10 Years of the IDCC&R Framework

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Amanda Smith,

Chief Advisor and Director IDCC&R

Ministry of Health

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Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CC&R) Act) provides the option of compulsory care and rehabilitation to people with intellectual disability who are going through the criminal justice system and have been charged with criminal offences.

The ID(CC&R) Act recognises that a small number of people present a serious risk to the community due to their offending, but that prison is not an appropriate environment for them.

How did the ID(CC&R) Act come about?

1969

Mental Health Act 1969

Prior to 1992 individuals with an intellectual disability came within the scope of the Mental Health Act 1969 and could be made subject to orders under that Act.

1985

Criminal Justice Act 1985

The 1969 Act was linked to the Criminal Just Act 1985. This link allowed the courts to make orders placing individuals with an intellectual disability under the 1969 Act, as an alternative to sending them to prison or discharging them into the community.

1992

Mental Health (Compulsory Assessment and Treatment) Act 1992 replaced the 1969 Act. One of the most significant aspects of the 1992 Act was the introduction of a new definition of the term “mental disorder”. This definition excluded from the mental health legislation those individuals who had an intellectual disability, unless they also had a mental illness.

Debates in Parliament included

- Whether to include children and young persons (under 17 years)
  - Decision no, but subsequently to enactment other law change now means that youth can be transferred to adult court.
- Whether to include Civil persons (non offenders)
  - Decision no but funding provision made called the High and Complex framework which include care recipients and ‘civil’ clients
- Whether to include disabilities outside ID, such as ASD, ABI, etc
  - Decision no, still stands ID only

Stated Purposes of the Act

- To provide the courts with appropriate compulsory care and rehabilitation options for people who have an intellectual disability and who are charged with, or convicted of, an offence.
- To recognise and safeguard the special rights of individuals subject to the Act.
- To provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to the Act.

Who is Covered by the Act?

For compulsory care to be permissible under the ID(CC&R) Act, a person must be assessed as having an intellectual disability as defined in the Act.

For the purposes of the Act an intellectual disability is described as….
A permanent impairment that:

- ✓ Results in significant sub-average general intelligence as measured by standard psychometric tests generally used by clinicians (IQ ≤ 70)
- ✓ Results in significant deficits in at least two of the following skills:
  - Communication
  - Home living
  - Use of community services
  - Health and safety
  - Leisure and work
  - Self-care
  - Social skills
  - Self-direction
  - Reading, writing and arithmetic
- ✓ Became apparent during the developmental period of the person

How Does a Person become Subject to the ID(CC&R) Act?

There are three ways that people can become subject to the Act:

- By an order being made through the courts
- By transfer from prison where that person has been serving a prison sentence
- By transfer from the Mental Health (Compulsory Assessment and Treatment) Act for special patients or former special patients (after being charged with, or convicted of, an imprisonable offence.

Levels of Care

The Act provides for two different levels of care:

- Secure care – either hospital level or community based. Special care recipients must always receive care and rehabilitation in a secure facility.
- Supervised care – Under this heading care recipients can, depending on their individual circumstances, receive care and rehabilitation either in a secure facility or in a supervised setting.

Rehabilitation

People brought under the ID(CC&R) Act must have their care and rehabilitation needs fully assessed. This means development of care and rehabilitation plans for each individual under the Act.

Every care and rehabilitation plan must be preceded by a needs assessment of the individual.

Wherever possible, the assessment must involve consultation with:

- The assessor who diagnosed the person's intellectual disability
- The person's lawyer
- Members of the person's family or whānau
- Others who are close to the person.

ID(CC&R) Act

Care recipients are subject to a court order under the ID(CC&R) Act. They have an identified Care Manager appointed by the National Intellectual Disability Care Agency (NIDCA) Care Coordinator.

The Care Manager will develop a care and rehabilitation plan outlining how care recipients can progress to greater independence by developing skills and supports in accordance with their care and rehabilitation plan.

Care and rehabilitation plans will be regularly reviewed as set our in the ID(CC&R) Act. Any changes to the care and rehabilitation plan must be in accordance with the court order.

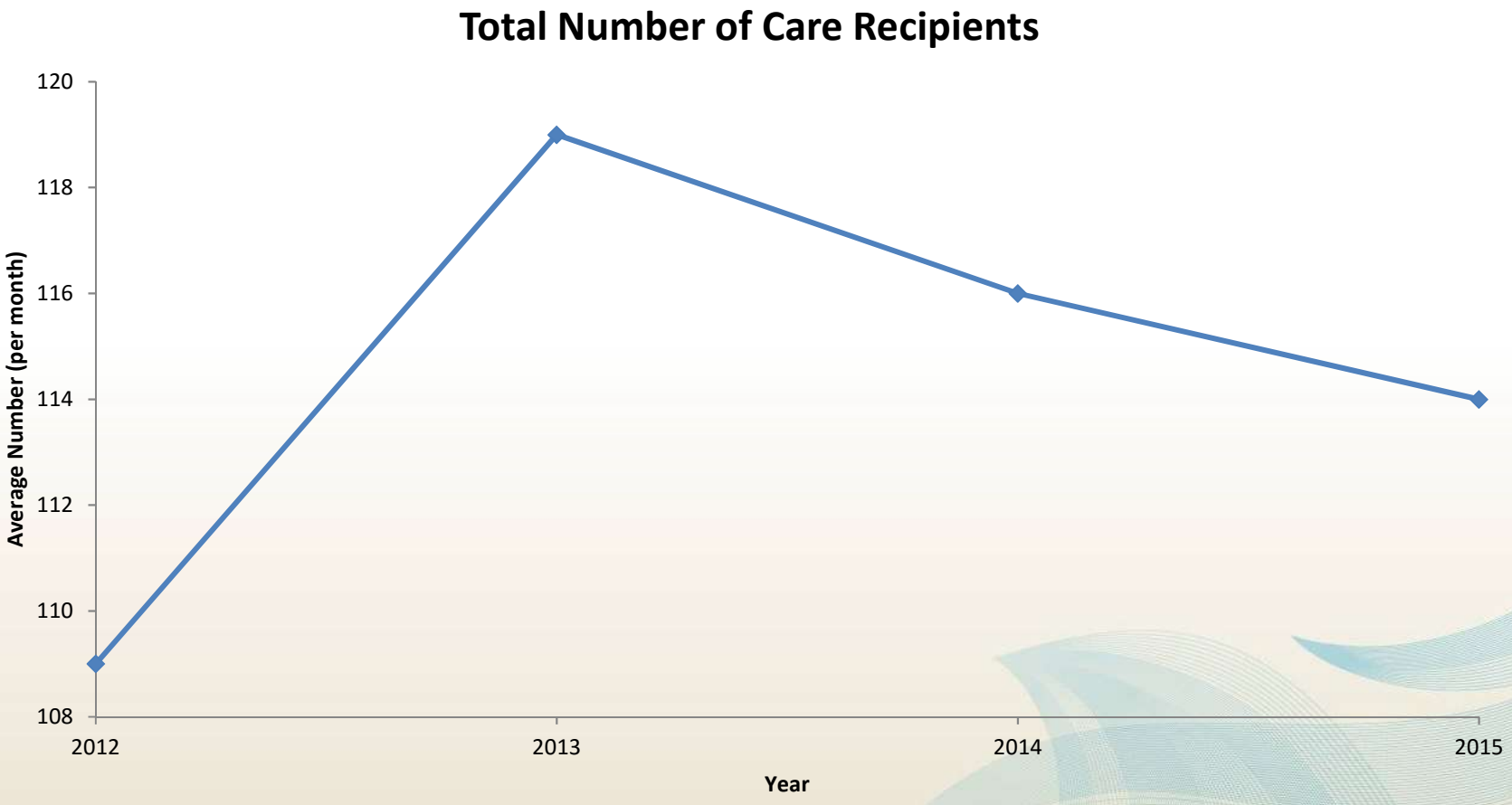
Rights and Safeguards

There may be times when the care recipient cannot give consent, but needs to be placed in special care or receive medical treatment. Care recipients still have rights in these situations.

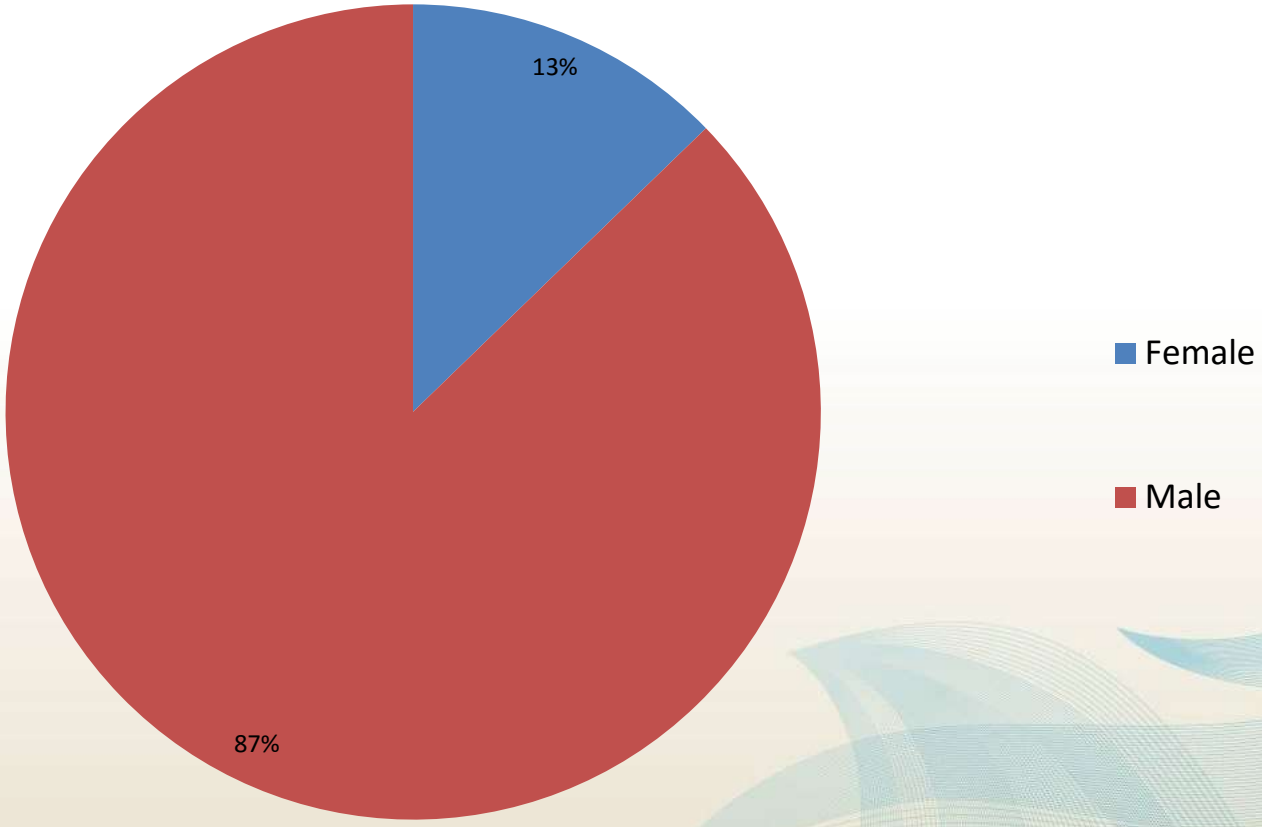
Safeguards for protecting and ensuring that individual rights are upheld include the appointment of District Inspectors who will carry out a role under the ID(CC&R) Act which is similar to the role under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The Act also provides for regular mandatory reviews of an individual's condition and legal status under the Act by health and disability professionals and the courts respectively.

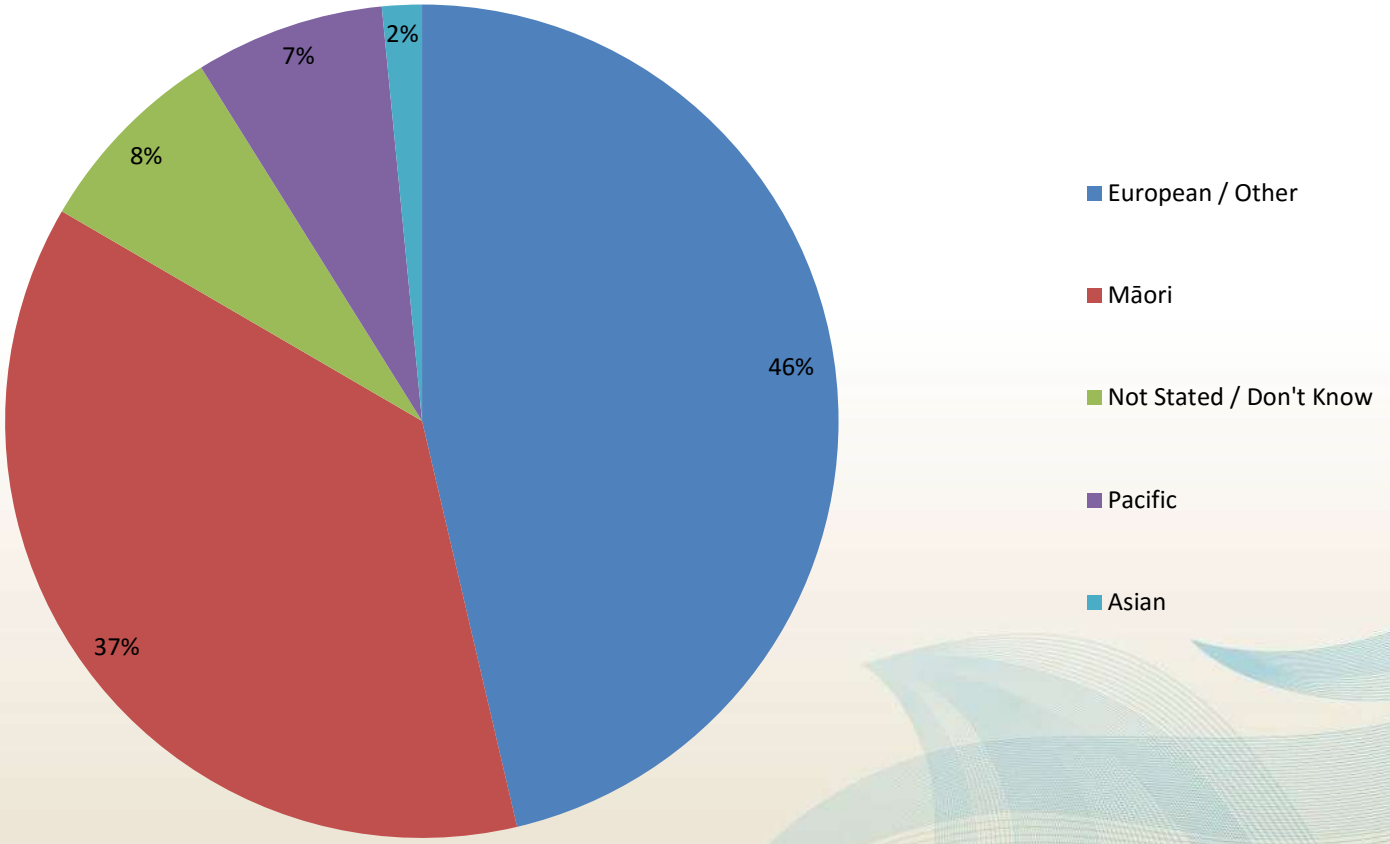
Demographics



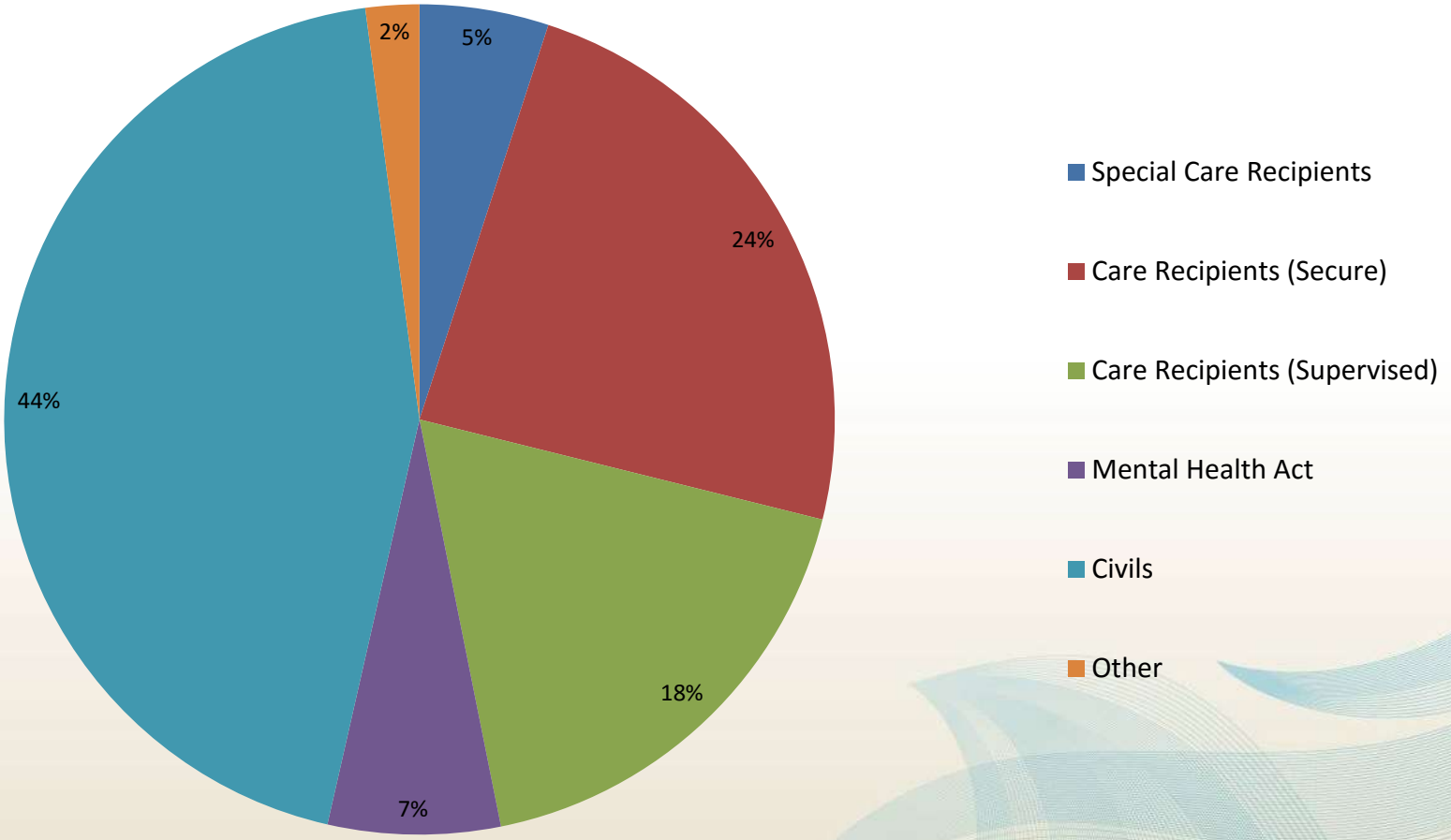
Gender of NIDCA Clients



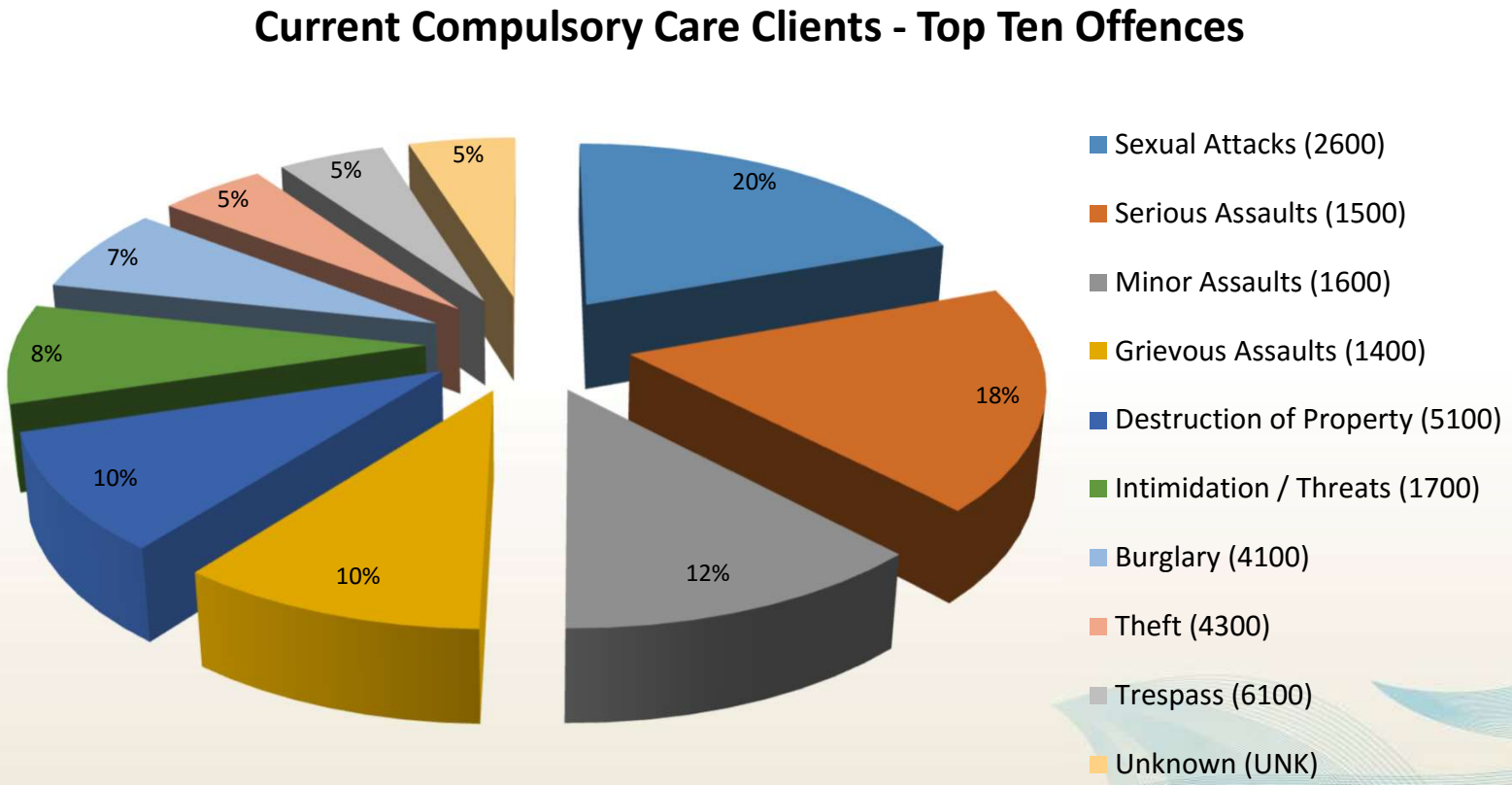
Ethnicity of NIDCA Clients



Order Type under high and complex framework



Most Frequent Offence Types



Service Development

Over this 10 years there has been significant service development:

National Hospital beds totalled 10 (not counting regional capacity) in 2004. In 2014 there were 36.

In 2004 there was only one level of hospital secure, we have now developed step down capacity and cottages on hospital sites.

We now have a dedicated national youth facility (not anticipating any youth no capacity was purchased until 2010 opened 2013)

Current Tensions

- Recent research suggests that the model of care provided under the ID(CC&R) Act needs to be further developed.
- Experience, case law and research has revealed the inherent tension between the requirements services have for compulsory containment and care and undertaking rehabilitation of these detained individual requires particular attention.

Current Tensions

- Most commonly reported dilemmas from professionals include role confusion between the need to manage risk and, what they saw as, an advocacy or support role. The questions becomes, 'how do we as a framework support people who present with behaviours of risk to have the greatest level of independence possible whilst ensuring risks are managed safely'?
- An increase in unfitness findings due to availability of act has had an limiting effect on the options available to the court.

Balancing Independence and Managing Risk

- Mainstream criminal justice services and disability service providers each have their own dominant models that drive the way that supports, and particularly rehabilitation, are provided.
- Models from the two different systems may not always be compatible when applied to the support of care recipients.
- Criminal justice services predominantly use relapse prevention/risk management models that emphasise the detection, management, and monitoring of individuals' risk to the community.
- The primary focus of established intellectual disability services is to provide support for individuals consistent with the social model using principles of participation and community integration.

Model of Care and Rehabilitation

- A new model of care approach has been developed for a more effective strengths based approach. This is designed to produce more long term success for behaviours that challenge.
- This model better reflects the current demographic and is more individually focussed. This model is more directed toward rehabilitation as opposed to more traditional risk based approach with a focus on containment.
- Broadly based on the principles of Positive Behaviour Support, Applied Behaviour Analysis with a rights based approach.
- The new approach has three core strategies: Changing the environment, coaching and implementing short term behaviour strategies. The document provides practical strategies for support workers to implement the new model of care approach.

Key Elements of the Model

- Positive Behaviour Support (PBS). This is a holistic approach that aims to provide the strategies and methods to assist a person to address behavioural concerns and increase their quality of life. It will be pivotal in the care and rehabilitation of people whose behaviour fits within the rubric of "challenging behaviour".
- Good Lives Model (GLM). This is a strengths based approach to offender rehabilitation. It is premised on the idea that it is necessary to build capabilities and strengths in people, in order to reduce their risk of reoffending.
- Risk, Need and Responsivity Model (RNR). The RNR model allows for the level of risk posed by an individual to be quantified. In addition, it identifies both the offender's stable dynamic risk factors which can then be addressed in their rehabilitation, and their responsivity factors, which will influence the choice of therapeutic options.

Care and Rehabilitation Plan

The model of care and rehabilitation has been developed to ensure that more than containment is provided for care recipients under the ID(CC&R) Act. The purpose of the model is to provide:

- Care and rehabilitation that is individualised but deliverable in a consistent and predicable way alongside the care and rehabilitative of the other High and Complex Framework clients with whom they share the service.
- Effective strategies for managing risk, minimising offending and offending like behaviour and creating long term behaviour change.
- An underlying philosophy of the least restrictive option and which takes account of the specific rights of care recipients.
- Ultimately the goal is to provide the best community integrated outcome possible.