel and their employers.
- The degree to which the time of personnel could be quarantined for the target group.
- The development of a system to build up specialist skills of the personnel.
- Demarcations affecting the circumstances in which an option might be available and the extent to which the option could focus on all of a person's needs and in an ongoing way.

**The recommended approach: establishing a dedicated specialist capacity in disability services with links to specialist capacities in other agencies -** Ultimately, it might be feasible to have professionals and workers with appropriate skills spread through the disability and generic service systems. However, in the short and medium terms, a more concentrated approach is needed to build up a body of expertise which can be used directly with some members of the target group and more broadly as a training and consultancy resource. There need to be identified local contacts and sources of specialist advice in relation to the target group.

The recommended model includes a dedicated specialist capacity in disability services. This would comprise:
- A centrally based forensic clinical team.
- A network of area based forensic support coordinators and forensic support workers.

(Victoria has a similar capacity. See *Victorian Disability Services Criminal Justice Program* in Chapter 8.1.)

This specialist capacity in disability services could be linked to specialist capacities that exist or are proposed for other agencies, in particular:
- The recently established multidisciplinary Disability Resource Team in the Department of Corrective Services. See *Department of Corrective Services* in Chapter 6.3.
- Local contact/resource officers as proposed in this report for Probation and Parole, Juvenile Justice Community Services and other agencies. See Chapters 4.20 *Links to the justice system* and 4.21 *Coordination between agencies*.

The **clinical team** would carry out some specialist assessments, program design and implementation and be a training and consultancy resource to other agencies. Its proposed functions are more fully stated in recommendation 101 below. The core of the team would be psychologists and special educators but it would also include a range of health professionals. This health professional time should be negotiated with the Health Department and would be partly covered by Medicare benefits.

The clinical team might be an autonomous agency or a centrally based part of an existing agency. The option of attaching it to the court system is not favoured as it may skew its work too much towards situations of immediate crisis and away from a prevention and early action role.

The **forensic support coordinators** would have a similar role to the local support coordinators currently being established by DADHC. As well as assisting individuals, local support coordinators will have roles in community development, fostering the roles of local generic agencies and service development. These functions would be included in the roles of the forensic support coordinators.

The forensic support coordinators would assist some individuals to obtain appropriate services and other support. They would also be a local expert resource to other agencies. For example, they would be a source of consultation for local police, lawyers and health professionals in relation to issues like identification of a person with an intellectual disability and services available for the person. They could be at least the initial local contact for Probation and Parole and Juvenile Justice for the proposed system of justice plans. (See Chapter 4.20 *Links with the justice system*.) They could perhaps also fulfil the support planning role under the Service Access System (SAS) for members of the target group. They would link into the DADHC regional planning systems.

This proposed role is similar to that of a court liaison nurse who acts as a link between the legal and mental health systems in Newcastle. An evaluation of that service reports very positive feedback from stakeholders in the justice and mental health systems. Relations between the two systems are seen as improved, referrals have been streamlined and the outcomes for clients are better.[56] A similar service now operates at Parramatta Court and includes a psychiatrist as well as a nurse [57].

56 J Walton and J Sharples *Evaluation of the Court Liaison Nursing Service, James Fletcher Hospital* (1999).
57 Corrections Health Service *Court Mental Health Team* (2000).

The **forensic support workers** would take a hands on support/case management role with some members of the target group. This could include practical tasks such as being available when an individual needs to "sound off" about a problem, support to attend appointments and programs, assisting rapport with a drug and alcohol counsellor and reinforcing what the counsellor has said. This is a similar role to that of paid "mentors" employed by the Department of Juvenile Justice to work with some young offenders. See *Department of Juvenile Justice* in Chapter 6.3.

The proposed forensic support coordinator and worker roles draw on features of some successful overseas programs that work with the target group: Lancaster County (PA), Developmentally Disabled Offenders Program in New Jersey, Pueblo Developmental Disability/Mental Health Consortium in Colorado and Continuity of Care Program (TCOMI). See Chapter 8 *Literature Review.*

Note – the adjective "forensic" is used in this report as a convenient way of distinguishing the proposed specialist roles. It may not be appropriate for the actual services.

The network of forensic support coordinators and workers would be coordinated to some degree by the clinical team. This coordination could include periodic meetings and regular communication between team members.

One thing that should be stressed is that the above model for a specialist capacity in disability services would only directly assist a small proportion of the target group. Most people would need to continue to look to other services. However, the specialist capacity could assist with enhancing the skills of those services.

**Alternative approaches -** There are numerous variations on this preferred approach that could be considered. For example:

- A network of interested clinicians might be formed across disability and generic services, with regular training and information sharing meetings. There might be some central coordination of the network. An assessment team might be gathered together on an ad hoc basis. However, this sort of approach would be much less able to build the necessary expertise, to operate evenly across the State, to be on call as a resource and to carry out a systematic program of training for other professionals. It would probably be harder to organise prompt and well coordinated multi disciplinary assessments, and to ensure that the experts had the necessary clout with local services.
- The role of the Training Resource Unit in DADHC could be developed to be a source of clinical expertise in relation to the target group. The TRU has done a significant amount of work with target group members in recent years. However, as well as developing the TRU's expertise, a number of structural issues would need to be addressed. The gradings of TRU staff are low (predominantly no higher than a 5/6 level) as compared with the complex work that they do with people with challenging behaviour. The TRU role is largely confined to dealing with individual cases and for DoCS clients, rather than more broadly improving practice in behaviour support across disability services. The TRU would need a clearer multidisciplinary capacity and enhanced linkages to other relevant professionals. The TRU was recently reviewed by DoCS and this review may be a useful reference.
- Some of the support planners engaged for the SAS might be trained to work with the target group. However, this would be a much narrower role than is needed. It would be confined to support planning for people approved for assistance under the SAS. See the discussion of the potentially useful but limited role of the SAS for the target group in Chapter 4.4 *Meeting individual needs*.
- The support worker role could be contracted as needed under the SAS. This may confine the role of the workers to a very small proportion of the target group. Also, it could be very difficult to ensure the workers had the requisite skills when they were only being engaged on an ad hoc basis.

The preferred approach above could build the needed body of expertise and resource a building of capacity in the general service system. Other approaches would be unlikely to be nearly as effective.

**Recommendations**

100. A body of expertise should be developed in assessing and meeting the needs of members of the target group, including addressing offending behaviour. That expertise should:
   a) Include expertise in assessment, program design and implementation, support coordination, case management, direct support and supervision of offenders.
   b) Be aimed at directly meeting the needs of some members of the target group and building up the capacity of generic and disability services generally to meet those needs.
   c) Be multi disciplinary across relevant professions, especially psychology and special education but also including psychiatry, alcohol and other drugs, speech pathology, neuropsychology, neurology, nutrition and general health care.
   d) Include a strong base in disability services but also include expertise across other service systems.
   e) Be placed so as to create respect and influence for it in decisions about individuals, policy and planning.
   f) Include competence in cultural diversity, experience with Aboriginal people and people from non English speaking backgrounds, and a clear capacity to be accessible to these groups, for example through having a budget for translating and interpreting costs.
   g) Have a statewide focus.
   h) Have specific work time of its personnel dedicated to issues relating to the target group.
   i) Have priorities focused on:
      - Prevention of people becoming offenders, for example fostering preventative strategies in schools and child and family services.
      - Early action when a person first comes into contact with the justice system.
      - Situations involving people with complex needs and whose behaviour is having the greatest impact on the person or others.
   j) Have roles in:
      - Advice and consultation, including a 24 hour capacity.
      - Training of personnel in generic and disability agencies.
      - Direct assistance to some members of the target group.
      - Participating in multi-disciplinary assessments and program design, implementation and review.
      - Developing cooperation between local communities and agencies in meeting the needs of the target group.
      - Developing specialised courses focused on offending behaviours.
      - Conducting research in relation to meeting the needs of the target group.
      - Service development and regional planning.

   The specialist capacity in disability services should be implemented in accordance with recommendations 101-108 below.

101. There should be a forensic clinical team focused on the target group and with the following functions:
   a) Being a source of expert advice, information, referral and training to other agencies.
   b) Assessing individuals' needs in some priority cases. Assessments by the team would be comprehensive, holistic, coordinated and, where appropriate, multi-disciplinary.

c) Developing some specialised courses focused on particular offending behaviours, conducting some such training and encouraging other generic and disability agencies to do so also.
d) Design and implementation of behaviour intervention and support programs for some members of the target group.
e) Developing expertise in, and disseminating information on, culturally competent behaviour intervention strategies and support programs.
f) Supporting a statewide network of forensic support coordinators and forensic support workers.
g) Providing evidence to courts and tribunals on matters relating to its other functions.
h) Monitoring, evaluation and research in relation to the work of the unit and of the forensic support coordinators and workers.
i) Having clear access to some specialist supported accommodation for members of the target group, including where necessary for assessment or program implementation purposes.

102. The forensic clinical team should be centrally based but with a strong regional outreach capacity through the following methods:
a) Links to area based forensic support coordinators and forensic support workers.
b) Travel to regional areas.
c) Local consultants.
d) A toll free phone number.
e) Possibly ultimately having staff in some major regional centres.

103. The forensic clinical team should have employees or consultants experienced with the target group and with expertise in psychology, special education, speech pathology, psychiatry, neurology, neuropsychology, alcohol and other drugs, nutrition, general health care, culturally competent service delivery to Aboriginal people and people from a Non English Speaking Background, research, and training of other professionals and workers.

104. The forensic clinical team should also have the capacity to coopt local clinicians to provide expert input to assessment and other work in relation to an individual.

105. Within its staffing, the forensic clinical team should have substantial experience with Aboriginal people and people from non English speaking backgrounds, such experience preferably arising from being a member of these communities.

106. There should be a statewide network of specialist forensic support coordinators and forensic support workers.

107. The forensic support coordinators should have the following functions:
a) Fostering the roles of local agencies and communities in assisting the target group including through being a local source of advice, consultancy and training.
b) A support coordination role for some members of the target group.
c) Being a link into the Service Access System.
d) Service development and participating in DADHC regional planning.
e) Being the key contact for justice system personnel in relation to the proposed system of justice plans.

108. The forensic support workers should have the following functions:
a) A hands on support role with some members of the target group to assist implementation of individual plans and to deal with crises.
b) A case management role for some members of the target group.

# 4.20 Links to the justice system

This project is mainly focused on community services rather than the justice system. However, community services need to have clear links to the justice system so that the likelihood of a person reoffending is minimised and people get equitable access to non-custodial or semi-custodial options including parole, bonds, community service orders, home detention and periodic detention[58].

The Police Service need close links with community services including when they are deciding whether or not to charge a person with a minor offence.

The Probation and Parole Service and its counterpart in Juvenile Justice (juvenile justice officers) need to work with community services. The project's consultation with stakeholders revealed concern about the adequacy of the knowledge of Probation and Parole officers about intellectual disability services. The Law Reform Commission recommended the establishment of a specialist service within Probation and Parole focused on supervision of members of the target group.[59] A preferable approach may be to have at least one worker in each Probation and Parole office who has specific training or expertise in working with the target group. This person could then be a resource to other staff.

In Victoria, there is a system of "justice plans" whereby Probation and Parole work with disability services to see what community services are available, including a specific focus on services that will reduce the likelihood of the person reoffending. These services are set out in the justice plan. Where appropriate, a court can then make compliance with the plan a condition of a bond. This system is set out in specific legislation.[60] The same approach could be used in NSW without specific legislation. However, legislation may be desirable to give the system a clear status and to provide a clear mandate for service providers to observe their obligations under the order. The system could apply to decisions about parole as well as bonds. In some cases, local police would be able to provide important input to justice plans, for example through their knowledge of geographical areas where a person may be exposed to a high level of criminal activity.

If a person is sent to prison or a juvenile detention centre, there needs to be continuity of programming and coordination in pre release planning so as to reduce the likelihood of the person reoffending. This is consistent with the "Throughcare" approach which has been approved in principle by the Department of Corrective Services.

**Recommendations**

109. Cooperation between justice system agencies and disability services should be promoted through implementation of the recommendations in *Coordination between Agencies* below.

110. In particular, the Departments of Corrective Services and Juvenile Justice should ensure that there is at least one officer in each Probation and Parole and Juvenile Justice Community Services office with specific training or expertise in working with the target group.

111. A system of justice plans should be developed whereby justice system and disability service personnel could work together to link services that will reduce the likelihood of reoffending to bonds and parole conditions. The proposed forensic support coordinators or other local officers designated by DADHC should be an initial point of contact in disability services for the development of justice plans.

58 Report 80, paras 11.30-11.33, 11.38.
59 Report 80, recommendation 59.
60 Sentencing Act 1991 (Vic) ss 80-83.

## 4.21 Coordination between agencies

Many government and community organisations have roles to play in meeting the needs of the target group. This applies both at the level of establishment of a service framework and in organising a coordinated package of services for an individual. A system is needed to coordinate cross agency responses.

The project's review of the international literature emphasised the importance of systems for coordination between agencies. Western Australia has taken significant steps on this issue. See *Western Australia* in Chapter 8.3

The Law Reform Commission saw little coordination between government agencies in relation to the target group. A number of agencies may be assisting an individual but in an ad hoc, uncoordinated and duplicative manner. Alternatively, no agency may be assisting because of gaps in responsibility or demarcation disputes.[61]

The NSW Government Disability Policy Framework encourages all government agencies to accept responsibility for meeting the needs of people with disabilities. The framework is based on section 9 of the Disability Services Act 1993 and anti-discrimination law. In its review of the DSA, the Law Reform Commission saw Section 9 as having largely failed to meet its aims. The section has various weaknesses and the Commission recommended its strengthening.[62]

Recent though limited initiatives in relation to cross agency cooperation that might be built on are:
- The establishment by the former DoCS disability services of a cross agency Special Support Needs Panel aimed at a coordinated response to the needs of some people who are due for release from prison or detention centres.
- The current development of a cross portfolio Disability Action Plan on justice issues.
- The recent development by DADHC and the other human services departments of the idea of support coordination as a kind of case management where multiple agencies are involved.
- Action towards a joint agency response to the care and support needs of a group of people with disabilities, challenging behaviour and complex support needs. The Health Department and DADHC are the main players in this initiative.[63]

**A system for coordination -** A system for cross agency coordination in relation to the target group needs to include the following elements:
- Coverage of:
  - Systemic issues about coordination between agencies.
  - Ensuring cross agency cooperation in relation to some individuals with particularly complex cross agency needs.
  - And otherwise oversighting implementation of this report.
- Focuses for cross agency cooperation should include:
  - Prevention of a person becoming an offender, and early action to address offending behaviour.
  - Availability of appropriate support in the community when police and courts are making decisions about laying charges, granting bail and sentencing.
  - Pre release planning prior to release from a prison or detention centre.
- High level commitment to the system, preferably through it being a system established by the Government at a Cabinet level.

61 Report 80 paras10.1-10.6.

62 NSW Law Reform Commission *Review of the Disability Services Act 1993* (NSW) Report 91 (1999) chapter 4, particularly para 4.25 and recommendations 13-15.

63 Health Department and ADD *Development of a joint agency response to the care and support needs of people with challenging behaviour – project plan* (2000).

- Involvement of all relevant agencies and interests including DADHC, the Attorney General's Department, the Police Department, the Departments of Community Services, Juvenile Justice, Corrective Services, Education and Training, Health and Housing, and community interests.
- Ensuring ongoing leadership by a relevant agency or agencies in the design and implementation of the system.
- Protocols between agencies with clear accountability measures to ensure the protocols are implemented. Protocols should include:
  - Clear roles and responsibilities of each agency.
  - Mechanisms for promoting an integrated approach between agencies to meeting the needs of individuals, including disability services providing other services with any necessary advice and support.
  - A process for handling conflict between the agencies.
  - Agreed measurable performance indicators.
  - Clear accountability mechanisms such as achievement of performance indicators being: part of the performance agreement of chief executive officers and relevant senior officers; part of the business plan of each agency; and reported on in each agency's annual report.
- A system of central and local contact officers. These officers would be responsible for ensuring that an agency acts on interagency protocols and sufficiently skilled in issues facing the target group to be a resource for other staff. These officers should be responsible to nominated senior officers.
- Addressing the impact on coordination of the varying structures of agencies, for example the high level of operational autonomy of area health services.
- Addressing the issue of the capacity of relevant agencies to share information about an individual so as to meet his or her needs.
- Consideration of any legislative changes that may be required.
- Establishing an information system so that data could be kept in relation to the prevalence and needs of target group members and assistance provided to them.
- Establishing a strategy for training in relation to the target group to be incorporated into:
  - In service training in all relevant generic and disability agencies.
  - And vocational training for workers in generic and disability services.
- Each relevant government agency incorporating in its Disability Action Plan actions to enhance the appropriateness of its services for members of the target group, pursuant to the above protocols and otherwise.

One focus for coordination between agencies would be a senior officers group. This group could deal with both macro issues about coordination between agencies and approval of plans for cross agency cooperation in relation to some individuals with particularly complex cross agency needs. This latter role was pressed by clinical issues group members as a way of meeting problems that arise where an individual's needs are outside usual demarcations or budgetary outlays. Meeting the person's needs can then be frustrated unless there is cohesive action by senior officers with the discretion to go outside the norm.

However, one senior officer's group involving a very large number of agencies and interests would not be an efficient forum for resolving the wide range of issues involved in implementation of an appropriate service framework for the target group. These issues involve varying groups of players. Also, a senior officers group may not be able to ensure commitment to action around an individual if one of the key agencies has a decentralised system of responsibility for operational decisions.

Further, many of the issues raised in this report about the roles of generic agencies and cross agency coordination do not just apply to the target group. They apply similarly to other people with disabilities. It may be appropriate for the Government to address some of these issues in an integrated way that applies to all people with disabilities.

It is important to have a high level committee such as a senior officers group as an overseeing body in relation to the overall implementation of the framework needed by the target group. However,

this group could be complemented by smaller groups each focused on particular issues or groups of issues. For example, one group might focus on issues of prevention and early action. Another might focus on post release planning.

There would need to be commitment to and oversight of both kinds of groups by relevant director-generals, and a system for resolving issues of group dysfunction. Also, group members need a high level of authority to commit their agency to action on matters discussed at the group.

Consultation on the options paper has emphasised the fundamental limitations of policies and protocols alone as ways of achieving interagency cooperation. There needs to be real commitment backed by concrete measures to ensure that protocols are implemented.

**The importance of leadership -** An important issue is that of leadership in implementing a community services framework for the target group. If one sees the issue as primarily one of crime prevention, it would be logical for the Attorney-General's Department to be lead agency. If one sees the issue as a disability services issue, then the lead agency might be the Department of Ageing, Disability and Home Care. DADHC has responsibility both for funding and planning specialist disability services, and for coordinating the implementation of the Disability Policy Framework. Another option would be to have the Premier's Department as lead agency given the whole of government nature of the issue.

It would be logical to have one lead agency so that it is clear who has overall responsibility for driving the implementation of the framework. However, it is also important to avoid a situation where other agencies are unwilling to accept their share of responsibility for action because a particular agency has been designated as lead agency. This problem could be avoided by first obtaining a very high level of commitment in Government and/or the bureaucracy to concerted action and dividing responsibility for leadership of groups dealing with particular issues.

**Recommendations**

112. The NSW Government should establish a system for ensuring coordination between agencies in meeting the needs of the target group and implementing the framework proposed in this report. The system should include the following elements:
   a) High level commitment to the system, preferably through the system being established by the Government at a Cabinet level.
   b) Involvement of all relevant agencies and interests including DADHC, the Attorney General's Department, the Police Department, the Departments of Community Services, Juvenile Justice, Corrective Services, Education and Training, Health and Housing, and community interests.
   c) Ensuring ongoing leadership by a relevant agency or agencies in the design and implementation of the system.
   d) Protocols between agencies with clear accountability measures to ensure the protocols are implemented.
   e) A system of central and local contact officers skilled in issues relating to the target group. These officers would be responsible for ensuring implementation of interagency protocols and act as a resource for other staff.
   f) Addressing the impact on coordination of the varying structures of agencies, for example the high level of operational autonomy of area health services.
   g) Addressing the issue of the capacity of relevant agencies to share information about an individual so as to meet his or her needs.
   h) Addressing any issues of legislative change that are related to interagency coordination.
   i) Establishing an information system so that enhanced data could be kept in relation to the prevalence and needs of the target group and assistance provided to them.
   j) Establishing a strategy for in service and vocational training in relation to the target group.

k) Each relevant government agency incorporating in its Disability Action Plan actions to enhance the appropriateness of its services for members of the target group, pursuant to the above protocols and otherwise.

113. So as to strengthen the system of Disability Action Plans, the Government should implement Recommendations 14 and 15 of the Law Reform Commission in Report 91, *Review of the Disability Services Act 1993*.

114. DoCS should pay particular attention to the target group in its development of a protocol between child and family services, and its former disability services.

## 4.22 Independent complaints, monitoring and review

Various bodies have roles in relation to members of the target group:

- The Guardianship Tribunal and Public Guardian – On application, the Tribunal can appoint a guardian or financial manager for a person whose disability prevents him or her managing personal or financial matters. The Tribunal can appoint as guardian a family member or friend or the Public Guardian.
- The Mental Health Review Tribunal – The Tribunal provides advice to relevant ministers about placement of people who have been charged with offences but:
  - Who do not understand the court process sufficiently to receive a fair trial.
  - Or who have been found not guilty because a disability prevented the person understanding what he or she was doing or that it was wrong.
- The Community Services Commission – Has a complaint handling, monitoring and review role in relation to services provided or funded by the Minister for Community Services, Minister for Disability Services or Minister for Ageing. The Commission also coordinates community visitors who monitor some residential services.
- The Health Care Complaints Commission – Deals with complaints about health professionals and services.
- The Administrative Decisions Tribunal – Makes binding decisions on appeals against a range of decisions of ministers and departments.
- The Commission for Children and Young People – Has a broad systemic role monitoring and promoting the welfare of children and young people. The Commission also manages a legislative system aimed at ensuring that unsuitable people do not work with children.
- The Children's Guardian – Will be guardian of state wards, review case plans for children and young people in out of home care, and manage an accreditation scheme for services.
- The Ombudsman – Deals with complaints in relation to NSW government agencies.
- The Parole Board – Makes decisions about the release of prisoners on parole before the completion of their full sentences.

If a system for transfer of some members of the target group from prison or detention centre was implemented as proposed in Chapter 4.15 *Transfer from prison/detention centre*, then the Guardianship Tribunal or Mental Health Review Tribunal would have a role in reviewing persons subject of that system.

Missing is one independent body with an overall monitoring and complaints role in relation to the target group in their dealings with the wide range of government and non government agencies. Without this, there is great potential for the various "watchdogs" to be duplicative in their actions both in relation to individuals and systemically. Also, no watchdog will have an adequate overview of issues affecting the target group. There is then a strong argument for one body to have this overview role. Given its expertise in relation to disability and community services issues, that body would logically be the Community Services Commission. This was the view of the Law Reform Commission in Report 80, though not in a subsequent broader report[64].

64 Cf Report 80 paras 10.23-10.24 and *Review of the Community Services (Complaints, Appeals and Monitoring) Act 1993* Report 90 (1999),para 3.134 and following.

**Recommendation**

115. The complaints, monitoring and related jurisdictions of the Community Services Commission should be expanded to cover any services provided or funded by a NSW government agency to members of the project target group.

## 4.23 Interplay with issues of challenging behaviour

The framework arising from this project is not directed at any challenging behaviour that is unlikely to lead to criminal charges or the like. This currently includes much aggressive behaviour in specialist intellectual disability services. Much of this is behaviour of people with severe intellectual disabilities but some is not.

There are situations involving people with intellectual disabilities where there are difficult decisions to be made about the appropriateness of police charges.

There is then a grey area between what is treated as challenging behaviour and what is also treated as offending behaviour. Also, whilst there are major differences between the framework that is needed for offending behaviour and that needed for behaviour that is only challenging, there are also similarities.

From their work on this project and other experience, the consultants note the following in relation to challenging behaviour that does not lead to charges:

- DADHC's *The Positive Approach to Challenging Behaviour* sets out good practice in preventing and responding to challenging behaviour.
- This good practice often does not happen due to factors including institutional environments, impoverished lifestyles, limitation in skills and training of service staff, difficulties for families in knowledge and implementation of good practice, and limited access to skilled assessment and programming staff. This last problem can be particularly great in non government services.
- The role of guardianship is important in regulating the use of restrictive behaviour intervention practices.
- In relation to the idea of compulsory care legislation, see Chapter 4.14 *Restrictions on freedom of movement.*

DADHC has been developing a policy on abuse and assault in funded services. The policy has not been released. It is to be trialed in particular geographic areas. The policy's focus on funded services limits its potential impact on the target group. Also, to date, aggressive behaviour in a funded service has seldom led to police charges. However, the policy may increase the incidence of police involvement.

**Recommendations**

116. The Government should continue the process of transition for congregate residences and other services that do not conform with the Disability Services Act 1993.

117. The Government, DADHC and funded disability services should pursue the following objectives:
    a) Ensuring that consumers of disability services have lifestyles that meet their needs and wishes, including constructive day activities.
    b) Enhanced information and support for families in preventing and responding to challenging behaviour.
    c) Enhanced training for disability services staff in preventing and responding to challenging behaviour.

d) Ensuring that all disability services and families have access to clinicians skilled in positive approaches to behaviour intervention and support.

e) Ensuring monitoring of responses to challenging behaviour across disability services, noting monitoring mechanisms recently established in the former DoCS disability services.

# Chapter 5

# Priorities for Action

This report sets out the kind of framework that is needed if members of the target group are to have a reasonable opportunity to avoid becoming offenders or continuing to offend. There are obvious benefits for the individuals concerned and the whole community if these patterns of offending do not occur.

Properly meeting the needs of the target group is a very large task and related to the broader issue of unmet need for community services. Implementation of the recommendations in this report may need to occur over time, and in a staged manner This in no way takes away from the need for the overall framework as proposed.

This section sets out some priorities for action. These priorities are steps that most need to occur in the first instance. After a period of two years, an evaluation should occur of what has been achieved by the implementation of the priorities and the next stage of implementation should then be decided. This would be informed by the more precise data that should be available in relation to the prevalence and needs of the target group and the extent to which action on the priorities has met those needs.

It was beyond the scope of this project to prepare costings of its recommendations. However, some indications are provided below in relation to some amounts, staffing positions and accommodation/support packages that would be required.

1. **Action within existing resources to make existing services more accessible and appropriate for the target group -** This applies to all relevant services provided or funded by government agencies. It needs to include a focus on issues for Aboriginal people and people from a non English speaking background.

   Action “within existing resources” includes action that can be taken:
   - by staff training and policy changes,
   - by readjustment of priorities for service provision and for spending of existing budgets, and/or
   - with the assistance of the proposed specialist capacity.

   This action would be in accordance with various recommendations through this report including, for example:
   - Disability services operated by DADHC recognising risk to an individual flowing from his or her offending behaviour and lifestyle as an important component in assessing relative need for services under the DSA standards. See Chapter 3.1 *Key themes*, Recommendation 1 b).
   - Action by disability services to increase the skills of their staff to assist members of the target group. See for example Recommendations 14 and 18.
   - Actions by generic agencies to increase the skills of their staff in assisting members of the target group, and to ensure that members of the target group receive equitable access to their services. See Chapter 3.1 *Key themes*, Recommendation 1 a) and recommendations relating to generic agencies through the report.
   - Recommendations relevant to both generic and disability services in relation to Aboriginal people and people from non English speaking backgrounds. See for example recommendations 84-90.
   - DADHC ensuring its programs and processes are adequately attuned to the needs of the target group, for example the Service Access System (Recommendation 21), the Regional

Planning Framework (Recommendation 23) and the Flexible Family Support Program (Recommendation 26).
- The Guardianship Tribunal and Public Guardian reviewing their processes in relation to the target group (Recommendations 38 and 77).
- Working with existing advocacy and mentoring groups to seek to enhance their roles with members of the target group (Recommendations 29 and 30).

2. **A specialist capacity -** Establishment of a specialist capacity in assessing and meeting the needs of the target group. The specialist capacity would do some direct work with the target group and promote an improved response from existing generic and disability services. The specialist capacity should include a strong base in disability services but also include expertise across other service systems.

The specialist capacity needs to be established very promptly. It would be a very important resource if the other priorities were to be effectively implemented.

The recommended form of the specialist capacity in disability services would comprise:
- Establishment of a forensic clinical team.
- Establishment of a network of area forensic support coordinators, and forensic support workers.

See Chapter 4.19 *A specialist capacity*.

Appropriate initial staffing for these elements are below. If the specialist capacity were to be established in another way, similar costs would be involved.

**Specialist clinical team**

| No | Position | Level |
|---|---|---|
| 1 | Director | SES1 |
| 1 | Senior clinical officer | Level 10 |
| 5 | Psychologists/educators | Level 7/8 |
| 1 | Clinical nurse consultant | N/a |
| 1 | Administration staff | Level 1-2 |
| 1 | Administration staff | Level 4-5 |
| 1 | Information and training officer | Level 7-8 |
| 1 | Coordinator of support coordinators | Level 7-8 |
| 1 | Research officer | Level 7-8 |
| As needed | Health professional consultants | Specialists |

**Forensic support coordinators -** Eight coordinators at level 7/8– two for each DADHC metropolitan region, one for each other region. This is a conservative estimate of what is needed.

**Forensic support workers -** 16 workers at level 3/4 – Four for each metropolitan region, two for each other region. (Again, this is a conservative estimate. It may be necessary to have some more senior workers given the part case management function. Eight workers at 5/6 level may be an appropriate addition.)

The specialist clinical team and support coordinators and workers should be funded out of a new budget allocation from Treasury. It would be very difficult to fund such an initiative out of existing budgets given the cost involved and the already overstretched capacity of disability services. However, the health professional consultants to the clinical team should be provided by the Department of Health and through usual claims on Medicare.

3. **Coordination between agencies** - Establishment of the system proposed in Chapter 4.21 *Coordination between agencies.* At least in the first instance, this should occur on a basis that is cost neutral to government. This would require the various agencies to absorb the cost of establishing the system. These costs would be offset to some degree by a reduction of the cost of duplicative and inefficient cross agency dealings with target group members.

4. **Links with the justice system** - Establishment of a system of justice plans to coordinate action between justice system and disability services personnel. Also, at least one officer in each Probation and Parole and Juvenile Justice Community Services office should have specific training or expertise in working with the target group. See Chapter 4.20 *Links with the justice system*. Again, these initiatives should be attempted on a basis that is cost neutral to government.

5. **Funding for individual needs and service development** - Ensuring that there is a significant pool of funding available to meet the needs of members of the target group, both through the Service Access System and funding of some services to meet common needs. Individual funding needs to include a capacity to provide an initial amount on an immediate basis to meet a crisis.

   Treasury should make a new budget allocation of $1.5M in the first year and $3.5M in the second year for these purposes. (The lower recommended allocation in the first year flows from the need to spend a large part of that year establishing the proposed specialist capacity and other structures required to ensure well based use of the budget allocations. However, substantial spending to meet urgent needs could still occur in that period.)

   See *Service access system* in Chapter 4.4 for examples of common needs for which services might be funded.

6. **Accommodation and support** - Funding some new accommodation and related support for at least 40 target group members in the first two years. To some degree, this could occur from the individualised funding above. However, an additional budget allocation from Treasury would also be required.

   These 40 placements should be seen within the context of the "key recommendation" on supported accommodation of the Legislative Council Standing Committee on Social Issues. In a recent report on disability services, the Committee recommended that the Government adopt a growth target of 200 new supported accommodation places each year for the next five years.[1]

7. **A screening process** - Implementation of screening processes so as to enhance the identification of members of the target group. See Chapter 4.1 *Identification.*

   This should be attempted on a basis that is cost neutral to government.

1 *A Matter of Priority, Report on Disability Services* (2000) at xii.

# PART 3
# PRINCIPAL INPUTS

## Chapter 6

## The Existing Service System

This section is primarily a factual description of the service system that is relevant to the target group. The section also includes some limited evaluation of factors that impact on the capacity of some parts of the system to assist target group members.

### 6.1 Disability services

**The Disability Services Act -** The Disability Services Act 1993 NSW (DSA) governs all disability services provided or funded by the Minister for Disability Services, Minister for Aged Services and Minister for Community Services. The Act applies to services provided "predominantly" for persons in its target group as defined in section 5. This includes a person with "a disability (howsoever arising and whether or not of a chronic episodic nature)":
- "that is attributable to an intellectual, psychiatric, sensory, physical or like impairment or to a combination of such impairments",
- that is "permanent or likely to be permanent", and
- that results in "a significantly reduced capacity in one or more major life activities" and "the need for support, whether or not of an ongoing nature".

The Minister has a duty to ensure that all services provided or funded under the Act conform with the objects, principals and applications in the Act or with a transition plan approved under the Act[1]. The objects, principals and applications represent a statement of good practice in relation to service provision for all people with disabilities including people in the project target group. This good practice is spelt out further in the Disability Services Standards.

The Act includes a process of transition to bring older style services into conformity with the Act[2]. This applies particularly to services that congregate large numbers of people for accommodation or day programs and only limited progress has been made in transition for these services. However, the Government has committed itself to devolving the congregate accommodation services over a twelve year period which will conclude in 2010.

The DSA also requires each public authority in NSW to prepare and implement a disability action plan to promote the authority's compliance with the principles and applications in the DSA[3].

The Department of Ageing, Disability and Home Care (DADHC) (formerly the Ageing and Disability Department - ADD) acts on behalf of the Minister as a funder and regulator of services under the DSA and as the coordinating agency for disability action plans.

1 Sections 6 and 7.
2 Section 7.
3 Section 9.

Another relevant act is the Youth and Community Services Act 1973 which establishes a licensing system to regulate boarding houses and other unfunded accommodation for people with disabilities. See *Boarding houses* below.

**Restricting freedom in a service funded under the DSA -** The DSA includes an emphasis on services imposing the "least restriction" on residents[4] and does not include a specific power for services to restrict the freedom of movement of consumers. However, the Guardianship Act 1987 allows the Guardianship Tribunal to appoint a guardian of a person with a disability. The Tribunal can empower a guardian to authorise restrictive measures to ensure that the person complies with the guardian's decision[5]. This approach is sometimes used to restrict the freedom of movement of a member of the project target group. Guardianship allows some people to be diverted from prison or a juvenile detention centre to disability supported accommodation.

However, there are also people for whom a judge or magistrate will see detention in prison or the like as the appropriate option. For some such people with disabilities, the criminal law does allow for them to be detained elsewhere than prison. This applies to:

- People who are "unfit to be tried" because their disability prevents an understanding of the trial process, and who are awaiting a trial or have had a "special hearing" and been given a "limiting term" of detention[6]. Where someone is unfit to be tried, it is unfair that he or she have a normal trial and be found "guilty" since the person's disability prevents a fair trial. Historically, such people were held in custody waiting for the person to become fit to be tried, an unlikely prospect for many people with intellectual disabilities. And so the idea a special hearing was developed. At a special hearing, if the court decides that the person has committed the crime, the court can impose a "limiting term" which is supposed to be the same term of imprisonment the court would have imposed if the person had been found guilty at a normal trial.
- People found not guilty by reason of "mental illness", which in this context includes an intellectual disability which prevented the person from knowing what he or she did or that it was wrong.

These people can be detained in prison, a psychiatric hospital or "a place other than a hospital".[7] In practice, the only alternative to prison is a psychiatric hospital and so the above procedure is of little use to people with intellectual disabilities. In the absence of specific provisions in the DSA, it would not be feasible for the procedure to be used to allow a person with an intellectual disability to be detained in a residence covered by that Act. The procedure also does not apply to people with intellectual disabilities who are on remand pending a normal trial or who have been sentenced to imprisonment following a normal trial or whose case is dealt with by a magistrate rather than in the District or Supreme Court.

See Chapter 4.15 *Transfer from prison/detention centre* for a proposed system to allow for some individuals to be transferred from prison to secure accommodation administered by DADHC.

**Commonwealth/State Disability Agreement -** This 1998 agreement (the CSDA) regulates the sharing of funding responsibility for specialist disability services between the States and the Commonwealth. It has a similarly defined target group as the DSA. Its objective for disability services is:

> to enhance the quality of life experienced by people with a disability through assisting them to live as valued and participating members of the community.[8]

4 Principal (g).

5 Section 21A.

6 A person is "unfit to be tried" if he or she lacks adequate understanding to properly participate in a trial. For such people, the law prescribes a system involving a quasi trial ("special hearing") which can lead to a "limiting term of detention". This term is the period of imprisonment that might have been imposed if the person had been found guilty at a normal trial.

7 Mental Health (Criminal Procedure) Act 1990 and Mental Health Act 1990 Chapter 5.

8 Clause 4(1).

**Department of Ageing, Disability and Home Care -** DADHC has absorbed the role of the previous Ageing and Disability Department as the key agency for strategic policy and planning in relation to disability services in NSW and for funding and monitoring disability services. DADHC also now runs the disability services previously provided by the Department of Community Services.

DADHC has various policies and other requirements applying to services provided or funded under the DSA.

The NSW Disability Services Standards 1993 are based on the National Standards for Disability Services. *Standards in Action* (1998) provides practical guidance to services in the implementation of the standards. *The Positive Approach to Challenging Behaviour* (1997) guides services in preventing and responding to challenging behaviour. All of these documents are useful for services assisting people in the project's target group.

DADHC is currently developing policies specifically focused on children and young people.

The Government has recently approved a set of Disability Reform Directions which are guiding current initiatives of DADHC. These Directions are:

- Managing demand for services to ensure that existing and new resources are provided to people with the greatest need.
- Reducing crisis in demand for services so that in future needs can be addressed in a planned and systematic way.
- Strengthening informal supports within families and communities by ensuring that demand management maximises opportunities for the inclusion of people with disabilities in their local communities.
- Emphasising prevention, early intervention and family and community based supports by developing a broader, more flexible range of formal support and accommodation options.
- Increasing the involvement of the non government sector in order to grow the capacity and responsiveness and thereby the cost effectiveness of the formal support system.

DADHC is the lead agency in funding of a range of Early Childhood Intervention Services. Also, the Disability Reform Directions bring a heightened focus on early intervention more generally. This is reflected in new and increased budget allocations that accompanied the Disability Reform Directions.

DADHC funds other organisations to provide particular kinds of services to people with disabilities. No funding is specifically devoted to services for the project target group. However, some members of the target group do receive these services.

Some funding packages are also provided by DADHC, with the funding specifically attached to an individual. Some of these packages have been given for members of the project target group and have tended to be above usual funding allocations. DADHC has recently introduced a Service Access System to provide a more ordered and accessible way to seek funding packages for individuals whose needs cannot be met from existing disability and generic services. If an individual is approved for funding under this system, an independent support planner will work with the person to identify the support he or she needs and find a service provider from whom DADHC can purchase services.

DADHC and other human services departments are seeking to implement a system of support coordination.

DADHC is implementing a regional planning framework. The Department is seeking to better match funding practice to comparative needs of people with disabilities. The needs of people in the project target group are currently not being highlighted in the planning process which is based on local input.

The Home and Community Care Program (HACC) is also administered by DADHC in NSW. HACC is a Commonwealth/State program that provides basic support services to frail aged people and younger people with disabilities to assist them to continue living in their own homes rather than going into residential care.

The 2000/2001 State budget included a major increase in funding for disability services. This included $500,000 for criminal justice issues. This money was initially earmarked to fund the development of a network of support people in police interviews and courts. It now appears that this money will be made available to non-government agencies for both support with police and courts and individual advocacy for individuals involved in the criminal justice system.

**Department of Community Services former role -** The new Department of Ageing, Disability and Home Care has taken over the disability services provided by the Department of Community Services (DoCS). These services include[9]:

- Support services through Community Support or Resource teams, eg case management, therapy, behaviour management programs, recreation programs, assessment.
- Accommodation services and accommodation support through large residential services, group home and some more individualised residential models.
- Respite care, mostly on a centre based model.
- And day occupation services.

Behaviour management programs are developed by local services with some support with complex cases from the Training Resource Unit.

The services have a two-fold history with most originating in the Department of Health, but some in the Department of Community Services.

Services coming from Health have a history of providing services to people with moderate to severe intellectual disability, with priority going to those with greatest need, generally interpreted as a greater degree of disability. Services that have always been with Community Services have been focused on people with all degrees of intellectual disability, in particular state wards.

DoCS has been providing services to some people with involvement with the criminal justice system although the extent of its responsibility has not been resolved. A recent survey revealed 175 such people.

DoCS and the Department of Corrective Services have recently had a temporary position for a worker to coordinate post release planning for people with intellectual disabilities who are leaving prison. This worker's role was complemented by the Special Support Needs Panel with representatives from DoCS, the Departments of Corrective Services, Health and Housing, and the Centre for Developmental Disability Studies.

DoCS policy 6.21, *Priority of Access and Intake Procedures*, gives priority of access to services to people with a developmental disability (including multiple disabilities) with moderate to high support needs. Any current risk to the health and well being of the person is also to be taken into account.

"Developmental disability" is defined as a "significant intellectual disability" arising before age 18 and with related limitations in two or more major skill ares. DoCS have not seen this as including borderline intellectual disability.

---

9 The description of DoCS recent role draws heavily on a paper by Margaret Andersen (Disability Directorate, DoCS) *People with intellectual disability and the criminal justice system* (1999).

"Support needs" are defined in terms of the assistance needed by the individual to cope with the ordinary challenges of everyday living in the community. In practice, support needs have been considered by DoCS, "more in relation to support needed as a result of the disability rather than as a result of criminal behaviour"[10]. The validity of this distinction is the subject of ongoing debate.

Once a person is accorded priority, each service provision unit in the Department is to allocate services on the basis of relative need. In the case of accommodation support services, the policy includes as examples of priority that the person is at risk of a more restrictive placement or has a risky lifestyle. Entry criteria include that the person would like to reside in the available residence and that the consumer is compatible with the support needs of other residents. Decisions about placement are made by Area Placement Committees and approved by the Area Manager.

DoCS' current corporate plan incudes strategies aimed at making clearer the target group of its disability services, the kinds of services it provides, the methodology for assessment of consumer support needs, and the priority of access processes. As part of this review, the Department has been considering whether people whose offending behaviour makes them a risk to themselves or the community should be a priority group[11].

One group who need specific mention are former state wards with intellectual disabilities. Many of these people are within the project target group. Prior to the Guardianship Act coming into force in 1988, these people were usually kept under ministerial guardianship as adults under Part 9 of the Child Welfare Act 1939. With guardianship came entitlement to a wide range of services including case management by the then Specialist Section of the Department, and in many cases, supported accommodation. When the Guardianship Act came into force, Part 9 was repealed. Where appropriate, guardianship was continued by the Guardianship Tribunal, usually with the Public Guardian as guardian. Both the then Minister for Community Services and the Department gave commitments of continuity of service provision both for people who had been under Part 9 and those who would have come under Part 9 in the future but for the enactment of the guardianship legislation.[12]

The commitment to people formerly under Part 9 continues as a special provision in the *Priority of Access and Intake Procedures*[13]. The commitment to more recent former wards has been dropped and the remaining commitment is not consistently acted on.

The Specialist Section of the Department was also abolished around the time of repeal of Part 9. A statewide network of District Officers (Disability) was established to continue Specialist Section's role and to take a broader role for people with mild disabilities. However, this network no longer exists. Responsibility for case management for people formerly under Part 9 has devolved to Community Support Teams. These teams'main focus is people with moderate to severe intellectual disabilities whereas former state wards usually have mild or borderline intellectual disability. This has led to reduction in the expertise of service provision.

DoCS has an extensive set of *Policies for Working with People with Disabilities* (1996) which includes, for example, operational procedures on Behaviour Intervention and Support.

Another DoCS initiative in recent years was the Senior Clinical Practitioner Strategy. This involved a Senior Practitioner in each DoCS area with responsibilities including ensuring the quality of behaviour intervention and support services. With the most recent restructure of DoCS, there has

10 Margaret Andersen (Disability Directorate, DoCS) *People with intellectual disability and the criminal justice system* (1999).

11 Communication with Ethel McAlpine, Executive Director, Disability Services, DoCS.

12 Hon John Aquilina, *Address to 1988 Annual General Meeting and Forum of NSW Council for Intellectual Disability*; David Marchant, Deputy Director-General, *Administrative Circular 91-65*.

13 Page 4 of the Procedures.

been a Manager (Clinical Services) and a Senior Practitioner focused on disability issues in each DoCS area. The Senior Practitioner role is now one of broad quality assurance.

DoCS is also the funding agency in NSW for services for homeless people, under the Supported Accommodation Assistance Program. See *Accommodation for homeless people* in Chapter 6.3 below.

**Arrangements between Ageing and Disability Department and DoCS -** There has been a Relationship Agreement between ADD and DoCS regulating their relationship as a funder and regulator of services in the case of ADD, and a service provider in the case of DoCS. This agreement was being revised but, at the time of the creation of the new Department of Ageing, Disability and Home Care, provided as follows.

The agreement stated that DoCS provided services to people with intellectual disabilities who were:

> more at risk and for whom no non-government alternate service, which will assist in minimising harm or injury or risk of homelessness, can be found[14].

The "principal objectives" of other arrangements between ADD and DoCS were to include facilitating "the provision of comprehensive, coordinated services" and "to ensure that as far as practicable [DoCS] is accessible to all in need of [its] services … without barriers related to cost or location"[15].

The agreement makes ADD responsible for determining guidelines for eligibility for and priority of access to services[16].

**Funded non-government organisations -** Non-government organisations (NGOs) are funded under the Disability Services Act NSW or, in the case of employment services, the Commonwealth DSA. They generally service a local geographic area though some have operations in various parts of the State.

These services could, and sometimes do, provide supported accommodation and other services to members of the project target group. As compared with the former DoCS services, NGOs do tend to have a focus on people with more mild intellectual disabilities. Some NGOs have been particularly innovative and flexible in their service provision.

However, to date, a number of factors have limited the role of NGOs with the target group. These factors include:

- Parents have established many services for their sons and daughters. Members of the project target group often do not have involved families or families who have been involved with the establishment of services.
- A lack of focus on, and expertise in, assisting people with challenging or offending behaviour.
- Generally lower pay rates than DoCS and therefore fewer well qualified staff.
- Not having the same culture as DoCS as a service provider who is obliged to provide continuity of service to a person no matter how difficult that task becomes.
- Not having the same support infrastructure as DoCS in terms of programming teams and the like.

In recent years, people in the target group may be more likely to receive a service from an NGO. This may have been encouraged by the implementation of the DSA, including its standard that requires access to services to be on the basis of relative need.

14 Preamble to Agreement.

15 Introduction to Agreement, para 4.

16 Clause 3.

**Boarding houses -** A substantial number of the project target group have tended to live in unfunded supported accommodation. This accommodation is run on a private for profit basis and usually takes the form of a boarding house. There have been longstanding concerns about the quality of the service that can be and is provided in such accommodation. [17] This accommodation has been licensed by the Ageing and Disability Department (but now by the Department of Ageing, Disability and Home Care).

ADD has been implementing some major structural changes to the boarding house system:

- Approximately 300 residents with high support needs are being rehoused in funded supported accommodation.
- The responsibility of boarding house proprietors will be centred on providing accommodation, food and shelter.
- Other support services will be provided by other government and funded services. These services may include behaviour management programs.
- A new entry screening tool is being trialed to ensure that only people with lower support needs are admitted to boarding houses. A person who needs close supervision because of risky or aggressive behaviour may not be admitted, at least unless external services are available to meet the person's needs.[18]

**Advocacy and support with police and courts -** A range of groups and individuals provide advocacy to people with disabilities including some members of the target group. Various advocacy groups are funded under the Commonwealth and NSW DSAs. Advocates often press for the provision of appropriate community services to people with disabilities. This includes systemic advocacy to improve laws and service systems that affect people with disabilities. Major reviews of funding for advocacy services have been conducted by the Commonwealth and NSW Governments in recent years.

The law requires the presence of a support person when a suspect with an intellectual disability is being questioned by the police. Under the Crimes (Detention After Arrest) Regulations 1998, the custody manager at a police station must try to contact a support person for a "vulnerable" suspect as soon as the suspect is taken into custody. Unfortunately, there is only one coordinated system for the supply of trained support people in NSW and, for the most part, police have to draw upon their own networks or the family of the suspect. The result is that it is not always possible to secure a support person at all, let alone someone with an understanding of intellectual disability and suspects' rights. The problem of lack of support people is particularly pronounced in rural areas and after hours. The interview cannot proceed without a support person if the suspect is a child, however, it can if the person is an adult.

A person who is under 16 at the time of going to court is entitled to a support person while giving evidence[19]. There is no legislative provision for the use of support people for adult accuseds with intellectual disability when giving evidence in court or otherwise during the court process. However, judges and magistrates have an inherent power to manage their courts and may exercise their discretion to allow the use of a support person where it is in the interests of justice so to do.

The only service that routinely provides a support person for police interviews and in court is operated by the Illawarra Disability Trust in the Wollongong area.

17 See, for example, *Report of the Task Force on Private 'for Profit" Hostels* ( Social Policy Directorate 1993).

18 Ageing and Disability Department *Licensed Boarding House Entry Tool* (1999). Note questions 1and 2.

19 Evidence (Children) Act 1997 s7.

## 6.2 Services for children and young people

**Care and protection, substitute care -** The Community Welfare Act 1987 gives the Department of Community Services the legal capacity to take a very wideranging role in providing and funding a comprehensive range of community services.[20] DoCS is currently reviewing the strategic directions for the Community Services Grants Program under the Act. However, budgetary restrictions mean that this role is a minor part of DoCS overall role. This actual role has two predominant parts, the provision of disability services under the DSA (discussed above) and the provision and funding of child protection and substitute care services. The latter role has been regulated by the Children (Care and Protection Act 1987, and now the Children and Young People (Care and Protection) Act 1998.

The child protection role of DoCS has two parts: an early intervention one and a reactive one. Its early intervention role is activated by a "request for assistance" from a parent, child or young person[21]. In response to a request for assistance, DoCS must provide advice, assistance or referral or take action to safeguard or promote the welfare of the child or young person[22]. DoCS' more reactive role is to respond to "reports" of abuse or neglect of a child or young person. In these cases, DoCS investigates the allegation and can commence care proceedings in the Children's Court. The Court then has a number of options, including the child being made a ward of the Minister.

If a child or young person needs to be in substitute ("out of home") care, there are a number of options, including:

- Foster care arranged and supervised by DoCS or a funded non government organisation.
- Group homes run by NGOs for children and young people with more challenging needs.
- And short term placements in "intensive services" that are being developed for those with the most challenging needs.

Case management responsibility lies with DoCS or with the NGO that arranges the placement. However, current resource limitations mean that there are many children and young people in out of home care who have no allocated case manager. As a result, foster placements may be unsupervised. The quality of foster placements also varies.

DoCS provides an allowance to foster carers related to a child's age and support needs and one off "contingency payments" for particular needs that arise.

A number of factors make it particularly difficult for the child protection/substitute care system to meet the needs of a child or young person with an intellectual disability. These factors include:

- The disability may not be identified, until perhaps there are difficulties in making a placement work.
- Psychological and behaviour management services are not readily available.
- Workers in substitute care services have limited training and skills.
- NGOs tend to see themselves as not equipped to provide services to children with intellectual disabilities.

A protocol has been under development between disability and children's services in DoCS. This was aimed at a more holistic approach to service provision and might assist with some of the problems above. At the same time, the Director-General of DoCS separated disability services from children's services in each DoCS area. This was part of the "transformation" of the structure of the department. (As already stated, the DoCS disability services have now been absorbed into the new Department of Ageing, Disability and Home Care.)

20 Part 2, Division 1; Part 4.

21 Sections 20 and 21 of the Children and Young Persons (Care and Protection) Act 1998.

22 Section 22.

The Children and Young People (Care and Protection) Act 1998 mainly came into effect in December 2000, with some parts of the Act to follow in 2001. Features of the Act that may assist the target group include:

- The introduction of a principle requiring relevant players to take account of any disability of a child or young person.
- The new focus on early intervention. In particular, DoCS has a role in providing or seeking services for a child or young person in a range of circumstances including where a child is at risk of harm or homeless. This builds on the Government's existing Families First initiative which is both a preventative and early intervention approach. This emphasis in the Act is a clear change from DoCS' traditional starting point of investigation of a notification of abuse or neglect with a view to possible court proceedings.
- An emphasis on interagency and whole of government cooperation in meeting the needs of children and young people. Government agencies and funded NGOs are required to use their best endeavours to meet requests from DoCS for assistance to a child or young person.
- A separation of service provision from guardianship by creating a Children's Guardian to fulfil the latter responsibility on behalf of the Minister.
- The Children's Guardian having other roles including accreditation of DoCS and other service providers, and examining case plans and regular reviews of case plans for each child or young person in out of home care.
- Greater flexibility in allocation of formal decision making and other responsibilities for a child.
- DoCS and NGOs arranging and supervising substitute care will be obliged to comply with standards in a regulation.
- A clear obligation on the agency supervising an out of home care placement to prepare a "leaving care" plan when a child approaches adulthood, and to implement the plan. The Minister's existing power to provide some assistance to ex wards will continue until the person is aged 25.
- There may be greater scrutiny on the voluntary placement by parents of children and young people with disabilities in permanent out of home care.
- Depending very much on how it is implemented, provisions in the Act allowing "compulsory assistance" through intensive 24 hour care and support of a child or young person where necessary to protect him or her from self-destructive behaviour.

Specific funding has been allocated for some but not others of these changes. Wideranging action has been occurring within DoCS and other agencies to implement the Act.

With the implementation of the new Act, DoCS will have a case management role for all children and young people in out of home care. DoCS will be using the "Looking after Children" model as a basis for developing case plans. It sees this model as a sound way of identifying all relevant issues for the child or young person and bringing all relevant players into the planning process[23]. The current transformation will also divide resources between DoCS' care and protection, and out of home care roles. These changes should lead to more consistent case management for children in out of home care.

The Community Services Commission has recently completed an inquiry into the substitute care system and made wideranging recommendations[24]. The Commission reports work showing that a significant proportion of children and young people in the substitute care system and in need of intensive services have disabilities. Poor outcomes for this group were linked to failure to identify the extent of the child's needs when first in care, lack of effective case management, limited access to specialist services and the absence of a multidisciplinary approach.[25]

---

23 Consultation with Michael Tizard, Principal Policy Adviser Child and Family Policy, DoCS.

24 Community Services Commission *Inquiry into the Practice and Provision of Substitute Care in NSW, Final Report* (2000).

25 Pages 53-54.

## Peter

Peter is 22 years old and has a mild intellectual disability. He is Aboriginal and was born in western NSW. He moved with his family to Sydney when he was about five.

Peter's first contact with the criminal justice system was for theft when he was ten. However, his first serious incarceration was when he was 18. This was for break and enter. Since then, he has been convicted of assaulting a police officer. Peter admitted to a serious drug problem which he says was to cover the pain of sexual abuse that occurred when he was ten. He "grew up smoking marijuana" and he has sniffed solvents since primary school. He smoked marijuana regularly from age 14, then began to use heroin and cocaine daily when he left prison the first time. He has never attended a drug and alcohol program and "does not like methadone".

Peter did not get along with his stepfather. Both his mother and stepfather have alcohol problems. He felt unwelcome at home and was eventually "kicked out". He has spent some time living on the streets and at other times with an aunt on the outskirts of Sydney. His grandmother, who lives near his aunt, is also supportive. Peter says that one of the problems of living with his aunt is that there are a lot of people in the area who "get him into trouble with drugs and the law".

Peter's schooling was disrupted with three school changes and truancy until he eventually left in year 8, aged 13. He states at school he was teased for being Aboriginal. When he left school, he "hung around with mates" and stole to get money and clothes. Peter is illiterate but says that he really wants to learn to read and write. He did return to a school program at Cleveland Street High School, but he felt taunted because he could not read and left very quickly.

Peter has worked once for a short time as a street cleaner. Although he says that he would not mind working, he had no idea how to go about achieving this.

Peter admits to needing a lot of help. He currently has a number of fines which he says are accruing interest while he is in prison. He has no idea how to solve this problem. He thought his accommodation would be fine at his aunt's except for the problems of peer group influences and pressure. His aunt also wants assistance because of Peter's "difficulty understanding things". Peter would like assistance with an Aboriginal pre and post release program. He wants ongoing support to meet any parole conditions and to access education or work opportunities. He would also like to play football again but does not know how to organise this.

**Mentoring -** The Big Sister/Big Brother Program recruits volunteer mentors for many young people in NSW. The Program currently includes pilot schemes linked to the Youth Justice Conferences. Burnside also has a small program of volunteer mentors for young people in its care.

The Department of Juvenile Justice has also established a program of paid mentors. See *Department of Juvenile Justice* below. The Department of School Education has also established a scheme of time limited mentoring of some students through critical transition points in schooling.

## 6.3 Other services and agencies

**Accommodation for homeless people -** This is funded by DoCS under the Commonwealth/State Supported Accommodation Assistance Program. Services provide accommodation and practical assistance to young people and adults. Some members of the target group are assisted by these services, in particular youth refuges.

Under the Children and Young People (Care and Protection) Act 1998, refuges will be specifically required to use their best endeavours to meet requests from DoCS for assistance to a child or young person. The Act may also prevent the placement of wards in refuges.

**Health services -** The Department of Health provides a range of services to people with mental illnesses. These services are relevant to members of the target group who have dual diagnoses, that is both an intellectual disability and a psychiatric disability. The Department also funds some services for people with psychiatric disabilities under section 12A of the Disability Services Act.

The Department also provides or funds a range of other services that are relevant to the target group, including:

- Alcohol and other drug services.
- Community health centres, whose roles can include counselling.
- Two services focused on assisting children and young people who are at risk of becoming sex offenders.
- Physical Abuse and Neglect of Children Services which provide counselling to children and young people who have experienced neglect or abuse in their families.
- Brain injury rehabilitation services, and neuropsychologists in public hospitals.

There are often difficulties accessing health services for members of the target group. These are discussed in Chapter 7.

**Department of Housing -** The priority housing system of the Department of Housing means that the Department can usually offer accommodation to a person with a disability within a few months. In the meantime, the Department can provide a disability rental subsidy. However, the Department needs to be satisfied that the person understands and can meet his or her obligations as a tenant. In the absence of support services, this could be an impediment for many members of the target group.

In each departmental area, there is a Senior Client Service Officer (Specialist) who is a resource in relation to departmental clients who have special needs.

Current initiatives of the Department that may be relevant to the target group are:

- Supported housing – the Department providing capital funds where there is a guarantee of support services from another source.
- Housing partnership – the Department and a community group pooling their expertise and funds in an innovative project.
- Community housing – a non-profit community group manages the housing instead of the Department. This may occur in conjunction with another organisation providing support that residents need.

These approaches can be used for crisis and longer term housing.

**Department of Education and Training -** Schools are very important sites for prevention and early intervention to address the needs of the target group.

For older adolescents and adults, TAFE provides a range of education and training which may assist people with intellectual disabilities.

**Police -** Police officers can be an important link between members of the target group and community services, especially at the time when police are considering whether to charge a person with an offence. The police often spend considerable time unsuccessfully seeking assistance from human services when they are called in relation to a member of the target group.

**Lawyers and courts -** Similarly, lawyers and other players in the court system often seek services for members of the target group. Two levels of service tend to be needed. One involves services

to support the person to engage with his or her solicitor and/or to participate in the court process. Sometimes, it can be impossible adequately to represent a client without these supports. The second involves services to give someone the opportunity to obtain bail, parole or a non-custodial sentence.

**Attorney-General's Department -** This Department has been acting as lead agency in the development of a cross-portfolio disability action plan focused on people with disabilities who are involved in the justice system.

**Department of Corrective Services -** The Department of Corrective Services has some specific services for the target group. There are separate units for inmates with intellectual disabilities accommodating 34 inmates. The Department plans to establish further separate units and programs with specific focuses including programs for sex offenders and violence prevention. The Department is currently establishing a multidisciplinary Disability Resource Team including expertise in psychology, education, health promotion, alcohol and other drugs and welfare.

The Department has worked closely with DoCS in initiatives set out in *Department of Community Services former role* above.

The Department's Probation and Parole Service is also an important link between members of the target group and community services. In preparing pre-sentence reports and in supervising people who are serving non-custodial sentences, Probation and Parole can link offenders to services. A bond, probation or parole may be made conditional on acceptance of these services.

**Department of Juvenile Justice -** The Department of Juvenile Justice (DJJ) is an important link between young offenders and community services. The Department's juvenile justice officers:

- Assist young people to get bail, including by providing information about accommodation and other support options.
- Provide reports to the court which may include accommodation and support options.
- Take a similar role in supervising bonds and probation as the Probation and Parole Service takes for adult offenders.

The Department's Intensive Program Units also provide psychological counselling to some young offenders.

When a young person has been held in detention, DJJ takes a case management role in assisting the person's reintegration into the community.

In some cases, the role of juvenile justice officers is complemented by paid mentors who are matched to particular young people on non-custodial orders. This is a hands on role aimed at supporting the young person in his or her family and cultural relationships and assisting the person to develop a positive lifestyle. The mentor program was initially focused on Aboriginal and Torres Strait Islander young people and those from non English speaking backgrounds but then extended to other young people.

Youth Justice Conferences are a recent innovation where a convenor assists a young offender and the victim of a crime to negotiate an agreed outcome plan rather than the offender being dealt with by a court. The outcome plan may include an apology and some reparation to the victim but also the young offender agreeing to accept some program or service. A conference administrator then supervises the implementation of the outcome plan.

The Youth Justice Conference system is currently of limited appropriateness for the project target group. The DJJ *Youth Justice Conferencing Procedures Manual* does include safeguards aimed at fairness for young people with disabilities. It would be valuable to evaluate how well those safeguards work in practice. Conferences could be very unfair if a person's disability was not adequately taken into account. The person might not understand the process and be vulnerable in

the negotiation process. For some members of the target group, a conference could not be a fair option. For others, it may be fair providing the process includes measures to accommodate the person's disability, for example through the way in which the conference is conducted and through providing a support person[26].

For indigenous people, there are particular problems with diversion through conferencing, warning or caution under the Young Offenders Act 1997 NSW. Aboriginal juveniles are diverted from court at a lower rate than that for all offenders (37.22% for all offenders compared to 24.38% for Aboriginal offenders)[27]. In the 1998/99 financial year, only 14% of Aboriginal young offenders were referred for conferencing[28]. Barriers to the equitable application of the Young Offenders Act have been identified as inadequate consultation with Aboriginal communities, insufficient allocation of resources, inflexibility of process design, extent of police involvement and reluctance of police to refer young Aboriginal offenders for conferencing[29].

Recently, the NSW Police Service has updated its handbook and *CRIME: Code of Practice* to clarify and reinforce officers' obligations under the Young Offenders Act. The Police Service has also advertised these requirements in its Police Service Weekly[30]

DJJ funds a number of organisations to provide or seek accommodation for young people. However, this accommodation may not be well equipped to meet the needs of young people with intellectual disabilities.

Both DoCS and DADHC need links with DJJ in relation to young people with disabilities who come into contact with DJJ. DoCS has a general responsibility for young people. DADHC needs to take account of young offenders in its disability planning and coordination roles.

Two 1999 reports have focused on problems with service provision for wards and other children and young people in contact with the juvenile justice system:
- *Just Solutions –Wards and Juvenile Justice*, Community Services Commission.
- *The Wards Report*, Department of Juvenile Justice and Department of Community Services.

The latter report calls for:
- An expansion of early intervention and prevention to avoid children and young people coming into care. This includes development of risk assessment tools for use within DoCS.
- A commitment to whole of Government service delivery for children and young people who are in out of home care or otherwise vulnerable.
- Improvement in the quality of DoCS and DJJ casework, and coordination between the two.
- Improvement of data collection systems in the two departments and in information sharing.
- Improvement in assessment of children and young people prior to placement.
- Data to confirm the need for expanded intensive placements for adolescents by DoCS.
- Consideration of whether an increased role played by DJJ in provision of accommodation support in recent times should be redirected towards joint initiatives with DoCS.

The report includes an action plan to guide implementation of the report.

Implementation of the report would assist the avoidance of problems such as:
- Lack of clarity of the respective responsibilities of the two departments.

---

26 See J Simpson *Alternative Dispute Resolution and People with Disabilities, a Discussion Paper* (2000) unpublished.

27 N Hennessy *Review of Gatekeeping Role in Young Offenders Act 1997* (NSW) Report to Youth Justice Advisory Committee (1999) 7 and 19.

28 Ibid p23.

29 NSW Law Reform Commission *Sentencing Aboriginal Offenders* Report 96 (2000) Chapter 4.

30 *NSW Police Service Police Service Weekly* Vol 12 No 45, 13 November 2000, PSC 00/22.

- A ward leaving a DJJ detention centre without any active case management or appropriate accommodation being in place.

ADD (now DADHC) has also been working with DJJ in trialing of support coordination approaches.

# Chapter 7

# Inputs from the Stakeholders, Case Studies and Clinical Issues Group

## 7.1 Introduction

This section summarises four sets of information that informed the project:
1. An initial broad consultation with stakeholders.
2. Study of eleven members of the target group and development of a case study in relation to each of these individuals.
3. Consultation on the case studies with a clinical issues group.
4. A selective consultation with particular stakeholders in relation to issues needing further exploration.

The information is summarised under a thematic system of headings based on that in Chapter 4 *The Framework in Detail*.

The methodology used to gather this information was as follows:

**Consultation with stakeholders -** With input from the project reference group, the consultants and project managers arrived at a stakeholder list. This comprised 30 individuals, community organisations and government agencies involved with the target group or issues concerning the target group. These stakeholders were contacted for interview or to be sent a questionnaire. In either case, each stakeholder was asked seven open-ended questions. See *Appendix.* The questions addressed:
- the definition of the target group,
- supports used by the target group,
- barriers to getting the best available services,
- missing services,
- good service models, and
- possible case study participants.

27 stakeholders responded. Sixteen of these completed questionnaires. Four individuals were interviewed. Three interviews were conducted with two participants from the same organisation and there were five focus groups with between three and five participants from the same organisation. In total forty-five individuals participated in the stakeholder consultation. See *Appendix.* The stakeholders can be classified in the following way.

| Type | Stakeholders | Individuals |
|---|---|---|
| Legal | 3 | 4 |
| Peak organisation | 2 | 2 |
| Advocacy | 6 | 9 |
| Health | 4 | 4 |
| Non-government organisation | 2 | 6 |
| Ageing & Disability Department | 1 | 5 |
| Police | 1 | 1 |
| Department of Community Services | 3 | 5 |
| Attorney General's Department | 1 | 1 |
| Department of Education & Training | 1 | 2 |
| Office of the Public Guardian | 1 | 4 |
| Parole Board | 1 | 1 |
| Research | 1 | 1 |
| **Totals** | **27** | **45** |

A report was compiled for the reference group aggregating the information gained from this consultation.

**Case studies -** Eleven case studies were developed to illustrate experiences of people in the target group. The Departments of Juvenile Justice, Corrective Services and Community Services, the Office of the Public Guardian and the Intellectual Disability Rights Service were approached to select potential participants. Research and ethics approvals were sought and received from the three departments. The individual or family member was approached about participation. If they were interested and willing to be involved, a process of consent was undertaken that outlined each stage of the process.

The stages of the case studies included file reviews, interviews with the individual (in eight out of eleven cases) and/or guardian or family member and workers from the services or department involved. The interviews were unstructured and support people were welcome. Interviewees were asked to talk about the individual's experiences with the justice system and if willing they were asked about the factors that contributed to the criminal behaviour. Moreover, all participants were asked about changes that could have altered the course of events.

Identifying information was changed and case studies were produced for use with the clinical issues group. Summaries of the case studies are interspersed through the project report.

The eleven participants were chosen from approximately forty candidates. They were selected so that diversity across the following variables would be represented.

- Gender
- Age
- Race
- Ethnicity
- Offences
- Disabilities
- Substance abuse
- Location
- Sentences
- Guardian

The case studies are an illustrative sample that complements the information about the target group that was collected in the literature review and from the stakeholders. They are not a statistically representative group. This was not their purpose.

**Clinical issues group -** The clinical issues group consisted of sixteen members including the project consultants. See *Appendix* for the list of members. The consultants and project managers chose the members predominantly on the basis of their expertise in relevant disciplines and experience with the target group in a clinical capacity. Group members were predominantly Sydney based, however, there were two members from Melbourne and two from regional NSW.

The group met twice to consider the case studies. At each meeting, five case studies were discussed. The discussion was loosely structured around the following questions:

- What support and clinical approaches are needed for individuals such as this?
- When should preventative or early intervention have occurred? What should have happened?
- What barriers are there to appropriate assistance?
- How could those barriers be overcome?

Detailed minutes were kept of the meetings.

(There were two further meetings of the group as part of the consultation on the options paper prepared later in the project.)

**Selective follow up consultation -** In the latter part of the project, further consultation occurred in relation to issues on which further information or perspectives were needed. These particularly related to advocacy and mentoring issues and policing issues. Those consulted are listed in *Appendix*.

## 7.2 Identification

A concern that stakeholders and clinical issues group members shared was that many people in the target group could reach the courts having had little contact with services and never having been assessed.

Barbel Winter from the Multicultural Disability Advocacy Association and Tony Pearce from Buddagwhan Indigenous Advocacy made the point that identification can be difficult for people from a non-English speaking background and Aboriginal people because of cultural differences and community practices. Ms Winter commented that children from a non English speaking background are often not identified as having an intellectual disability at school because of language problems and that when there are problems they are more likely to be attributed to language difficulties as in the case of Chuan. Ms Winter emphasised that culturally specific support workers are needed to overcome issues, attitudes and perceptions to disability within communities.

## 7.3 A fair process with police and courts

The overriding view expressed by the stakeholders and clinical issues group, about fair process in the legal systems, was that legal agencies have little knowledge of intellectual disability, yet they may be the sole support and/or first contact for the individual. The comment extended to magistrates who may deal with the individual as if he or she has no intellectual disability. It was observed that generally, clients access generic legal services, not specialist services for people with disabilities. Furthermore it was suggested that the fact that lawyers and magistrates are not informed about the issues of people in the target group could help explain large numbers of people with disabilities in jail.

The comment was made that there is a lot of inconsistency in the use of s32 of the Mental Health (Criminal Procedure) Act, which the case studies illustrate. Section 32 allows the court to dismiss charges conditionally or unconditionally where the accused has an intellectual disability. It was suggested that there is a problematic degree of inconsistency between magistrates in their use of this discretion.

Anne Langford, Clinical Co-ordinator of Disability Programs in the Department of Corrective Services, noted that many people with an intellectual disability appear to be excluded from periodic detention and community service orders. They are thought to be unable to comply with the orders and there are no services to adequately assist them with compliance.

The Ageing and Disability Department (ADD) focus group identified the need for clear protocols and a framework that spell out how the justice system should deal with people with an intellectual disability.

There was a strong view amongst stakeholders and clinical issues group members that expert support within the legal system is essential. A system where the court has advisers who recommend an assessment to the magistrate was suggested.

They also emphasised that the courts and police need support with communication with people from the target group. This support could include different methods of interviewing and presenting evidence.

Finally, training for legal aid solicitors was recommended as essential.

# Roland

Roland is twenty-one and has a mild intellectual disability. He has a history of starting fires since the age of two. His first contact with the criminal justice system was for lighting two fires when he was 15. These charges were dismissed under Section 32 of the Mental Health (Criminal Procedure) Act. Roland has continued to offend and is currently in gaol for arson and malicious damage. He says he has been in juvenile justice facilities seven times and in adult gaols four times.

A number of additional diagnoses have been provided for Roland. These include personality disorder, oppositional and defiance disorder, and attention deficit and hyperactivity disorder. In the past, he was prescribed amphetamines which his parents reported "helped him think" but Roland refused all compliance with medication.

Roland lived at home with his family. His parents both work. They have been actively involved with Roland all his life and although he was always difficult to manage they say that the main problems began when he was 15. At that time, Roland's older sister moved away from home and Roland started to leave home often for up to four days at a time. He lived on the streets and travelled on public transport over long distances. This period also coincided with Roland leaving school.

Roland attended a regular school until he was eight when he was shifted to a special school which he liked. Roland cannot read or write but says he is good at maths. His mother on the other hand says he never liked school and his defiant behaviour increased over the years until he eventually refused to attend. When this happened, his mother locked him in the house with her while she tried to sleep as she worked night shifts. He left school officially when he was 15 but his attendance was poor leading up to that time.

After each fire setting episode, Roland received some counselling from Community Health Centres. His mother also sought help from a child, adolescent and family service. It assessed Roland when he was 16 after he was charged with an arson offence. Recommendations included support for the family, such as respite. Recommendations for Roland included counselling for his offending behaviour, further medical assessments, a full psychometric assessment and for his DoCS caseworker to seek out work or training programs. Most of these recommendations were carried out.

Roland was enrolled in TAFE (a builders labouring course) and he obtained Post School Options funding. It is unclear whether Roland ever actually participated in either of these programs.

Roland states that he smokes marijuana monthly and gets really drunk "monthly".

Roland does not appear to have any friends other than those he has met in detention centres. When interviewed, Roland spoke at some length about a relationship with a young woman with whom he has a child and said that she was pregnant again. According to the prison staff, this is untrue. They say he is homosexual and has relationships with other prisoners.

## 7.4 Assessment of support needs

The stakeholders and clinical issues group members had various serious concerns about assessment of support needs. First and foremost, assessments when they happened seemed to be less about future support than demarcation issues. It was said that it has been difficult to get DoCS disability services to acknowledge that high support needs is not just about intellectual functioning but about all the peripheral aspects and impacts of an intellectual disability as well. DoCS has been seen as not recognising the potential to reoffend as a support need. It was acknowledged that there are no specialist units for assessment for people in the target group and there are no funds to outsource the role. Moreover, assessments are done by professionals without a knowledge of the particular needs of the target group, which leads to very poor assessments. Finally, it was emphasised that there are not enough services or support systems available and consequently people in the target group more often than not are assessed ineligible and fall through the gaps.

It was suggested that a full assessment upon entry to prison is desirable. Kathy Arentz said that in Victoria an assessment is done by the Statewide Forensic Service upon entry into prison at the latest. Clinical issues group members recommended a one-stop multidisciplinary assessment clinic to minimise clinical contact for the client and to provide useable recommendations. It could be a tertiary referral centre for high needs clients which would avoid duplication and could pay for itself.

In relation to Aboriginal people and people from a non English speaking background, the comment was made that assessment needs to be comprehensive including language and communication skills.

Clinical issues group members added that knowledge about sexuality and sexual offending should be included in assessments. This was in keeping with the recommendation that a full neurological assessment needs to be obtained for people with an acquired brain injury (ABI) so that programming can be specific and effective. Finally it was recommended that effective assessments required interviews in order to identify and understand issues that are not recorded in case files and assessment results.

## 7.5 Meeting individual needs

Stakeholders and clinical issues group members had major concerns about the barrier to services created by eligibility criteria. Matthew's experience effectively illustrates this concern. The Department of Community Services' (DoCS) eligibility criterion excluded Matthew whose intellectual disability initially tested in the mild/borderline range even though he had high support needs.

Another major issue raised in relation to meeting individual needs was that of funding. It was emphasised by a wide range of stakeholders and members of the clinical issues group that the current funding of services is inadequate and ineffective. Essentially, there are never enough funds, which leads to many of the other problems. The people in the target group are long term funding responsibilities. It is not possible to see existing funds extending to include the target group. The point was made that it is important for any service system to allow the possibility that people have long-term service needs with fluctuating costs.

A strongly held view by stakeholders and clinical issues group members was that the current mode of support, if any, given to people in the target group is about risk reduction, that is, reducing the severity and frequency of crimes. It is not about prevention.

The issue of funding processes was raised. It was pointed out that individual funding occurred on the basis of submission, the allocation of a package and then an expression of interest process. This process could unduly delay responding to people's needs. In addition to this it is difficult to get enough information on a person for a funding submission when they are in gaol. There are environmental constraints in conducting assessments.

The stakeholders and clinical issues group members identified as an overriding priority, a need for case-management and coordination. In practical terms, case management rarely exists and as a consequence opportunities for services and support are often lost. Tony's and Sean's cases illustrate a desperate need for case management and the lost opportunities in its absence. Both groups expressed the view that where case management is available, in many respects the role is unclear. Furthermore, case managers lack the necessary expertise with the legal system.

It was acknowledged that in general support that is provided is not structured or goal driven. Currently, there is fragmented service provision with no unified approach or continuity. In short, the provision of support is inconsistent. With the exception of Hassid, the ten remaining case studies illustrate this experience.

It was noted that, in some cases, individuals could be over programmed; a situation that could be avoided with more effective modes of support and community links.

The view was expressed that non government organisations (NGOs) tend to lack the experience to work with people in the target group and when a case becomes too hard they often 'pull the plug'. This comment was supported to some extent by an NGO participant who said that it is difficult to support people in the target group due to the multitude of issues such as disability, non-English speaking background, substance abuse, accommodation and criminal behaviour. This is the experience in both John and Matthew's cases.

Both the stakeholders and clinical issues group members emphasised the need for both disability and generic services. Often an individual's needs cannot be met by generic services so there is a need for disability services. However, most people prefer generic services. Services are needed that help to support people in mainstream activities and services, however most service providers do not offer ongoing support for this purpose.

The Office of the Public Guardian (OPG) focus group suggested that people in the target group re-offend because there are no support systems in the community and that the prison set-up might seem preferable to what is currently offered in the community. This would appear to be the case for Joanne, who reoffends very quickly after her release from prison and Roland who has no networks other than those from detention centres. In general, it was observed that there are very few activity options, which leaves people with a lot of time on their hands. This is the case for nine out of the eleven people in the case studies.

Police Service representatives highlighted how often they unsuccessfully seek assistance from human services for young members of the target group. The opportunity to deflect people from a "criminal career" is lost. With this group and the target group generally, they need access to skilled community services workers 24 hours a day. This includes when there is an issue about whether a person has an intellectual disability and/or a psychiatric condition justifying admission to a mental hospital.

Both the stakeholders and clinical issues group members identified the following programming needs as essential:

- Psycho educational programs – social skills training in relationships, assertiveness, problem solving, self esteem and anger management.
- Sex offender programs appropriate for school age children and youth.
- Literacy & numeracy skills.
- Vocational training.
- Leisure skills and sustainable leisure options.
- Post release programs that teach living skills and establishes sustainable links with generic services.

It was also noted that there is less expertise in rural areas, for example psychiatric assistance.

There was full agreement that services should be needs based and referenced to ‘criminogenic’ needs. It was noted that the criteria for success needs to be clear when evaluating services and interventions.

Barbel Winter made the point that a non-English speaking background and the associated cultural issues made it even harder to find services. She suggested that there is inherent racism in all areas manifesting itself in:

- a lack of cultural sensitivity,
- stereotyping families with the assumption that they will take care of the person,
- a lack of interpreters and funds to use them, and
- a lack of information in languages other than English.

It was also mentioned that people in the target group from a non-English speaking background are less likely to access services. 75% of all people who are from a non-English speaking background and have an intellectual disability do not receive support outside of their family.

Tony Pearce did not think that generic or disability specific services successfully catered for Aboriginal people.

In terms of recommendations, the stakeholders and clinical issues group emphasised the need for quality case-management, beginning at an early stage so that it is preventative. It could provide consistent and constant professional guidance and advocacy and follow a person through the multiple moves that can be characteristic of people in the target group. A number of the non-government stakeholders suggested that it would be desirable to have a case manager that is independent from individual departments, but with the authority to direct the involvement of each party. Such a coordinated approach provided by an independent service could circumvent interdepartmental demarcation.

It was recommended that life skills training, employment and sustainable leisure options were essential for members of the target group.

Finally, the lawyers from IDRS emphasised that people in the target group should have input into the types of services needed.

## 7.6 Advocacy/mentoring and social networks

Overall, the role for citizen advocates and peer support in meeting the needs of people in the target group was emphasised. Tony’s case illustrates the benefits of an effective citizen advocate. Tony Pearce and Barbel Winter both commented that there is a need for Aboriginal, ethnic and culturally aware advocates. Aboriginal youth need strong cultural mentors from the same community. Mr Pearce suggested that this would assist in cases like Peter’s and Careena’s. Judy Toombs made the point that advocates need training to support people in contact with the criminal justice system.

At another level, it was stressed that many of the people in the target group do not have effective and positive friendships. The case studies of Joanne, Roland, Tony, Steven, Matthew and Peter all illustrate in different ways problems associated with friendships or the lack thereof. Some people just need a positive peer role model/mentor who will stay around over time. A peer support and mentoring program was strongly recommended.

Consultation with people experienced in advocacy and mentoring emphasised the following points:

- It is very difficult to recruit volunteer advocates and mentors to form relationships with offenders, especially if this will involve commitment to a long-term relationship. Shauna McIntyre from the Big Sister/ Big Brother Program emphasised how much easier it is to recruit mentors for non-offenders.

- Volunteers to work with offenders may need considerable training and support.
- Identification of offenders who need an advocate or mentor may depend on service providers or justice system personnel bringing the individuals to the notice of the program.

Both the stakeholders and clinical issues group members identified the following personal characteristics as common to people in the target group:
- Peer group pressure and exploitation, often by non-disabled “mates”.
- Poor social and interpersonal skills.
- Poor self-image.
- Social isolation and loneliness.
- Inability to appropriately meet relationship and sexual needs which, at times leads to inappropriate sexual habits such as public masturbation.

These characteristics are illustrated in the case studies.

Barbel Winter commented that some families from non English speaking backgrounds are socially isolated. She said that Chuan’s case illustrated this phenomenon and the associated issue of cultural isolation, which can be accompanied by considerable cultural pressure within the family. Josephine Anderson, psychiatrist, emphasised the issue of loneliness, illustrated in the case studies of Joanne and Roland. She reinforced the need for social skills and friendship skills training.

Many stakeholders and clinical issues group members emphasised the role of the family in the lives of people in the target group. Many of the people in the target group come from families that are dysfunctional and experience poverty. Families often lack adequate knowledge, support and skills to deal with the issues involved with a target group member. The need for parenting skills programs was identified. Rodney Beilby from Juvenile Justice said that it was important to work with families where benefits could be derived. Families need to be involved in thorough assessments of juveniles. They need to be supported in order to support their sons or daughters effectively. Josephine Anderson commented that sometimes all it takes is subsidising travel costs. Furthermore, it was acknowledged that it is important to maintain and support family involvement although the individual is not living with the family. Clinical issues group members emphasised that these comments and recommendations also extend to ‘substitute families’. For example, in the case of Tony, Dot has a role in his life that is similar to that of a foster mother.

Tony Pearce emphasised the importance of linking in with supports in an Aboriginal community to support the person and their carers. He stressed the strength of community bonds and the importance of identifying an appropriate community member to support an individual at risk. This would be particularly useful in Peter’s case and it could provide the positive connection that Careena is seeking with her Aboriginal family and culture.

## 7.7 Addressing the offending behaviour – behaviour intervention and support

A major concern of the stakeholders and clinical issues group was that there is very little, if any, behaviour intervention and support offered to people in the target group. Nine of the eleven people in the case studies have not received any behaviour support. There is no framework for clinical intervention including case work and behaviour intervention. Often, when behaviour support is offered, it is only in times of crisis. Where good, intensive behaviour support exists, a client’s chances of success are improved considerably.

Kathy Arentz and Rodney Beilby emphasised that behaviour support needs to address relapse prevention and that in order to do this it needs to take into account motivation (eg sexual preoccupation or loneliness), knowledge, attitudes and beliefs. The need for this type of behaviour support is particularly evident in the cases of Hassid, Tony, Joanne, Matthew, Roland and Chuan.

There was strong agreement that additional support is needed that is specific to the offending behaviour an individual is exhibiting as opposed to general supports such as housing. An example of this is one specialist program run by DoCS (now DADHC).

In terms of recommendations, stakeholders and clinical issues group members emphasised the need for specialist services in clinical intervention. These specialist clinical services could be provided by an interdisciplinary group of clinicians, possibly working for the courts and accessible to all. Josephine Anderson suggested the need for an easily accessed, multi disciplinary inpatient/outpatient unit for assessment that could be monitored by an interdepartmental team of senior representatives. The importance of counselling services was also emphasised.

## 7.8 Education and training

The stakeholders and clinical issues group members identified the following education and schooling issues that are common to people in the target group and illustrated in the case studies:

- a history of behaviour problems, dating back to pre school,
- no early intervention,
- numerous changes in schools,
- truancy,
- suspensions, and
- expulsion often with no follow up and no alternatives for education/employment training offered or available.

Professor Susan Hayes pointed out that people in the target group are often not afforded their right to education. They are often made to leave school due to their challenging behaviour. Chuan, Careena, Steven, Matthew and Sean were all denied the opportunity to continue at school because of their behaviour. They all experienced suspensions and for most of them these were on multiple occasions.

Josephine Anderson strongly argued that all students should be referred to a counsellor before being suspended or expelled from school. Furthermore, psychometric evaluations should be completed whenever there is a conduct disorder that would justify expulsion. Current DET procedures do not prescribe any minimum standards for addressing the welfare needs of a student before or in conjunction with suspension or expulsion[1]. In Matthew's case, he received psychometric testing at the end of year 10 and the results were used to justify the school's position when asking him to leave. He left with no viable alternative or direction.

Barbel Winter said that school can be the first place that a child is identified as having a disability. However, a disability can be overlooked for children from non-English speaking background because of language problems. Chuan's experience illustrates this problem at the high school stage. Ms Winter recommended the need for policy development around early intervention for NESB children.

The Aboriginal focus group made the point that many Aboriginal parents lack confidence in dealing with schools and the education system. Strengthening the role of the Aboriginal Student Support Parent Groups and the Aboriginal Education Assistants in schools would help here. A stronger presence of support for Aboriginal students may have assisted Peter in his schooling.

The officers interviewed from DET identified the following barriers experienced in their work:

- Access to information. Juvenile Justice and allied health files are only available to clinical people, not teachers or case managers.

1 NSW Department of Education and Training *Good Discipline and Effective Learning: Procedures for the Suspension and Expulsion of School Students.*

## John

John is thirty five. He has a mild intellectual disability and mild cerebral palsy. John's family lived in the Blue Mountains. During his childhood, John had a number of hospital admissions. He went to a school for specific purposes. When he was 16, his rebellious reaction to his father led to his placement in a large residential facility for people with intellectual disability. He stayed there until he was 20 during which time he commenced working at the local sheltered workshop.

In 1985, John was referred to Cumberland Hospital from the residential facility because he was wandering and displaying aggressive behaviour. He stayed at Cumberland for quite a while. John was discharged to a boarding house in the mountains. Over the next five years, John developed a history of admissions to psychiatric units and hospitals in NSW and interstate. The admissions followed self-injurious gestures and threats. However, he was never identified as having a psychiatric disability.

Whilst living in the mountains, John did not work. He attended church regularly, he also started to spend considerable time observing proceedings in the courts.

Since 1989, in NSW alone, John has had approximately 54 court appearances. He also mentions a number of interstate appearances. The following list provides an example of the range of charges:

- malicious damage
- offensive conduct
- public mischief and nuisance
- improper use of telecommunications service
- enter enclosed lands
- assault
- lighting fire in prohibited time zone
- impersonating a police officer
- breach of an apprehended violence order
- false representation resulting in police investigation
- maliciously damage property
- offensive language in a public place
- stalking/intimidation
- attempted armed robbery (using a toy gun)

John has spent periods in different prisons. Since the 1990s, he has lived a somewhat itinerant lifestyle all over NSW and interstate. Currently, John is living in Department of Housing accommodation in a regional city. He works voluntarily at his church.

- Remand centres place youths at great risk. There is little assessment done; the care is custodial; the workers are untrained; and the experience seems to perpetuate criminal behaviour.
- Counsellors in Juvenile Justice do not provide ongoing assistance after an individual is released. They refer the person on when they can.
- There are no services to the most difficult youth, those with conduct disorders.

Various stakeholders expressed concern that there is very poor information exchange between primary and secondary schools. The case studies support this concern. It is particularly evident in Careena's case where her primary school experiences were essentially positive, yet she refused to return to high school after the first month.

The comment was made that TAFE in general is discretionary and requires literacy and numeracy levels rarely found in the target group.

In terms of special education and vocational and employment training, there was strong agreement that there are never enough programs available and the programs that exist can be particularly inaccessible for many people with borderline intellectual disabilities. Neither mainstream programs nor those designed for people with more clearcut disabilities may be suited to their needs.

Stakeholders and clinical issues group members pressed that early intervention & prevention should be the joint responsibility of the DET, DoCS & Health, and with continuity of care happening after school. Action should include active follow up; assistance with courses, accommodation, social security and work, day programs and specialist programs for people who have challenging behaviour and/or have committed sex offences and /or engaged in substance abuse. Furthermore it was recommended that experts visit schools to alert teachers to the problems of people in the target group. Finally it was recommended that crime prevention programs be conducted in schools. One NGO representative took the suggestion a step further and recommended education and training across all services to assist with early identification.

## 7.9 Mental health services

Dual and multiple diagnoses and prior contact with a mental health agency were identified as common for people in the target group. This included being labelled with attention deficit hyperactivity disorder as in the cases of Careena and Roland. However the point was made that there are no specific services available to people in the target group who have a dual or multiple diagnosis even though their needs are immense.

Stakeholders and clinical issues group members shared a serious concern that mental health services “try hard” to keep people in the target group out of their system. This fits with the experiences of Joanne, John, and Chuan. Roland received some counselling from community health centres after each arson episode, however, it was insufficient and consequently ineffective.

In relation to Chuan’s case study, Barbel Winter commented that medication for psychiatric disabilities may work differently for people who are not Caucasian, particularly if a person is Asian.

## 7.10 Alcohol and other drug services

The stakeholders and clinical issues group members identified drug and alcohol abuses as one of the experiences common to people in the target group. Anne Langford pointed out that, at one point, fifteen out of the eighteen inmates at the Special Purpose Unit at Long Bay Correctional Centre had drug problems. This ratio is reflected in the case studies where nine out of the eleven participants had alcohol and/or other drug problems.

The following reasons for substance abuse were suggested: sexual abuse, depression, boredom and meeting leisure needs. There is evidence that these reasons exist for the nine case study participants mentioned above. Joanne explicitly links her alcohol abuse to her loneliness. Matthew was diagnosed with depression at the same time as his marijuana use increased.

Meredith Adams, Clinical Nurse Consultant (Drug and Alcohol) expressed concern that current drug and alcohol programs are heavily reliant on language and literacy skills and inaccessible to people with an intellectual disability. Furthermore there is a lack of specific workers experienced in working with people with an intellectual disability. It was observed that there are no drug and alcohol programs for youth.

Clinical issues group members strongly recommended a holistic approach that is integrated with planning processes. It was pointed out that programs operate on two levels: providing information and changing attitudes. Less verbally based cognitive behaviour therapy programs need to be developed. Both the stakeholders and clinical issues group members pressed the need for appropriate alcohol and other drug services for people with an intellectual disability, including an early intervention component.

## 7.11 Employment

The stakeholders and clinical issues group members identified unemployment as a major issue common to people in the target group. All the adult participants in the case studies have experienced long term unemployment. In the cases of Tony, Chuan and Peter, there is a desire to work and evidence of the capability to do so. However, in each case the support necessary to establish and sustain employment and work habits is not there. Hassid, on the other hand, has received considerable support from an employment service and has successfully worked in the same job for the past two years. A lack of educational/employment services available to the target group means that there are many missed opportunities to provide effective intervention.

## 7.12 Accommodation

Another service area that got special and repeated attention was housing and accommodation. The Department of Housing refuses to provide housing unless there is support in place. It is very difficult to obtain accommodation in the private market. Boarding houses offer little support. There is overall instability in supported accommodation. Consequently, housing and accommodation are endlessly problematic for people in the target group and there is considerable homelessness and transience as a result. This experience is common to Matthew, Steven, Tony, Roland Sean and John.

Police Service representatives highlighted the lack of 24 hour emergency accommodation that is often needed by people that they apprehend.

Overall accommodation support options are insufficient. Where options do exist, often people in the target group are excluded for a range of reasons. Two examples were given, age in relation to boarding houses and a lack of expertise in intellectual disability on the part of Supported Accommodation Assistance Program (SAAP) funded youth services. The options available to adults are mainly short term such as boarding houses and proclaimed places and there are no services provided specifically for people in the target group on release from prison. Kathy Arentz pointed out that in Victoria, Chuan would be released from prison to a 12 month program at Francis House to support reintegration into the community, including links with generic services and to teach him living skills.

The case studies highlighted some of the different accommodation needs. It was agreed on the clinical issues group that Hassid required some form of heavily supported and supervised accommodation that would strike the balance between safety and the least restrictive option. It was also noted that Hassid would need specially trained staff and integrated behaviour intervention services. Such an option would require thorough and ongoing supervision and management of staff.

In Joanne’s case, she needed some shared accommodation which could address her loneliness and reduce her need to drink and get into trouble.

There needs to be accommodation that meets the needs people like Roland seek to satisfy with prison terms.

Lyn Ready from the Department of Housing made the point that public housing requires tenants to understand and manage a tenancy, or have the support of a service to assist with this. Normally public housing does not accept people under 18 but in particular circumstance it will accept people over 16 if a solicitor explains the lease. The Office of Community Housing funds some youth accommodation. Community housing options could incorporate peer support models of service and accommodation.

Anne Langford suggested that highly structured, restrictive accommodation options were needed for some individuals during a court ordered period such as parole or a community based order. The period could be used to design an ongoing support option for the individual. This approach could influence the nature of court orders imposed.

Stakeholders and clinical issues group members made the firm recommendation that a continuum of accommodation services is needed. Quality, stable, supported accommodation is required that is non-institutional and both preventative in purpose and available to people when they are on bail. There was strong support for specialist accommodation units that include assessment and early programming services. The units could potentially be secure to meet some people's needs. There could be 24-hour support for some people and possibly day attendance for others. There could be post release accommodation staffed with specialist workers. However, concerns were also expressed about a special unit approach because that approach could attract significant stigmatisation.

Anne Langford suggested that an interim option between jail and the community is needed to allow assessment and transition planning. She said that the parole period could be used for this purpose.

## 7.13 Promoting acceptance of services

Both stakeholders and clinical issues group members identified substantial problems with people in the target group accepting services. The point was made that people might resist assessment and support from DoCS because its reputation is tarnished from people's experiences of "care and protection". However, it was emphasised that acceptance of services is often caught up with the quality case management. Tony's case study illustrates this experience. It is also a common theme in the case studies of Peter, Joanne, John, Sean, and Roland.

It was recommended that acceptance of services could be promoted through parole orders, guardianship, and citizen advocates. Anne Langford strongly agreed and said that, where there are difficulties with accepting services, it is important to use the parole period effectively to establish service use. However, individuals would need support to assist with compliance. Frank Lambrick from the Victorian Statewide Forensic Service reported that the Victorian experience is that a person can generally be brought around to accept services during the period of a court order so that service provision can then continue on a voluntary basis.

Tony Pearce concurred with the negative reputation of "welfare" services and said that it was the reason Aboriginal people often did not seek to access services. He suggested that this could explain Peter's lack of contact with services. Mr Pearce reinforced the need for more links between services and Aboriginal communities.

Finally the point was made by various people that some people in the target group need assistance to access and use the services offered. If people lack this support and do not access the services, then they are labelled inaccurately as non-complaint. Tony's case study illustrates this point effectively.

## 7.14 A specialist capacity

There was a very strong and wide body of opinion that there is a lack of expertise within existing services. It was stated emphatically that service providers do not feel competent to work with this group. Moreover, decisions are made by non-clinical personnel based on budgetary concerns as opposed to what an individual needs. This is clearly illustrated in the case studies of Sean, Joanne, Roland, Tony and Matthew. It was suggested that DoCS disability services were in an ideal position to provide the specialist support required for the target group. However, to do so, they would need specialist positions created in their community teams. Both Kathy Arentz and Anne Langford reinforced the point that case management is essential and that case managers must have experience with offenders and not just disability.

Both stakeholders and clinical issues group members strongly recommended a specialist role within the disability system.

## 7.15 Links to the justice system

The overriding concern of the stakeholders and clinical issues group in relation to links with the justice system was that there is not enough follow up after a person is released from prison. This is clearly illustrated in the case studies of John, Chuan, Peter, Roland and Joanne. It was emphasised that pre release planning is essential and required early in a person's prison term so that it is in place when release is imminent. This would have made a significant difference in Matthew's case and may have prevented his parole period being spent in prison and his placement in an institution upon his release. It was strongly recommended that an individual plan be established when a person first comes in contact with the justice system and all involved agencies receive copies. Furthermore, the plans should include court ordered access to services as part of the post release conditions.

A concern was also strongly expressed that probation and parole officers are not adequately informed about options that may be appropriate for people with intellectual disabilities.

Police Service representatives emphasised the importance of close cooperation between police and community services.

## 7.16 Coordination between agencies

The stakeholders and clinical issues group identified coordination between agencies as an issue of paramount importance. They described a number of experiences that are common for people in the target group:

- No ongoing service provision or follow up.
- Casework and service inefficiency.
- No specific services and a lack of services so that people fall through the gaps.
- No inter-service cohesion, for example between youth services and DoCS and no specific agreements on intervention and treatment that dovetails with service provision.
- A lack of appropriate clinical interventions after an individual's first contact with the justice system, including early intervention and counselling.

In one way or another all of the above points are present in the experiences of the eleven case study participants.

Demarcation issues were identified as one of the major contributing factor in the unsatisfactory experiences of people in the target group, their support workers, families and advocates. One stakeholder made the point that demarcation disputes have led to wasted years for many misplaced individuals.

It was emphasised that DoCS disability services and Health (and other agencies) would not "own" responsibility for people who are in the target group because they are considered to have a mild or borderline intellectual disability. Consequently there is no central agency that takes responsibility for the case management and coordination role. It was noted that the lack of interagency coordination leads to under and over servicing in some cases and a doubling up on services.

The lack of information sharing between departments and services was identified as problematic. For example, the police do not feel able to advise Corrective Services that a new inmate appears to have a cognitive impairment. The comment was made that each department becomes attitudinally institutionalised within its particular culture.

Bill Glaser emphasised that some studies have shown that costs to the government are decreased by appropriate service provision.

Various stakeholders and clinical issues group members strongly agreed and emphasised that service coordination needs cross agency liaison at the Director- General and senior officer level to be effective. Josephine Anderson made the following recommendation that was well received by the clinical issues group. The service system as it ordinarily operates cannot cope with people whose situations are significantly more complex than others. Much time, often at the expense to their well being, is spent trying to work out how to help them. There needs to be a high level committee composed of senior members of all relevant departments each of whom have sufficient clout to enable the committee to make decisions and override usual rules of practice. There would be cost savings because the committee itself would be cost neutral and it would obviate the existing duplication of decision-making within different services. The committee would need ministerial backing and it should substantially reduce the number of ministerials and complaints.

Finally stakeholders and clinical issues group members recommended a point of contact for inquiries from agencies so that they can streamline support, action and coordination. The need for a 24-hour referral service that provides advice and refers people to the appropriate services was also recommended.

Chapter 8

# Literature Review

Both Australian and international searches were conducted to find the most recent details on any programs or models which provide services to people with an intellectual disability who are in contact with the criminal justice system. The searches were conducted on the Internet and in libraries, as well as by asking key stakeholders for any relevant information. A total of 16 different programs were found which had sufficient detailed information to be useful for the current study. Some programs have more than one component but have been counted as one program. Of the 16 program references, 11 are located in the USA, 2 are Australian, 2 are located in the United Kingdom and 1 is Canadian.

## 8.1 Service delivery models

The majority of the research consists of reports on programs rather than empirical evidence or analysis on the effectiveness, efficiency or outcomes of different models. Information on costings is not included for most of the programs. In particular, missing in current research is an examination of the development, implementation and effectiveness of prevention programs.

There is general agreement in the program descriptions that there is a need for a continuum of services. The characteristics of such a continuum are not well researched and most of the programs reviewed do not offer a continuum. They do however call for a continuum of services and those that are more accountable certainly offer some coordinated range of services.

The one program, which did give some detail on the need for a continuum of services, was the Texas Council on Offenders with Mental Impairments (TCOMI)[1].

***TCOMI -*** *This is a targeted state funded program for offenders with special needs, including those with intellectual disabilities. The objective of the funding is to divert offenders into alternatives where their offending behaviour is addressed. There are 3 program areas: Community Based Programs; Continuity of Care and Special Needs Parole. The Council (TCOMI) includes 18 different agencies with an interest in offenders with special needs. In addition, the Governor appoints nine members who serve staggered 6 year terms. The Council's membership includes multi dimensional expertise in working with offenders with special needs. It is a collaborative approach between the criminal justice and human services departments. TCOMI funds 9 community based programs which include case management, psychiatric treatment, rehabilitative supports, medication support, substance abuse treatment, residential and vocational training.*

*The Continuity of Care Program provides a formal pre and post release support system for all offenders with special needs released from criminal justice facilities. TCOMI contracts for continuity of care workers to conduct on-site visits with the offender and institutional staff to discuss and prepare aftercare plans. Through its members and other agencies, TCOMI has also focused its efforts on revising regulatory, procedural or statutory practices that served as impediments to an integrated service delivery system.*

Another program which directly mentioned the components of a continuum was the *Oregon State Hospital's Social Skill's Program*[2] which suggested that a continuum of services should include

1 *Texas Council on Offenders with Mental Impairments Biennial Report* (1999).
2 J Haaven R Little and D Petre-Miller *Treating Intellectually Disabled Sex Offenders, A Model Residential Program* (The Safer Society Press, Orwell, VT 05760-9756, 1990).

community outpatient services, supported living arrangements in the community, and open or closed residential settings. The Social Skill's Program offers one part of the continuum. That is, an intensive residential model for 31 men in a secure unit with a variety of specialised aftercare arrangements in supervised dorms, sheltered housing and community placements.

This program noted that within a continuum of services, a quality program must have various organisational and clinical elements to succeed:

- Organisational - A program must:
  - Be a cooperative effort between all the agencies
  - Show strong leadership (ie be willing to take risks).
  - Create customised organisational systems with a priority on addressing the offending behaviour.
  - Include community training, staff training and staff supervision from the beginning.
  - Include systems for collecting data on the effectiveness of the program.
  - And be located off prison grounds.

- Clinical – A program should:
  - Be as voluntary as possible.
  - Incorporate a multi-diagnostic, holistic approach.
  - Be based on a self help model (eg modified therapeutic model).
  - Include cognitive restructuring as a primary intervention tool.
  - And incorporate learning which is fun.

Components in a continuum include not only the physical facilities but also the services offered. Most studies agree that a secure facility is necessary although in some cases the prison is the secure facility. This is not seen as ideal although the best option in this case is a specialised unit for inmates with an intellectual disability. Secure environments need to be complemented by community based services with support.

The other frequently mentioned component of a continuum was case management. Other essential components include services for clients with dual diagnosis and substance abuse problems as well as intense support and follow-up after discharge from a program.

The Victorian Disability Services'Criminal Justice Program[3] was one of the few services which does offer a range of services.

***Victorian Disability Services Criminal Justice Program***
*The Department of Human Services funds a number of services for people with an intellectual disability who are involved in the criminal justice system or at risk of involvement. These services are: The Statewide Forensic Service (SFS); two emergency accommodation houses (Furlong House and Charlton House); a Prison Program offered from within the Statewide Forensic Service and two programs run by non-government agencies.*

Also, each region in the Victorian Department of Human Services has a client services team that provides a number of services to people with disabilities including some specialist criminal justice staff who work closely with the specialist services listed above.

***Client service workers -*** *These staff are responsible for assessing a client's needs in collaboration with the client, guardian and/or primary carer and for developing and implementing a plan for achieving their goals[4]. A client service worker may act as case manager and carry out a number of roles if a client is involved in the justice system. Prior to a court hearing, the worker ensures the client has access to legal advice and develops a client overview report on request from the client's*

3 Department of Human Services, Victoria *Victorian Disability Services'Criminal Justice Program*.
4 Victorian Disability Services Criminal Justice Program *IDS Client Service Practice Manual* (1992).

*solicitor. The worker identifies and accesses services to support a bail application and attends bail hearings to give relevant information to the court. With the client's consent, the worker informs appropriate people of the client's bail conditions. If the client is held on remand, relevant people are notified, including the region of origin. If a client is found guilty the court may request that a Justice Plan to be prepared to assist the court in making a decision on sentencing. Where a Justice Plan's conditions are attached to an order by the court, Intellectual Disability Services has a responsibility to the court to monitor their implementation. Client service workers also develop pre-release plans about six months before release from prison.*

***Statewide Forensic Service -** This consists of a Program Support Team and an Intensive Residential Treatment Program. The Program Support Team is a specialist team for the target group. It consists of the Forensic Assessment and Intervention Team (FAIT) and the Client Services Coordination and Evaluation Team. The FAIT includes both psychologists and psycho-educational trainers who provide services to regional workers on a consultancy basis, as well as conducting assessments, psychotherapeutic groups and cognitive behavioural therapy and relapse prevention programs to individuals. Staff responsibilities also include research and staff training.*

*The role of the Client Services Coordination and Evaluation Team is to develop service agreements with regions, and develop and monitor justice plans, general service plans and individual program plans. The team also provide reports and evidence to courts, the Intellectual Disability Review Panel and the Parole Board.*

*The Intensive Residential Treatment Program (IRTP) has four stages of security, supervision, program intensity and community access. All stages are in houses which accommodate 4 or 5 clients and the fourth stage is located in a community setting while the others are on the grounds of a large residential facility. Only the first stage is a locked facility and all have 24 hour staff supervision. Some of the clients accessing the IRTP had been in custody and released to the program or had been found 'unfit to plead'. Other clients had community based orders and Justice Plans and were seen as at risk of committing serious offences. Also, some clients were awaiting trial. The majority of clients are in the program because of serious sexual offending behaviour or assault (including murder). The program's houses are considered transition or short term 'treatment houses' but because of a number of individuals who were not moving through the stages of decreasing restrictions, an additional long term house has recently been established.*

***Emergency accommodation -** The Department of Human Services also runs two "Emergency or Crisis" houses which offer up to 3 months accommodation for members of the target group, usually when they are on bail. The houses also accommodate other people with an intellectual disability who are in crisis, and so are not for the exclusive use of the target group. Each house accommodates up to five residents selected by a panel of representatives from the regions involved, taking account of household compatibility. The time at the emergency houses is utilised by the regional case managers to identify and organise appropriate accommodation and support services for the client. The houses are staffed 24 hours per day.*

***Post release programs -** Two NGOs are funded by the Department of Human Services to provide post release services. These are the Australian Community Support Organisation (ACSO) and the Jesuit Social Services. These services offer short-term (usually one year) accommodation and training.*

*ACSO (formerly called Victorian Offender Support Agency (VOSA)) offers two residential services and a sex offender program. The services are located in the metropolitan area although they provide for a statewide clientele. The services will accept residents on bail in special circumstances.*

*ACSO runs two residential services. One is Francis House, with 24 hour support staff, and the other consists of 8 flats, supported by one outreach worker on a drop-in, as needed, basis. Francis House accommodates up to 4 adults over the age of 22. The house has been designed for both male and female residents, with separate sleeping areas electronically monitored for movement. The actual*

*resident mix is determined by the nature and needs of the residents at the time of referral. Programs at Francis House assist clients to improve living skills, redress deficits and deal with challenging behaviour. Residents are expected to share household tasks, participate in meetings and comply with their agreed program plan.*

*Individual programs are planned with each resident in the context of general service plans, Justice Plans and community-based orders. Responsibility for case management remains with the region of origin. The client services worker maintains contact, undertakes the general service plan, assists with the Individual Service Plan and participates in three monthly reviews. The client services worker is also responsible for arranging future accommodation and services for the resident.*

*Francis House has one worker during the day, two at peak times and a sleepover at night. The house has electronic sensors so that client movement can be monitored, although it is not a locked unit. The staff also provide some outreach support to past residents and to regions when requested. Residents stay a maximum of one year at Francis House.*

*The 8 flats are known as the Supported Living and Accommodation Program (SLAP). They offer a service to clients from any region although they are all located in the one suburb. A drop in worker from ACSO offers individual support, in areas such as shopping, banking and vocational skills, depending on the needs of the resident. Staff from other agencies, such as a mental health nurse, may also support the residents. The flats, which are provided by the Department of Housing, are considered to be the resident's permanent home and if a resident no longer requires the support of ACSO, he or she can remain in the flat and another one is obtained from the Department of Housing.*

*The ACSO sex offenders' program is a non-residential service for adults with an intellectual disability who are at risk of committing, or who have committed, sexual offences. "The program aims to meet the gap between services currently available, which specialise in human relations interventions but do not address dangerous or potentially dangerous sexual behaviour, and the service that is provided by the SFS to clients who have demonstrated dangerous sexual behaviours."*[5]

*The program offers the following services:*
- *client assessment,*
- *comprehensive intervention plans,*
- *individual client counselling,*
- *staff training, and*
- *consultancy to staff working with this client group.*

*Perry House is a 12 month residential and outreach program run by the Jesuit Social Services (JSS). The residential program is for four clients between the ages of 17 and 21 years. They are supported by 24 hour staff. The aim of the Perry House program is to assist young offenders with an intellectual disability to decrease the frequency of their offending behaviour and to increase their range of independent living skills. The program assesses the young person's life skills across a range of areas, eg. education, health, vocation, recreation, leisure, human relations and sexuality, finance and domestic skills.*

Other studies suggested a number of other elements in a continuum of service delivery for the target group. These included:
- Volunteers as mentors to assist parolees. (Massachusetts Community Assistance Parole Program[6], and Special Needs Offender Program[7])

5 Victorian Department of Human Services Publication No. ID&CJ9 *Sex Offenders Treatment Program*.

6 J Petersilia "Massachusetts Community Assistance Parole Program (MassCAPP)" (1997) *Corrections Management Quarterly* 1 (4) at 36-44.

7 "Special Needs Offender Program" (Texas Department of Criminal Justice and the Dallas County Mental Health and Mental Retardation Center. *Community Services Reporter*, 1997).

- Interdepartmental teams from justice and human services to provide joint case management. (Lancaster County, PA, Office of Special Offender Services[8]) or to coordinate services between different departments (Western Australia Criminal Justice Program[9]) or to provide joint 'Personalised Justice Plans'(Developmentally Disabled Offenders Program, Arc of New Jersey[10])
- Consortiums consisting of all the different departments and agencies to coordinate or monitor the delivery of services (Texas Council on Offenders with Mental Impairments, and The Pueblo DD/MH Consortium[11]).
- Personnel with expertise to provide training and support across large areas, coordinate assessments, devise programs and offer direct program intervention to some of the target group. (Victorian Disability Services' Criminal Justice Program[12], DDOP[13]).
- Secure residential programs ranging in size from 3 to 80 beds, which usually included multi-disciplinary teams and graded levels of security including community options. (Colorado Bluesky Enterprises, Inc. DD Offender Program[14]; The Centre for Intensive Treatment, New York State Office of Mental Retardation and Developmental Disabilities and the Sunmount Developmental Disabilities Services Office[15],[16]; Oregon State Hospital's Social Skills Program[17]; Connecticut Department of Mental Retardation[18]; The Kenneth Day Units at Northgate Hospital, UK[19]; the Victorian Statewide Forensic Service, Intensive Residential Treatment Program[20]).
- Prison programs were also often cited as a necessary component.

Studies also noted the importance of separate facilities for youths and adults and separate areas for clients with intellectual disabilities and non-disabled custodial clients.

With reference to prison programs, there were arguments for "normalisation' and therefore mixing of inmates, but there were also arguments for protection and habilitation. The general consensus from the literature was that mixing in the regular prison is not the same as mixing in the regular community. There are intellectually disabled prisoners who do not want to be identified and so will not access programs in a mixed setting. There is no evidence that the offending behaviour of these prisoners is successfully addressed in an integrated setting but there is anecdotal evidence that intervention is more likely to be successful in separated facilities outside a prison setting[21],[22].

The literature does not support the use of existing institutions for people with intellectual disability as places of custody of the target group. The criminal justice clientele are mostly mildly intellectually disabled and better able to mask their limitations. They are often resistant to participate in programs because of a "need" to hide the disability. People in the facilities with lower intellectual and functional levels are at risk of victimisation and disruption of routines[23].

---

8 Lancaster County (PA) Office of Special Offender Services, Internet Reference: Mr. Deon E. Roth, Director, Lancaster County Courts, Office of Special Offenders Services, 225 West King Street, Lancaster, PA 17603. Tel. (717) 299-8184.

9 Western Australian Criminal Justice Program *Justice and People with Disabilities in Western Australia* information provided by Francine Holder, Acting Justice Coordinator (2001).

10 S Lustig (Director) *Developmentally Disabled Offenders Program* (DDOP) (Arc of New Jersey) http://www.arcnj.org.

11 L Velasco *The Pueblo DD/MH Consortium* (Colorado, USA).

12 *Victorian Disability Services'Criminal Justice Program*.

13 Lustig .

14 *Developmental Disability Offender Program* Colorado Bluesky Enterprises, Inc.

15 *The Centre for Intensive Treatment* New York State Office of Mental Retardation and Developmental Disabilities and the Sunmount Developmental Disabilities Services Office. 44 Holland Ave Albany New York 12229.

16 A Langford, NSW Department of Corrective Services, personal communication 27/9/00.

17 Haaven, Little and Petre-Miller.

18 Conneticut Department of Mental Retardation. *Community Services Reporter* (1997).

19 K Day "A Hospital-Based Treatment Programme for Male Mentally Handicapped Offenders" (1988) *British Journal of Psychiatry* 153 at 635-644.

20 *Victorian Disability Services'Criminal Justice Program.*

21 J Petersilia.

22 W Glaser, personal communication, 14/7/00.

23 L A Reynolds *People with mental retardation in the criminal justice system* (The ARC, Arlington Texas 1999).

## 8.2 Best practice characteristics of services

There were a number of characteristics of services that emerge from the literature as 'best practice' features. These are:

**A range or continuum of services** - As already discussed.

**Joint departmental responsibility** - This could include joint funding responsibility, or at least a joint "steering committee" which has powers to oversee and respond to issues within the program. The legal system must be included on this committee and it must have status and clout. Two models which were particularly effective and accountable examples of joint 'management'were the Pueblo DD/MH Consortium[24] and the TCOMI[25]. In both cases the consortium consisted of all involved agencies or departments and the composition was adjusted as needed or as other groups were identified. Although these two organisations were somewhat different in how they operated, they both achieved excellent outcome data, they continually reviewed and modified their procedures based on their outcomes and they had both a direct client focus and an educational and prevention emphasis. In the case of TCOMI they were also very proactive in legislative changes and ensuring there were no service gaps. It was stated that the Consortium breaks down barriers between agencies, creates synergy, and establishes trust, commitment to excellence and increases rapport.

***Western Australia -*** *The Western Australian model is another example of a formal interagency arrangement to improve services to the target group. Since 1994, the Disability Services Commission has convened the Access to Justice Working Party to promote access to justice for people with disabilities. The terms of reference are to make recommendations to the Corporate Executive and Board of the Disability Services Commission on:*
- *Matters relating to legislative reform, legal policy and administrative matters;*
- Reform which will protect the interests of persons with disabilities when they have contact with the criminal and civil justice systems.
- *Co-operation and liaison between the Disability Services Commission, the Ministry of Justice, the Police Service and other agencies; and*
- *Legal policy matters of a general nature arising from State and Commonwealth legislation.*

*A Federal Court justice is the Chairman of the Working Party. Membership is currently as follows: Executive Director, Policy and Legislation, Ministry of Justice; Chief Magistrate of Western Australia; Manager In-House Practice, Legal Aid Commission; Public Advocate; Assistant Commissioner, Police Service; Mental Health Division, Health Department of WA; Director, Statewide Forensic Psychiatric Services; and Director, Policy and Planning, Principal Clinical Psychologist and the A/Justice Coordinator, Disability Services Commission.*

*The Access to Justice Working Party has been responsible for a number of initiatives including:*

- *A Diversion Project - The Fremantle Police Diversion Pilot Project began in 1996 as a 12-month pilot and was a joint initiative of the Disability Services Commission, the Ministry of Justice and the Police Department with support from the Legal Aid Commission, Fremantle Council and Fremantle Mental Health Services. The program was extended and independently evaluated in 1997, and in 1998 the evaluation report recommended the project be extended throughout the metropolitan area. The program terminated in 2000 when the Police Service withdrew its support. The Access to Justice Working Party continues to support diversion of people with decision-making disabilities who commit minor offences from the justice system into programs designed to minimise the risk of re-offending. A sub-committee has been set up to examine alternative models of diversion.*

24 Velasco.

25 *Texas Council on Offenders with Mental Impairments.*

- *Least Restrictive Viable Alternatives for Difficult Offenders Model - This model was developed to provide coordinated pre and post-release options for people with disabilities serving indeterminate sentences or who are constantly in and out of the prison system because of frequent, minor offences. It includes the setting up of an assessment panel to support and resource transition plans, and to make recommendations to the Parole Board and Mentally Impaired Defendants Review Board.*

- *The "Paired Resource" - This consists of two dedicated positions, the Manager Disability Services in the Ministry of Justice and the Justice Coordinator in the Disability Services Commission. Their roles are discussed in more detail below.*

- *Information Booklets for the Courts.*[26]

**Interagency management of clients -** Joint responsibility for clients was an element of the most successful programs. The Lancaster County (PA) Office of Special Offender Services employs teams of two, each comprising a probation officer employed by the Probation Department and a case worker employed by the County Mental Health and Mental Retardation Program. The role of these teams is to assess the person, to provide appropriate alternatives to incarceration, to educate criminal justice personnel regarding the needs of the target group and to ensure that local disability and parole and probation services work cooperatively. The recidivism rate of the Lancaster County clients is noted as 5 percent average for the past 9 years[27].

The Peublo DD/MH Consortium in Colorado[28] was another example of effective cooperation modelled on the Lancaster County Program. The Consortium, which consisted of all related departments, met monthly to discuss particular cases and to address issues in service delivery.

*The Western Australian Criminal Justice Program also includes a joint management approach. There are two dedicated positions, the Manager Disability Services in the Ministry of Justice and the Justice Coordinator in the Disability Services Commission[29]. These positions work jointly to develop programs to address the needs of people with intellectual disabilities in the justice system. Projects include:*
- *A "Structured Day Program" at Riverbank Prison for prisoners with intellectual disabilities.*
- *A pilot "Life Skills" program in prison.*
- *A modified sex offenders treatment program for cognitively impaired offenders, operating both in prison and in the community and staffed jointly by Ministry and Commission staff.*
- *Support for the "Frequent Offenders Program", an accommodation program managed by a community agency for people with intellectual disabilities who are frequently imprisoned for minor offences because of a lack of suitable accommodation.*
- *The development of "Keep Cool", a modified anger management program for adolescents with intellectual disabilities, including the production of a video to support the program.*
- *And the ongoing development of the "Ending Offending" modified alcohol program for people with intellectual disabilities.*

*This joint management system only began in 1996 and its effectiveness is reported to be as follows:*

> *There is a quicker and more effective response to clients, duplication of efforts and services is prevented, there is a single point of reference for each agency, there is easier collection and collation of data and it assists each department understand each other.*

26 F Holder *Justice and People with Disabilities in WA*. Information provided to reviewers January 2001.
27 Lancaster County (PA) Office of Special Offender Services.
28 Velasco.
29 F Holder *Justice and People with Disabilities in WA* Information provided to reviewers January 2001.

**Flexibility of funding -** So as to respond to individual needs at the times the response is required.

**Comprehensive individual programs -** Programs should:
- Be individually designed and based on a comprehensive assessment.
- Be highly structured and accountable, eg movement through accommodation or supervision stages being based on measurable progress.
- Include recreational and vocational skill building.
- Include regular monitoring of outcomes and review of the program.
- Include both behavioural and therapeutic components to address both offence related and offence specific behaviours.
- Emphasise a consistency of programming and intervention strategies.
- Use a multidisciplinary approach.
- And include a system for monitoring an individual's progress for up to five years after leaving a service.

**Strategies for consistent and accountable program intervention -** These include having trained and experienced staff with expertise in assessment and in behavioural and offence specific intervention programs. Other staff related necessities include regular staff meetings, documenting programs and recording of progress, regular review of strategies and program outcomes, staff supervision, and staff debriefing. (Oregon State Hospital's Social Skills Program[30]; Northstar Program, Canada[31]; Colorado Bluesky Enterprises DD Offender Program[32]). Communication is important to ensure consistent implementation, review and modification of programs.

**Advocacy and support -** This is seen as important particularly during the post release phase of a program. This can also function as a positive role model and was particularly effective in the MassCAPP program[33] and the Special Needs Offender Program[34]. Monitoring and support for up to 5 years was considered an essential component of the DDOP, Arc of New Jersey[35]. This program also reported a particularly low recidivism rate of 6.5 percent over 5 years as compared to 62 percent for the National average.

**A community and agency educational component -** Programs that had a joint systems management approach also tended to emphasise community and agency education. Part of the education came about as a result of departments working together and part from planned training activities. The Lancaster County Model also included a school prevention program to educate special education students about the law, consequences of breaking the law and about problem solving.

As part of the educational strategy of the Pueblo DD/MH Consortium,[36] they developed a flow chart of the process called "Criminal Justice Intervention Process". This described the role of each criminal justice system participant after a person with intellectual disability has committed an offence. The flow chart assists in planning appropriate intervention services and provides the different parties with the necessary direction.

The DDOP, Arc of New Jersey[37], has a specific educational role in developing training programs for criminal justice professionals and service providers in addition to developing Personalised Justice Plans (PJPs) for actual clients. The program states that the combination of these roles is essential to the program's low recidivism rates.

---

30 Haaven, Little and Petre-Miller.

31 *Northstar Program Canada* (Regional Health Centre, Pacific, Correctional Services of Canada, Box 3000 Abbotsford, British Columbia V25 4P4).

32 *Developmental Disability Offender Program* Colorado Bluesky Enterprises, Inc.

33 Petersilia.

34 *Special Needs Offender Program*.

35 *Developmental Disability Offender Program*.

36 Velasco.

37 Lustig.

**Case management -** The form of case management varied with the different programs. For instance, the Lancaster County Program has case managers whose functions are threefold: to arrange the assessment of client needs and locate services; to co-ordinate the provision of services; and to monitor ongoing service provision and contracts arranged for clients.

Other programs which emphasised the case management role were DDOP, Arc of New Jersey[38], Oregon State Hospital's Social Skills Program[39], TCOMI[40], the Victorian Disability Services Program, and the Western Australian Criminal Justice Program.

## 8.3 Interventions to address offending behaviour

It is now clear from the literature that the popular myth that "nothing works" to change offending behaviour is far from true[41]. The review of the literature included examination of the intervention models used in the various services. Few gave full descriptions of their intervention models, but the following section is a brief discussion from an analysis of the different international and Australian programs.

It must be emphasised first that the review of the literature does not suggest that there is any single, outstanding approach that is guaranteed to work as a means of reducing recidivism.

In the more effective programs, there is a matching between the offender risk level and the degree of service intervention. That is, the people who present a higher level of risk receive more intense services, while those of lower risk receive lower or minimal intervention. The difficulty here is the actual determination of risk but it is usually based on factors including prior history. More work is needed to establish expertise and experience in multi-dimensional assessment with the target group, including assessment of risk of offending.

Most of the programs also noted the need to assess the offence specific and offence related aspects of a persons behaviour. That is, there is a need to separate client problems or features that contribute to or are supportive of offending, from those that are more distantly related, or even unrelated to it. This principle underpins direct work on offending behaviour.

There was general agreement that the intervention models should be "multi-faceted". That is, the more effective programs were:

- Multimodal - that is, they recognised the variety of offenders problems.
- Skills oriented – that is, the content and methods employed were designed to teach problem solving, social interaction and other types of coping skills.
- And utilising methods drawn from behavioural, cognitive or cognitive-behavioural sources.

Intervention programs should be offered by expert staff and should include a behavioural component, individual and group therapy and skills development. The programs should target areas that are indirectly related to the offending behaviour (such as work skills, literacy etc.) as well as areas that are specific to an individual's offences (such as specific therapy for sex offenders etc).

The behavioural component of the different programs varied from highly structured "point systems" or levels based on different aspects of an individual's behaviour, to more informal management based on behaviour management principals. The levels systems of progression were the most highly favoured[42]. For example, The DD Offender Program, Colorado Bluesky Enterprises, has a strong

38 Lustig.

39 Haaven, Little and Petre-Miller.

40 *Texas Council on Offenders with Mental Impairments*.

41 McGuire and Priestly at 7.

42 A Langford NSW Department of Corrective Services personal communication 27/9/00.

behavioural emphasis with a 5 level points system. Each level, with the accompanying responsibilities, privileges and criteria for movement to a level are specified in a detailed written plan and there is a system of losing points as well as gaining them. Clients are involved in all review meetings and there is a gradual shift from staff to client responsibility. Three other programs had similar well-developed level systems for behaviour management. These were the Centre for Intensive Treatment, New York State Office of Mental retardation and Developmental Disabilities[43], Oregon State Hospital's Social Skills Program[44] and the Victorian Statewide Forensic Program Intensive Residential Treatment Program[45].

In addition to the behavioural component, a number of programs which address the offending behaviour are offered. The programs were usually in groups or in some cases individual counselling either by the service itself or by contracting out to other specialised intellectual disability or mental health services. The programs that provide the individual counselling sessions themselves had psychologists employed to carry out this role (DD Offender Program, Colorado Bluesky Enterprises[46]; The Centre for Intensive Treatment, New York State Office of Mental Retardation and Developmental Disabilities[47]; the Victorian Statewide Forensic Service[48]).

The individual and group therapy work appeared to emphasise two main approaches. There was a psychotherapeutic approach which aimed at increasing offender empathy and sense of responsibility. There was also a cognitive-behavioural approach which aimed to remediate skill deficits by altering cognitions related to offending behaviour and to alter deviant patterns of sexual arousal or preference. Most programs used a combination of these approaches rather than strictly applying only one. The emphasis was on devising an individual program for each person according to a comprehensive assessment.

The range of programs offered by the more comprehensive services included:

- Group therapy such as
  - for sex offenders
  - relapse prevention therapy
  - anger management
  - arson therapy
  - citizenship training (eg. rights and obligations and the court process), and
  - victim empathy training.
- Specific areas for skill development such as
  - employment skills
  - literacy and numeracy
  - problem solving
  - communication
  - leisure and recreation skills
  - independent community living skills, and
  - food preparation.

There were also courses relating to personal development and understanding such as

- human sexuality
- managing illness and injury
- self-medication administration
- values and choices

43 *The Centre for Intensive Treatment*, New York State Office of Mental Retardation and Developmental Disabilities.
44 Haaven, Little and Petre-Miller.
45 *Victorian Disability Services'Criminal Justice Program.*
46 *Developmental Disability Offender Program* Colorado Bluesky Enterprises, Inc.
47 *The Centre for Intensive Treatment*, New York State Office of Mental Retardation and Developmental Disabilities.
48 *Victorian Disability Services'Criminal Justice Program.*

- social skills, and
- substance abuse.

It was noted that several programs (MassCAPP[49]; Developmentally Disabled Offenders Program, New Jersey[50]; The Centre for Intensive Treatment, NY[51]; Texas Council on Offenders with Mental Impairments[52]) put a stronger emphasis than others on the development of leisure and work or vocational skills. The rationale for this was the high levels of skill deficit for offenders with intellectual disabilities in these areas and also the relationship of poor social skills to the person's ability to make and sustain friends in both social and work contexts. There was strong agreement that programs should include a large educational component.

In summary, the essential program elements appear to be:

- An initial orientation and comprehensive assessment which may be up to 3 months;
- A multi-faceted approach to the assessment by a coordinated team;
- Assessments that are structured in terms of risks and need, and program allocations being made accordingly. This area needs considerable development.
- A multi-modal and holistic intervention approach, including specific skills development, behaviour management, and therapy or counselling components relating to the individual's offence specific needs and offence related needs;
- Individual plans, including objectives and strategies related to the specific comprehensive assessment;
- Learning that is provided in an active, participatory style rather than in either a didactic style or loose, unstructured and 'experiential'mode. The treatment programs should have a clear structure that is closely monitored.
- Stated aims that are linked to the methods used; and
- Review process/committees.

Also, community based programs would appear to be more effective in that there is greater generalisation to the client's actual living situation.

Inherent in all of the above 'essentials' is the need for staff expertise from a range of disciplines. Some expertise is required to understand and to adapt existing programs for people with an intellectual disability. Other expertise is required to provide the offence specific programs and to coordinate the overall management of the person with an intellectual disability. There needs to be staff training and supervision from appropriately trained and experienced people in the criminal justice/intellectual disability area.

## 8.4 Evidence of success

The most common response to those found guilty of an offence is punishment, usually in the form of fines. The next most common response is imprisonment[53]. Yet, in a number of recent studies of all the available literature, it has been concluded that contrary to popular thinking, reductions in recidivism are obtained amongst "treated" as compared with untreated groups:

> Indeed, focusing on those studies that employed psychological therapy as the 'treatment' in controlled experimental designs, almost 50% of the results had demonstrated a positive advantage for therapeutic intervention. In the remainder of the studies, no differences were detectable and in one, therapy yielded a net disadvantage.[54]

---

49 J Petersilia.

50 S Lustig.

51 *The Centre for Intensive Treatment*, New York State Office of Mental Retardation and Developmental Disabilities.

52 *The Texas Council on Offenders with Mental Impairments*.

53 J McGuire and P Priestly "Reviewing 'What Works': Past, Present and Future" in *What Works: Reducing Reoffending-Guidelines from Research and Practice* (Ed by J McGuire J Wiley and Sons Ltd 1995) at 3.

54 Thornton (1987) in McGuire and Priestly at 6.

Thus although many questions could still be asked as to what works best and under what circumstances, the one conclusion that is 'not permissible' is that 'nothing works'.

There are no success measures for the Australian programs. However, there is significant American data in relation to reductions in recidivism.

In the USA, the national average recidivism rate for inmates is 62% per annum[55]. In the Developmentally Disabled Offenders Program (DDOP) of New Jersey where 140 clients in a 3 year period were managed in community placements with Personalised Justice Plans there was a 6.5% recidivism rate per annum over 5 years data (to 1998). This service acts as a clearing house for information on intellectually disabled offenders and acts as a liaison between criminal justice and human service systems. Its four main functions are: to provide technical assistance and education to criminal justice professionals; to develop Personalised Justice Plans; to develop training programs for professionals and service providers; and to develop brochures and videos. Clients are supported and monitored for up to 5 years and good data are kept on the program.

In a residential[56] program for sex offenders with intellectual disabilities, recidivism averaged 23% for sex offences but ranged up to 65% for all offences. This was based on 199 cases (mild intellectual disability 20% and borderline 80%, with 25% also having mental health problems and 85% substance abuse problems). It was noted that the drop in recidivism was related to whether the clients received community after care services once they left the intense residential treatment program.

The Lancaster County (PA) Office of Special Offenders Services program is frequently cited as a successful model. As explained earlier, it is a jointly funded program from probation and Mental Health/Disability Services. The program has teams consisting of 2 people each (1 from each department). The role of these teams is to assess clients, to provide appropriate alternatives to incarceration, to educate criminal justice personnel and to ensure that local disability and parole and probation services work cooperatively. Clients cannot refuse assistance without risking going to prison. The caseload for two disability teams includes 50 adults and 35 juveniles. The system requires a close relationship with the courts as one violation leads to a warning and a return to the program, but another leads to prison.

Clients referred to the Mental Retardation Program (which does not include borderline intellectual disability) are assigned a case manager whose functions are threefold:
- Arrange assessment of client needs and locate services;
- Co-ordinate the provision of services; and
- Monitor ongoing service provision and contracts arranged for the client.

The case management approach is based on a different philosophy than many case management approaches by not making immediate referrals. The client must be interested in the service, in personal growth, and in skill building. The client then earns the right to the service. Initially, the client reports daily to establish routines and for evaluation purposes. Accountability and responsibility for one's behaviour are stressed. There is a major emphasis on recreation skills. Included in this are the necessary social skills and the how to use spare time.

The recidivism rate of the Lancaster County program for the past 9 years has averaged 5% (again compared to a National Average of approximately 60%).

The Peublo DD/MH Consortium in Colorado[57] was another example of effective joint systems cooperation modelled on the Lancaster County Program. The Consortium, which consisted of all related departments, met monthly to discuss particular cases and to address issues which were occurring in service delivery. The outcomes for this program were noted as:

55 S. Lusitg *Developmentally Disabled Offenders Program* ARC of New Jersey.
56 J Haven, J, R Little & D Petre-Miller, D. *Treating Intellectually Disabled Sex Offenders, A Model Residential Program* (The Safer Society Press, Orwell VT, USA 1990).

> Over 80 percent of the 50 individuals who have been served through the Consortium have been successful in their programs. Also the rate of recidivism through the courts is about 20 percent.

Another Texas program is the Texas Council on Offenders with Mental Impairments (TCOMI)[58]. This program is outlined in Chapter 8.1. For the financial year 1998/99, an outcome target for reduction of arrests was set at 21%. The actual figure achieved was a reduction of 34%. Other indicators were return to prison rates – 2% during 1998. This was for the 2,188 offenders served by the TCOMI programs during this year.[59] However, people with intellectual disabilities are a comparatively small minority of the people assisted by TCOMI; most of the service users have psychiatric conditions.[60]

## 8.5 Implications for program management and design

This literature review has a number of implications for the planning and management of services for offenders with an intellectual disability. Following are some suggestions as to how the process of acting on 'what works' might be advanced.

First, those managing and working in services for people in the target group need to become more familiar with the relevant research evidence. While some mechanisms may already exist for this to happen, the need to remain in touch with research findings is often a low priority amongst many other pressures of day-to-day work.

Second, if the 'risk' and offence specific principles of intervention are to be implemented, major efforts should be directed towards the development of reliable risk-needs assessment methods and the development of an appropriate range of clinical interventions. Many programs have attempted to do these things but the more effective ones do them in a coordinated and systematic way across large areas and with a number of different services. As McGurie and Priestley[61] suggested,

> It would be more advantageous, however, were it to be conducted on a wider scale …it would be preferable if some coordinating function was created..(including) a research and advisory unit.

Another recommended function of a specialist capacity is to oversee the systematic implementation of 'what works' by ensuring the provision of necessary resources for clinical programs to be developed, run and evaluated. This would have positive implications for the partnerships created between the different departments and agencies supporting the target group as it would facilitate the coordinated delivery of services.

Finally, there are implications for staff. They will require additional knowledge and skills to work in a coordinated way with other agencies and departments or professionals. McGuire and Priestley[62] suggest that implications for staff management will be related to styles of supervision, team management and staff allocation to different roles or types of work. This in turn will have "significant implications for the training of staff for new tasks and roles".

57 Velasco.
58 *Texas Council on Offenders with Mental Impairments, Biennial Report*, January 1999.
59 Ibid at 12.
60 Communication with Anne Langford, Clinical Coordinator, Disability Programs, Department of Corrective Services reporting on a study tour in 2000.
61 McGuire and Priestley at 23.
62 McGuire and Priestley at 23.

## 8.6 References and programs

Brown, B. S., & Courtless, T.F. (1971).*The mentally retarded offender.* (Washington. D.C.: US Govt. Printing Office, Department of Health Education and Welfare Pub. No. (HSM) 72-90-39).

Bucke, T. & Brown, D. (1997). *In Police Custody: Police powers and the suspects'rights under the revised PACE codes of practice* (Home Office Research Study 174 Home Office Research and Statistics Directorate London Home Office).

Community Services Commission (1999). *Just Solutions-Wards and Juvenile Justice.*

Conley, R. W., Luckasson, R. & Bouthilet, G. N. (Eds.) (1992). *The criminal justice system and mental retardation.* (Baltimore: Paul. H.`Brookes Publishing Co.)

Conneticut Department of Mental Retardation *Community Services Reporter* (1997).

Day, K. (1988). "A hospital-based treatment programme for male mentally handicapped offenders". *British Journal of Psychiatry*, 153.

Deane, K. and Glaser, W. (1994). *The Characteristics and Prison Experience of Offenders with an Intellectual Disability: An Australian Study* (University of Melbourne).

Denowski, G. C. & Denowski, K.M. (1985). *The mentally retarded offender in the state prison system: Identification, prevalence, adjustment, and rehabilitation*. Criminal Justice and Behaviour, 12(1), 53-70.

*Developmental Disability Offender Program* Colorado Bluesky Enterprises, Inc..

*Developmentally Disabled Offenders Program* (DDOP) (Arc of New Jersey) http://www.arcnj.org S Lustig (Director)

Haaven, J., Little, R. & Petre-Miller, D. (1990) *Treating Intellectually Disabled Sex Offenders, A Model Residential Program* (The Safer Society Press, Orwell, VT 05760-9756).

Hayes, S. C. & McIlwain, D. (1988). *The prevalence of intellectual disability in the New South Wales prison population: an empirical study*. (Canberra: Criminology Research Council).

Hayes, S. C. (1991). "Sex offenders". *Australia and New Zealand Journal of developmental Disabilities*, 17 (2), 221-227.

Hayes, S. C. & Craddock, G. (1992). *Simply Criminal* (2nd ed, Federation Press, Sydney).

Hayes, S. C. (1994). "The criminal law and the person with intellectual disability", *Australia and New Zealand Journal of Developmental Disabilities*, 19 (4), 287-292.

Hayes, S.C. (1997). "Prevalence of intellectual disability in local courts", *Journal of Intellectual and Developmental Disability*, 22 (2), 71-85.

Hayes, S. C. (1997). "Learning and intellectual disabilities and juvenile crime". In A. Borowski & I O'Connor (Eds), *Juvenile Crime, Justice and Corrections*. Addison, Wesley, Longman, Aust. Ltd.

Hayes, S. C. (1998). *Developing a screening test for intellectual disability-findings from a study of juvenile offenders in NSW*, information produced for the Department of Juvenile Justice, NSW.

Hayes, S. C. (1999). *Needle in a haystack- Identifying the offender with intellectual disability.* Paper presented at Justice for Everyone, 2nd National Conference on Intellectual Disability and the Law, Wollongong University.

Hayes, S. C. (1999). *Good behaviour? - A comparison of cognitive and adaptive behaviour impairments in offender populations*. Paper presented at Australian Society for the Study of Intellectual Disability 35th Annual Conference.

Hodgins, S. (1992). "Mental disorder, intellectual deficiency and crime: Evidence for a birth cohort", *Archives of General Psychiatry* 49 (6).

Hudson, A., Nankervis, K., Smith, D., & Phillips, A. (1999). *Prevention of sexual offending amongst adolescents with an intellectual disability: Identifying the risks*. (Final Report, Department of Psychology and Intellectual Disability Studies, RMIT University).

Jones, G.P. & Coombes, K. (1990). *The prevalence of intellectual deficit among the Western Australian prisoner population*. Perth: Western Australia Department of Corrective Services.

Kunjukrishnan, R. (1979). "10-year survey of pre-trial examinations in Saskatchewan", *Canadian Journal of Psychiatry*, 24, 683-689.

Lancaster County (PA) Office of Special Offender Services, Internet Reference: Mr. Deon E. Roth, Director, Lancaster County Courts, Office of Special Offenders Services, 225 West King Street, Lancaster, PA 17603. Tel. (717) 299-8184.

Lund, J. (1990). "Mentally retarded criminal offenders in Denmark", *British Journal of Psychiatry*, 156. Cited in S. Hayes, & G. Craddock, Simply Criminal (2nd ed, Federation Press, Sydney, 1992).

Lustig, S. *The hidden population in the criminal justice system: Providing successful advocacy services to defendants with mental retardation*. (Submitted to the President's Committee on Mental Retardation, August 1998).

Lyall, M. Holland, A.J., Collins, S. & Styles, P. (1995). "Incidence of persons with a learning disability detained in Police Custody. A needs assessment for service development" *Medicine, Science and the Law* 35 (1).

McGuire, J., & Priestly, P. (1995). "Reviewing 'what works': past, present and future". In J McGuire (Ed.) *What Works: Reducing Reoffending-Guidelines from Research and Practice.* J Wiley and Sons Ltd.

Mouzos, J. (1999). "Mental disorder and homicide in Australia". *Trends and Issues on Crime and Criminal Justice* (133).

New South Wales Law Reform Commission. (1996). *People with an intellectual disability and the criminal justice system.* Report No. 80. Sydney: NSW Law Reform Commission.

*Northstar Program*, Canada (Regional Health Centre, Pacific, Correctional Services of Canada, Box 3000 Abbotsford, British Columbia V25 4P4).

Petersilia, P. (1997). "Massachusetts Community Assistance Parole Program" (MassCAPP). *Corrections Management Quarterly* 1 (4), 36-44.

Petersilia, J. (1997). "Unequal justice? Offenders with mental retardation in prison". *Corrections Management Quarterly*, 1(4), 36-44.

Quinsey, V. "Assessment, management and treatment of sex offenders", *British Journal of Psychiatry*, 117, 529-541. http://198.103.138/sexoff/confe.htm#3E9E12

Reynolds, L.A. (1999). *People with mental retardation in the criminal justice system*. The ARC (Arlington Texas).

"Special Needs Offender Program", (Texas Department of Criminal Justice and the Dallas County Mental Health and Mental Retardation Center.) *Community Services Reporter* (1997).

Svendsen, B. B., & Werner, J. (1997) "Offenders within ordinary services for the mentally retarded in Denmark". In P. Mittler, (Ed). *Research to Practice in Mental Retardation.* 1977. Vol.1, *Care and Intervention*. Washington D.C.: IASSMD.

*Texas Council on Offenders with Mental Impairments Biennial Report*, (86110 Shoal Creek Blvd. Austin Texas 78757, January 1999).

*The Centre for Intensive Treatment*, New York State Office of Mental Retardation and Developmental Disabilities and the Sunmount Developmental Disabilities Services Office. 44 Holland Ave Albany New York 12229.

Velasco, L. *The Pueblo DD/MH Consortium* (Colorado, USA).

*The Standing Committee on Social Issues' Inquiry into Juvenile Justice in NSW* (NSW Parliament, 1992a: 31-48) as reported in *Just Solutions-Wards and Juvenile Justice* (Community Services Commission, March 1999).

Tomasina, J. & Lambrick, F. (1996). *A service model for the assessment, treatment and management of intellectually disabled offenders who commit serious offences.* Statewide Forensic Service, Disability Services, Department of Human Services, Victoria, Australia. Paper presented at 6th European Conference of Psychology and the Law: Sienna, Italy, 1996.

*Victorian Disability Services'Criminal Justice Program*, Department of Human Services, Victoria.

Victorian Disability Services' Criminal Justice Program, *IDS Client Service Practice Manual*, 1992.

Victorian Department of Human Services Publication No. ID&CJ9 *Sex Offenders Treatment Program.*

Western Australian Criminal Justice Program

## Programs (and References to Programs)

"Connecticut Department of Mental Retardation". *Community Services Reporter*, 1997.

Day, K. (1988). "A hospital-based treatment programme for male mentally handicapped offenders". *British Journal of Psychiatry*, 153.

*Developmental Disability Offender Program* Colorado Bluesky Enterprises, Inc..

*Developmentally Disabled Offenders Program* (DDOP) (Arc of New Jersey) http://www.arcnj.org S Lustig (Director)

Haaven, J., Little, R. & Petre-Miller, D. (1990) *Treating Intellectually Disabled Sex Offenders, A Model Residential Program* (The Safer Society Press, Orwell, VT 05760-9756).

*Lancaster County (PA) Office of Special Offender Services*, Internet Reference: Mr. Deon E. Roth, Director, Lancaster County Courts, Office of Special Offenders Services, 225 West King Street, Lancaster, PA 17603. Tel. (717) 299-8184.

*Northstar Program*, Canada (Regional Health Centre, Pacific, Correctional Services of Canada, Box 3000 Abbotsford, British Columbia V25 4P4).

Petersilia, P. (1997). "Massachusetts Community Assistance Parole Program" (MassCAPP). *Corrections Management Quarterly* 1 (4), 36-44.

"Special Needs Offender Program", (Texas Department of Criminal Justice and the Dallas County Mental Health and Mental Retardation Center.) *Community Services Reporter* (1997).

*Texas Council on Offenders with Mental Impairments Biennial Report*, (86110 Shoal Creek Blvd. Austin Texas 78757, January 1999).

*The Centre for Intensive Treatment*, New York State Office of Mental Retardation and Developmental Disabilities and the Sunmount Developmental Disabilities Services Office. 44 Holland Ave Albany New York 12229.

*The Pueblo DD/MH Consortium* (Colorado, USA). Director, L Velasco.

*Victorian Disability Services'Criminal Justice Program*, Department of Human Services, Victoria.

Western Australian Criminal Justice Program. *Justice and People with Disabilities in Western Australia,* information provided by Francine Holder, Acting Justice Coordinator, January 2001.

Western Australian Disability Services Commission, Corporate Executive Briefing Note. *Proposed Policy and Funding Framework to Underpin Justice Funding under the Business Plan and the Implementation of the Least Restrictive Viable Alternative for Difficult Offenders Model.* Undated but provided to the reviewers November 2000.

# Acknowledgements

Numerous people deserve acknowledgment for their assistance and support for the Framework Project. Most of these are named in the Appendix below or in references through the report. Some people and organisations need particular mention here.

The project looked closely at the lives of eleven members of the target group. The consultants much appreciate the willingness of these individuals and members of some of their families to be involved with the project. Whilst the anonymity of these individuals has been preserved in the report, their participation exposed to scrutiny life experiences that have often been very painful.

The project managers were Georgina Connelly from the Intellectual Disability Rights Service and Helena O'Connell from the NSW Council for Intellectual Disability. The consultants acted in close liaison with them. Georgina and Helena provided a great deal in the way of support, rigorous thinking, good sense and a clear focus on making the project achieve practical gains in the lives of people with intellectual disabilities.

Bruce Hawker of Hawker Britton Pty Limited was extremely generous with his experienced counsel.

The Department of Ageing, Disability and Home Care (formerly Ageing and Disability Department) half funded the project and provided a range of other assistance. Towards the end of the project, it was very important to liaise closely with the Department and Megan Mitchell and Anna Edwards provided very helpful input.

Warwick Neilley, adviser to the Minister for Disability Services, The Hon. Fay Lo Po', provided frank and valuable comments on the project as it unfolded.

The other half of the funding came from the Law Foundation of NSW. This continued the Foundation's strong support over many years for projects in the intellectual disability field.

Members of the project reference group and clinical issues group were particularly generous with their time and interest in the project. The Disability Council of NSW and its chairperson, Leonie Manns, provided helpful guidance and the use of a meeting room.

This study of individuals occurred with research approval from the Departments of Community Services, Corrective Services and Juvenile Justice.

Perspectives in this report are of course not necessarily those of the agencies that provided funding or research approval for the project. In accordance with funding and research approval requirements, the consultants specifically note as follows. The information and views contained in this report do not necessarily, or at all, reflect the views or information held by the NSW Government, the Minister for Community Services or the Department of Community Services. Nor are the views and recommendations in the report necessarily those of the Law and Justice Foundation or its Board of Governors.

Business Backup Centre set out the report with its usual efficiency and cooperation.

Jim Simpson, Meredith Martin, Jenny Green
June 2001

# Appendix

## Reference group

| | |
|---|---|
| Imelda Dodds | NGO service provider |
| Megan Fahey/<br>Anna Edwards | Senior Project Officer<br>Ageing and Disability Department<br>(now Department of Ageing, Disability and Home Care) |
| Melissa Gibson/<br>Elena Murty | Acting Director, Health Services Policy<br>Department of Health |
| Julia Haraksin | Coordinator, Disability Strategic Plan<br>Attorney-General's Department |
| Pamela Jenkins | Senior Complaints Officer<br>Community Services Commission |
| Anne Langford | Clinical Coordinator, Disability Support Unit<br>Department of Corrective Services |
| John Le Breton | Director<br>Office of the Public Guardian |
| Ethel McAlpine | Executive Director, Disability Services<br>Department of Community Services<br>(now Department of Ageing, Disability and Home Care) |
| Jeanette Moss | Advocate |
| Tony Pearce | Coordinator<br>Buddagwhan Indigenous Advocacy |
| Mark Powell/<br>Debbie Knight | Business Improvement Manager<br>Department of Housing |
| Gwenda Schreiber/<br>Rodney Beilby | Director, Psychological and Specialist Services<br>Department of Juvenile Justice |
| Barbel Winter | Executive Officer<br>Multicultural Disability Advocacy Service |
| Donald Urquhart/<br>Cathy Mackson | Police Service |
| Janice Wortley | Coordinator, Disabilities and Learning Difficulties<br>Department of Education and Training |

**Project managers:**

| | |
|---|---|
| Georgina Connelly | Principal Solicitor<br>Intellectual Disability Rights Service |
| Helena O'Connell | Executive Officer<br>NSW Council for Intellectual Disability |

# Initial consultation with stakeholders

The following were the respondents to the consultation:

| Code | Number<br>Ind | Stks | Type | Individuals |
|---|---|---|---|---|
| Legal | 4 | 3 | Interview<br><br>Questionnaire | Georgina Connelly & Melissa Bellanta – IDRS<br>Mark Ierace – Barrister<br>Robert Wheeler – Mental Health Advocacy Service |
| Peak | 2 | 2 | Interview<br>Questionnaire | Phillip French – PWD<br>Christine Regan – NCOSS |
| NGO | 6 | 2 | Focus group<br><br>Questionnaire | L. Matthews, D. Leary, J. Sanders, J. Parsons, P. Mariano – Youth NGOs<br>Sandy Clarke – solicitor with Burnside |
| ADD | 5 | 1 | Focus group | Megan Fahey, Suzanne Pierce, H. Menzies, M. Jolley, W. Williamson |
| Police | 1 | 1 | Questionnaire | Pedro Fernandez |
| DoCS | 5 | 3 | Interview<br><br>Questionnaire<br>Focus group | Ethel McAlpine – Executive Director, Disability Services<br>Tony Cottier – Community Resource Team<br>Margaret Anderson, Mary-Ellen Burke, Cathy Newman |
| Advocacy | 9 | 6 | Interview<br><br>Questionnaire<br><br><br><br><br>Focus group | Jan May & Margaret Bowen – Illawarra Disability Trust<br>Jeanette Moss<br>Barbel Winter – Multicultural Disability Advocacy Association<br>Brett Collins – Justice Action<br>Peter Hutten – Illawarra Disability Trust<br>T. Pearce, S. Pearce & T. Smeaton – Disability Services Aboriginal Corp. |
| Health | 4 | 4 | Questionnaire | Helen Moloney – psychiatrist<br>Peter Champion – clinical Psychologist<br>Colin Hudson – CNC Forensic<br>J. Anderson – Head Psychiatrist, Acute Adolescent Unit Westmead Hospital |
| Research | 1 | 1 | Interview | Susan Hayes – Associate Professor, Sydney University |
| A-G | 1 | 1 | Questionnaire | Andrew Haesler – Director, Criminal :Law Review & Public Defender |
| Education | 2 | 1 | Interview | S. Thorley- Smith & E. Brown – CEO Behaviour & Attendance & SEO Community Care |
| OPG | 4 | 1 | Focus Group | J. Bidenko, J. Ramos-Conna, M. Coote - Pearce & F. Rush -<br>Office of the Public Guardian |
| Parole | 1 | 1 | Interview | Mary Bolt |
| **TOTAL** | **45** | **27** | | |

The respondents were asked the following questions:

1. Are there any points that require change or further clarification in our definition of the target group?
2. Are there common factors in people's histories that were indicators of the risk that they would become an offender?
3. What support do the people you know in the target group use? Please explain the type and extent of support. For example: what level of support do they get; what degree of support do they receive over a week or month; how does it look in terms of times, regularity and degree.

   The following list contains some common examples of support
   - accommodation
   - clinical services
   - legal
   - activities/educational/recreational/vocational/therapeutic
   - community services
   - coordination support/case management
   - support from family, friends and advocates

4. Is this adequate support? Please explain why or why not?

5. What are the barriers to getting services that do exist? Please explain the issues. The following list is a guide.
   - legislation
   - policy
   - funding
   - service coordination
   - interdepartmental demarcation
   - administration
   - other

6. What is needed to provide effective support to people in the target group? What would be the best possible service? Please describe.

7. Do you know any examples of good models that are around at the moment in Australia or overseas? Please describe them or provide references.

8. We are looking for people who can be used in case studies that describe the target group. We are not seeking a representative sample. We are seeking people with different characteristics and different features in their lives. They may have both good and bad experiences. We would like to interview some people, however this is not a requirement for the case studies. Can you recommend any people for the case studies? If so please give a brief description of why they may be suitable. We are keen to preserve the anonymity of individuals involved so please use pseudonyms or initials. We will contact you to discuss the possible inclusion of anyone you suggest.

## Selective follow up consultation

This occurred with the following people:

| | |
|---|---|
| Frank Lambrick | Psychologist, Statewide Forensic Service, Department of Human Services Victoria |
| Kaye Fraser | Coordinator, Citizen Advocacy Western Sydney |
| Mark Daley | Coordinator, Citizen Advocacy North West |
| Kate Milner, | Coordinator and President |
| Lea Maher | Citizen Advocacy Eastside |
| Lisa Stelc | Executive Officer, Western Sydney Intellectual Disability Support Group |
| Judy Toombs | Illawarra Disability Trust |
| Shauna McIntyre | Big Sister/ Big Brother Program |
| Cathy Mackson | Operational Programs Branch, Police Service |
| Cheryl Clarke | A/Team Leader, Operational Programs Branch, Police Service |
| Vicki Arender | Superindent, Police Service |

## Clinical issues group

| | |
|---|---|
| Mary Ellen Burke | Clinical psychologist, DoCS disability services |
| Anne Langford | Clinical Coordinator, Disability Programs, Department of Corrective Services) |
| Josephine Anderson | Head Psychiatrist, Acute Adolescent Unit, Westmead Hospital |
| Judy Tombs | Advocate and expertise in support with police and courts |
| Gary Raftl | Psychologist, formerly DoCS |
| Margaret Andersen | Psychologist and service manager, DoCS |
| Lyn Ready | Department of Housing |
| Meredith Adams | Clinical nurse consultant, drug and alcohol |
| Rodney Beilby | Juvenile Justice psychologist |
| Jo Hewitt | Experience in disability and young people in substitute care |
| Bill Glaser | Consultant psychiatrist to Victorian Statewide Forensic Service |
| Kathy Arentz | Manager of Victorian NGO disability offender program |
| Jenny Green | Experience in special education and management |
| Meredith Martin | Experience in special education and challenging behaviour |
| Jim Simpson | Experience in advocacy and disability law and policy |

The Intellectual Disability Rights Service and the NSW Council for Intellectual Disability commissioned this report with funding from the Law Foundation of NSW and the Department of Ageing, Disability and Home Care.

The report is available from the NSW Council for Intellectual Disability, 22-36 Mountain Street, Broadway NSW 2007. Telephone (02) 9211 1611 or 1800 424 065. The report will also be available online at www.idrs.org.au