Complex needs

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Presentation Outline

• ‘Complex needs’
• MHDCD project findings
• Discussion
• Conclusions
CI & pathways into the CJS
Multi-factorial and multi-stage

- Socio-economic / poverty / disadvantage / discrimination / geography
- Individual
- Lack of family capacity & intergenerational aspects
- Lack of appropriate identification, assessment and support

- Negative synergistic interactions between agencies and services creating complex needs
- Consider along with institutional pathways’ costings
Why the development of ‘complex needs’?

• Moving beyond limited categorizations to recognise reality of lived experience

• Terms dual diagnosis & co-morbidity assume an individual is:
  • defined by the presence of a primary medical diagnosis,
  • only two disorders or impairments exist simultaneously
  • these attributes are in some way static within each individual and do not interact
Complex needs

• People who have complex needs require high levels of health, welfare and other community based services including individuals who experience various combinations of mental illness, intellectual disability, acquired brain injury, physical disability, behavioural difficulties, homelessness, social isolation, family dysfunction, and have problematic drug and/or alcohol use (Hamilton 2010).

• Will return to the problems with this definition.
Negative synergistic interactions amongst agencies

The cumulative long-term effect of moving among these different [CJS] sites is rarely explored ... combined personal, social and economic costs of this re-cycling process tend not to appear in the formal calculations of cost effectiveness... (2003: 229)

The study

- ARC Linkage study 2007-2010
- CIs: Eileen Baldry, Leanne Dowse, Ian Webster
- PIs: Tony Butler, Simon Eyland, Jim Simpson
- Partner Organisations: Corrective Services NSW, Justice Health, NSW Police, Housing NSW, NSW Council for Intellectual Disability, Juvenile Justice NSW
- Continuing with ARC Linkage *Indigenous Australians with mental health disorders and cognitive disability in the CJS*
The Study approach

- **Method:** Innovative data linkage and merging
  - Cohort: 2001 Inmate Health Survey & DCS Statewide Disability database
  - Add Data drawn from:
    - The Centre for Health Research in CJS Health NSW (+data from 2009 survey)
    - NSW Department of Corrective Services
    - BOCSAR
    - NSW Police
    - Juvenile Justice
    - Housing NSW
    - ADHC
    - Legal Aid NSW
    - NSW Health (mortality, pharma., admissions)
    - Community Services – out of home care
    - Negotiating Public Guardian & Financial Manager
SQL server, relational dataset

Cohort ID
2,731

DCS
Police
Court
Health
Housing
Justice Health
Disability
Child Services
Legal Aid
Juvenile Justice
Cohort - Summary

- Full Cohort N = 2,731
- Women = 11%
- Indigenous Australians = 25%
- ~40% had been Juvenile Justice clients
Pathways
MHDCD Study: Education

- Diagnosed groups even lower levels than general prisoner pop.

- Those with complex needs have higher rates of expulsion

- Those with some form of CD have the worst levels of education.

- Complex groups: over 80% have no formal qualification with majority leaving school without completing Yr10
Out of home care

- 12% of the cohort had been in OHC
- 60% of the OHC group have complex needs
- 80% of this group has cognitive impairment
- Women in the MHDCD cohort had a higher rate of their own parent having been in OHC than all others

- Earlier police contact
- Twice as many police contacts
- Twice as many custodial episodes
- Three times as likely to have been incarcerated as juvenile
Of those in the ID range (680) 26% ADHC clients

Of those BID range (783) 5% ADHC clients.

Very low rate (15%) of CD in cohort with ADHC services

Only 10/709 JJ CD group were ADHC clients

79% of ADHC clients imprisoned prior to becoming a client
Housing Assistance

- Significant numbers of the complex groups experienced homelessness and unstable housing as young people and as adults
- Significant numbers had parent(s) in public housing
- Significant numbers accommodated in refuges and other crisis accommodation.
Police Contacts

People with Complex Cognitive Disability had significantly more police contacts over their lives, starting young, and significantly higher rates of police contacts per year.
Contact with Juvenile Justice

Sig. higher rate of being a JJ client for compounding CD groups - between 40% to 60%; Aboriginal young people sig over-represented

But ~ 20% for those with no diagnosis or MH only
First police contact & JJ

- All CD complex significantly higher police contacts before JJ client

- Younger at first police contact and younger at first custody than no diagnosis group.
All custody

Those with compounding disabilities have shorter duration each time in custody, than BID, MH or no diagnosis but similar av. number of days per year in custody (ie more short stays).
Indigenous Australians

• Over-represented in all categories
• Aboriginal women experienced highest levels of compounding factors and disability
Pathway Indicators

Individuals with CI complex needs who end up in adult prison:

- significantly higher rates of and earlier contact with police
- more likely to be Indigenous Australian
- significantly worse education experience & attainment
- significantly more likely to have been in OHC
- significantly more likely to have experienced abuse and be a victim
- lower level of disability services than community counterparts although very likely to have been identified by school & police as a child with problems
- more likely to have been in public housing as a child and have higher housing support but also higher failed tenancies as an adult
- significantly higher rates of JJ contact
- significantly higher number of offences, convictions, imprisonments (particularly remand) from an earlier age
- significantly shorter and more frequent prison episodes
- significantly higher continuing lifelong CJS episodes

than single diagnosis (although these are also generally worse than non diagnosis) and non-diagnosis groups
Importance of where live

- People with CI complex needs come from and move around amongst a small number of disadvantaged suburbs / towns; those with complex needs have more addresses (recorded by agencies) than those without.
- Indigenous and non-Indigenous people & males and females have different address patterns and move around amongst different suburbs and towns
Pathways: iterative, looping, cycling, compounding

- Poverty/disadvantage
- Poor School Education
- Lack Disability services
- Mental Health
- Courts
- Housing/homelessness
- Police
- Legal Aid
- Prison
- Post-release
- Breaching
- Reincarceration
Complex Needs

• disability experiences and negative factors that are not addressed and over time compound to form ‘a complex’ or a web that grows more complicated and multifaceted;

• multiple interlocking and compounding experiences and factors that span health and social matters (Rankin & Regan 2004:i).
Individualisation

• The compounding disabilities and disadvantages are attributed primarily to the individual

• Problems individualized (she or he is responsible for the complexity); social & structural factors that created and maintained the need or dysfunction written out of the story

• From *at risk* to being *a risk*
So …

- Not simply compiling a checklist of needs.
- Three dimensional web of factors, elements and circumstances that interact simultaneously and across time. The interactions have a compounding effect (like interest on money in a bank account) in that the effect is not just the sum of the individual parts but each aspect adds to and increases the potency of each of the other effects.
Figure 1 captures the breadth, depth and interlocking nature of disadvantageous factors that coalesce to create ‘complex needs’. The dimensional complexity of the interactions created by the compounding of the factors is illustrated by mapping the case studies of ‘Matthew’ and ‘Michael’. (Figure by Han Xu)
Creation of complex needs

• Lack of appropriate support and services, the use of control agencies (eg police as ‘care managers’), application of ‘risk’ management for individuals experiencing multiple disadvantages together with mental and/or cognitive impairment, compounds these multiple difficult life issues creating complex needs
What is needed

• Dynamic multi-point socio-development services approach that identifies before deep engagement with CJS as well as during CJS = preventive not just diversionary.

• Requires linked data and holistic integrated disability services.

• A key for the individual seems to be secure, safe, stable human relations & housing with one or more people (parent, relative, worker/case worker) who understand how to support and work with people (children, youth & adults) with CI.