CIDP Evaluation

Cognitive Impairment Diversion Program (CIDP)

Final Process Evaluation Report

5 April 2019

Acknowledgement of Country

WestWood Spice acknowledges the Aboriginal and Torres Strait Islander traditional Owners and Custodians of Country throughout Australia and recognises their continuing connection to land, water and community.

Acknowledgements

WestWood Spice thanks all the many people who contributed to this evaluation.

Particular thanks are due to the CIDP participants and family members who shared their experiences so candidly and honestly.

The program Implementation Working Group members were invaluable in contributing their expertise, both to the evaluation and the program more broadly.

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Abbreviations and acronyms

CBA	Cost benefit Analysis
CCO/CommCor	Community Corrections Officer/Community Corrections
CIDP	Cognitive Impairment Diversion Program
CIN	Criminal Index Number
FACS	Department of Family and Community Services
IDRS	Intellectual Disability Rights Service
IWG	Implementation Working Group
JH&FMHN	Justice Health and Forensic Mental Health Network
LRC	Law Reform Commission
MHFPA	The Mental Health (Forensic Provisions) Act 1990 (NSW)
MIN	Master Index Number
NDIS	National Disability Insurance Scheme
OOC	Out of custody
PWI	Personal Wellbeing Index
PWI-ID	Personal Wellbeing Index — Intellectual Disability [scale]
SCCLS	State-wide Community and Court Liaison Service
S32	Section 32
WWS	WestWood Spice

Executive Summary

> *It's 101% the best thing ever (CIDP participant).*

The Cognitive Impairment Diversion Program (CIDP) has operated as a pilot model in both Gosford and Penrith local courts since October 2017. In its first 12 months of operation, it has achieved significant results in its two core goals of:

1. Diverting people with a cognitive impairment from the criminal justice system
2. Connecting people with the National Disability Insurance Scheme (NDIS) and other services.

Out of a total of 53 completed participant section 32 hearings, 46 CIDP participants have been diverted from the courts. This represents an 87% diversion rate. For section 32 alone, 75% of completed participant section 32 hearings resulted in a section 32 order being made.

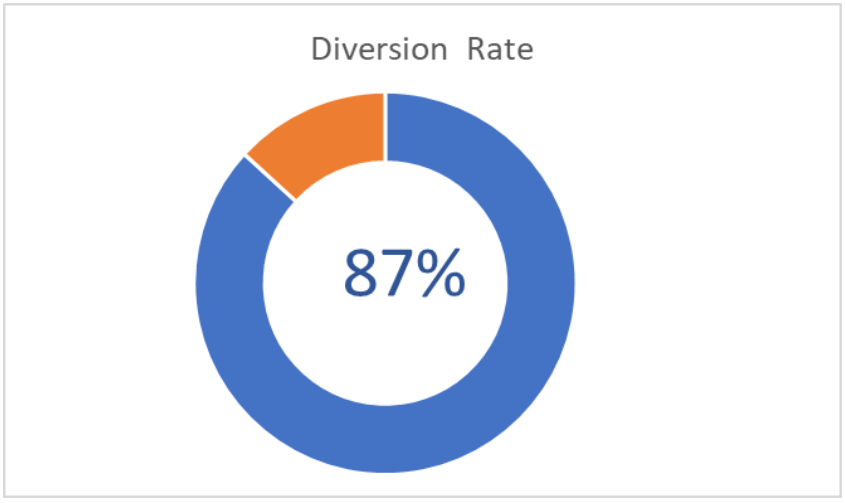


Figure 1: Diversion Rate

Diversion under section 32 is the most common outcome, accounting for 40/46 (87%) of all diversions made. In total the diversion outcomes achieved included 40 section 32 orders, four bonds (sections 9, 10 and 12) and two matters where charges were withdrawn.

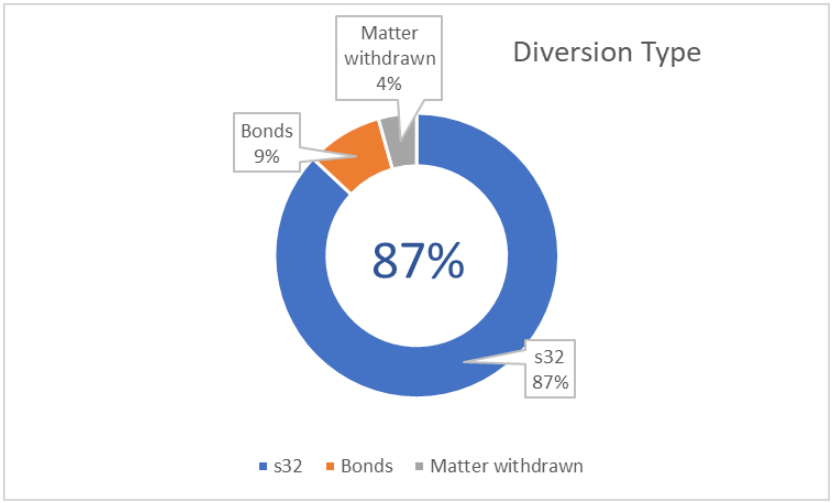


Figure 2: Diversion Types

The program has also assisted many participants to access the NDIS. In the first 12 months of operation, 79 individuals were assessed as eligible for the program and consented to participation. Across these 79 participants, 15% had an active NDIS plan at the time of referral. At the 12-month mark, 58% had an active implemented NDIS plan. The figure increases to 60% when three people who were ineligible for NDIS are excluded.

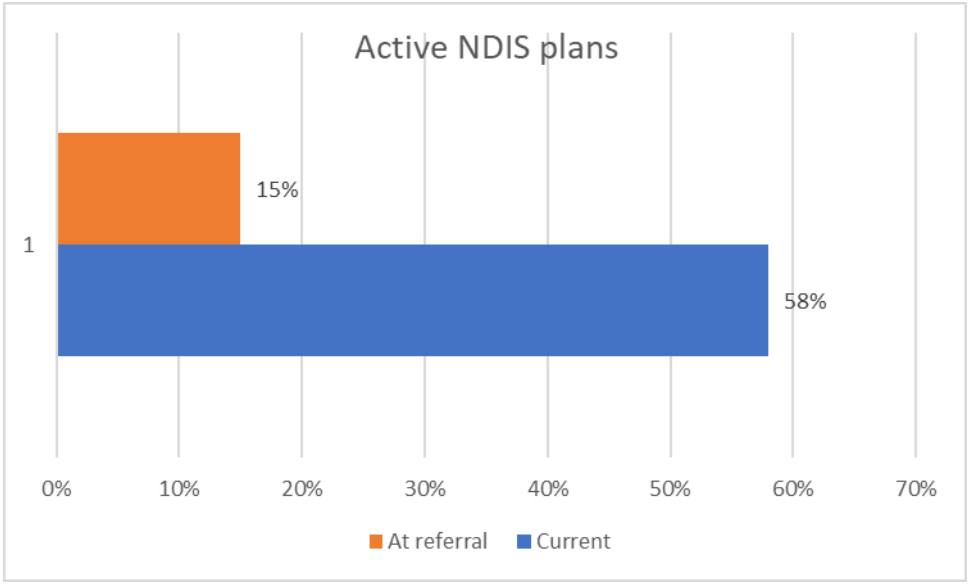


Figure 3: Active NDIS Plan rates at referral and after 12 months of CIDP operation

Participant characteristics

- CIDP participants are overwhelmingly male (85%)
- More than half (57%) are less than 30 years old
- Almost two-thirds (32%) are Indigenous
- Seventy-seven percent have an intellectual disability or borderline intellectual functioning
- For 19 participants (almost one in four), this was the first time that their disability had been diagnosed

- From the data available, 40% of eligible CIDP participants have a mental health comorbidity
- A quarter of participants have some issues with either alcohol or drug misuse
- Most participants were not in custody at the time of their referral to CIDP

Average adjournment periods

The CIDP database recorded both the date of screening and the date of court outcome. This enabled some testing of the average time from screening to court outcome.

- Data from Penrith indicated an average elapsed time of 12 weeks and for Gosford, 14 weeks prior to July 2018 and 10 weeks after July 2018 (six cases).

Average time to develop support plans

There was limited accurate data to measure average time to develop a support plan. Data available was extracted for ten Penrith participants and 15 Gosford participants with completed matters. At Penrith, the average duration for support plan development was 9.47 weeks, with a range of 2.5 to 17 weeks. For Gosford, the figures were an average 6.77 weeks, with a range from 5 to 9.86 weeks.

Background to the evaluation

This report presents the findings and recommendations of a process evaluation of CIDP for the first 12 months of operation of the two-year pilot. The report is supported by a separate cost benefit study.

People with a cognitive impairment are over-represented in the criminal justice system.[1] The CIDP attempts to redress the imbalance for this cohort through a model designed to increase the use of section 32 diversion by magistrates.

Section 32 is a provision of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA) which allows a local court magistrate to make an order dismissing the charge.

The CIDP model has three elements:

- Screening and clinical assessment — this provides evidence of a participant's cognitive impairment to the court.
- Support planning — case management support to access the NDIS and/or other services to meet the participant's needs.
- Monitoring/court reporting — progress reports which help inform magistrates about a participant's compliance with their support plan (only where monitoring by a Community Corrections Officer has been included in the section 32 order at the discretion of the magistrate).

[1] Law Reform Commission (2012) People with cognitive and mental health impairments in the criminal justice system: Diversion (Report 135) p xv

The CIDP model is delivered through a multi-agency partnership, including Offender Strategy, Diversity Services and Community Corrections (CommCor) within the Department of Justice, Justice Health & Forensic Mental Health Network (JH&FMHN), and the Intellectual Disability Rights Service (IDRS).

Governance is shared through an Implementation Working Group (IWG). The IWG terms of reference and membership are at Appendix B.

The overarching question for the evaluation is: "Has the CIDP achieved its purposes and anticipated outcomes?"[2]

Table 1: CIDP purposes and anticipated outcomes

○ CIDP Purposes	○ Anticipated outcomes	○ Measure and data source
1. Screen and assess people for eligibility for section 32 diversion	Identification of people with a cognitive impairment who may be eligible for diversion	#'s of people screened as eligible for CIDP (CIDP database)
2. Connect people with NDIS and other support services	Improved health and welfare outcomes for participants	Participant and family feedback; #'s/% of active NDIS plans, (Participant and family interviews and CIDP database)
3. Provide reports to support an application for section 32 diversion	Increased use of diversion for people with cognitive impairment	#'s/% of participants diverted from court (CIDP database)
4. Monitor compliance with section 32 orders made, as required	Reduce likelihood of further interaction of the person with cognitive impairment with the criminal justice system (reduction in reoffending rates)	# of breach reports (CIDP database)

Ethics approval for the evaluation was received from the Bellberry Human Research Ethics Committee on 8 October 2018. (Application number 2018-08-644)

Key findings

CIDP is achieving diversion

The evaluation concluded that:

- CIDP is an important mechanism to boost the level of diversion from the criminal justice system with 87% of finalised matters resulting in a diversion.

[2] RFT DJ2018-10 Part A — Page 1

The 2012 NSW Law Reform Commission (LRC) Report 135 "People with cognitive and mental health impairments in the criminal justice system: Diversion" described the issues behind the underutilisation of section 32:

- lack of clarity around the definition of cognitive impairment[3]
- challenges in identifying and assessing people
- challenges connecting offenders with the right services and maintaining that connection when problems arise
- ineffective breach and non-compliance reporting to the court.

The CIDP model addresses each of these issues.

Proactive identification of people with cognitive impairment eligible for diversion

Cognitive impairment screening and clinical testing by JH&FMHN neuropsychologists is providing the court with evidence of cognitive impairment for individuals who are potentially eligible for section 32 diversion.

Two-thirds of individuals recorded as screened for CIDP in its first 12 months of operation were deemed eligible for the program (118 people screened, 79 eligible).

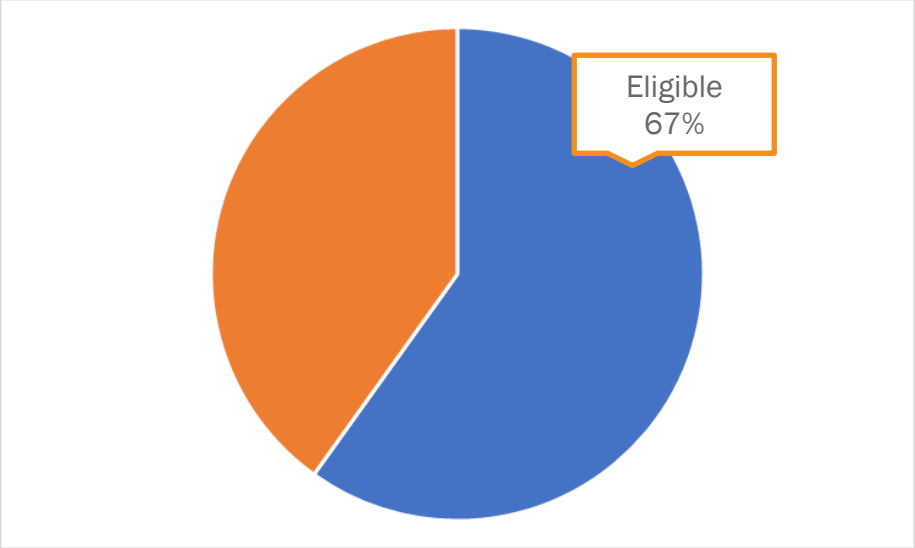


Figure 4: **Proportion of those screened who were eligible**

There is scope to further improve the processes and rate of identification of potential participants.

Securing and maintaining effective connections to the right services NDIS

CIDP is a significant pathway into the NDIS and is achieving first time access, plan reactivation and plan enhancements for many participants. Calculation of the leveraged benefits of NDIS access are contained in the cost benefit analysis (CBA) report.

[3] This has been addressed by the inclusion of a specific definition of cognitive impairment in the section 32 legislation

- The JH&FMHN neuropsychology/clinical assessments, in particular the functional assessments undertaken, provide a body of evidence which streamline NDIS eligibility considerations and provide planners with information about support needs
- Speedy access to the NDIS is further enhanced by the nomination of a dedicated NDIS planner for each of the pilot locations
- The IDRS case manager brings all the support players together. They ensure participant engagement and assist participants to voice their support needs and goals
- Active NDIS plans have been achieved for 60% of eligible[4] CIDP participants

CIDP is an important program which improves the health and welfare of a cohort of people with a cognitive impairment and complex needs

- Participants who have previously missed out on services are now receiving support
- Participants can access a range of services to build a network, rather than relying on a single source of support
- Participants report feeling respected and valued in a way not previously experienced

Reduced likelihood of further interaction with the criminal justice system

- In the period covered by the evaluation, amongst the nine participants who had monitoring included, no breaches of their section 32 orders were reported.

> *It's helped me stay out of jail and stick to appointments (CIDP participant).*

Summary of CIDP strengths, barriers and opportunities

The evaluation identified a range of strengths in the delivery of CIDP. Some of these are intrinsic to the theoretical model; others are the result of divergence in how the CIDP has been implemented in practice.

There are other aspects of delivery which could be enhanced. The table below summarises the strengths, barriers and opportunities presented by CIDP today. These have informed the recommendations which follow.

[4] Three participants were recorded as ineligible for the NDIS: one over the age of 65, one with Lifetime care and support from iCare and one receiving Aftercare workers compensation

Table 2: Strengths, barriers and opportunities of CIDP

Strengths	Barriers	Opportunities
Screening and assessment: ▪ Practice of JH&FMHN neuropsychologists providing direct feedback to participants helps them understand assessment results ▪ Clinical assessments are free of charge to CIDP participants ▪ (Early) referral to case management at the time of screening shortens the time taken to access supports and facilitates participant engagement Support planning: ▪ Case managers expedite access to the NDIS/reactivation of NDIS plans ▪ NDIS acceptance of borderline intellectual disability from the ABAS functional assessment assists establishment of NDIS eligibility ▪ Dedicated NDIA support planner in each location streamlines NDIS engagement ▪ Holistic approach of the support plan to meeting the needs of CIDP participants enhances welfare outcomes e.g. stable housing ▪ Strong relationships between case managers and participants underpin participant motivation to succeed Court processes: ▪ Lawyers have comprehensive evidence to support a section 32 application ▪ Lawyers report a reduction in adjournments saving court time ▪ Local court decisions to have separate list days improve participants' experience of court	▪ Staff turnover amongst key stakeholders, requiring ongoing education about CIDP ▪ Informality of referral processes for screening and lack of associated data capture ▪ Assessment on the same day as screening can be strenuous and difficult for participants ▪ Bottleneck with neuropsychologists limiting program capacity ▪ Monitoring — difficulties obtaining updates on participants' engagement with service providers ▪ No clear agreed program exit point/exit planning — impacts stress of transition for participants	▪ Better program communication and associated promotional material ▪ Quality assurance: (1) Improved data collection processes and content, including potential to manage data on a dedicated system rather than excel sheets (2) Regular review of CIDP policies & practices based on feedback and data ▪ Investigate if screening can be performed elsewhere/by others giving the JH&FMHN neuropsychologists increased capacity for assessments. ▪ Investigate alternatives to the current clinical assessment component of the model e.g. panel of psychologists ▪ Identify key assessment tools which can be used to reduce time delays in reports being made available to the NDIS ▪ Participants have benefited from the support role/case management function providing more hours of support than originally envisaged ▪ Opportunity for the case manager to explain the section 32 orders and conditions to the participant after sentencing ▪ Review who undertakes the function of monitoring and how it is delivered and made meaningful for the participant ▪ Include exit planning as part of early engagement with participants

Recommendations

Quality and intensity of program delivery

Recommendation 1:

Standardise current practice to refer a participant to a case manager as soon as they are screened as likely to have a cognitive impairment. To facilitate this, case managers should be present at the court on listing days.

Recommendation 2:

Develop enhanced tools for case managers to support participants in understanding the program, possible court outcomes, the details of their own court outcome, any requirement for monitoring and anticipated timing of program exit.

Recommendation 3:

Review the existing capacity of staff in each function to maximise program outputs.

This should include:

(a) Review of the referral and intake process, as in the current model JH&FMHN neuropsychologists are at capacity, restricting the flow through to case management support. Possible strategies which could be considered are:
   a. a “hub” base for JH&FMHN neuropsychologists who provide outreach to the courts
   b. more flexibility in who can undertake screening
   c. outsourcing assessment e.g. to a panel of providers appointed by CIDP and accessed on a fee-for-service basis
   d. prioritising/limiting assessments to those needed for NDIS applications

(b) Review of the duration of case manager involvement with each participant, as in the current model IDRS case managers have had capacity to stay involved longer than anticipated. This review should consider learnings about the levels of engagement which have maintained diversion to guide future benchmarks for the duration of CIDP case management support.

Recommendation 4:

Review the exit criteria of the program so that the timing of program completion is clear.

Program entry and screening

Recommendation 5:

Review the referral process and recording of referrals to streamline the process and collect accurate data.

Recommendation 6:

Formalise, as part of the model, the requirement that the person undertaking the clinical assessment provides direct verbal feedback to each CIDP participant about their assessment results.

Court processes

Recommendation 7:

The informal decision of both Penrith and Gosford Local Courts to create a separate CIDP list day should be considered best practice for the model.

NDIS

Recommendation 8:

Noting the benefit of the current NDIS components in the CIDP model, the NSW Government should include and advocate for these components, for example, by negotiating an MOU with the NDIA across the state or at other sites where CIDP roll out is contemplated.

Monitoring

Recommendation 9:

Identify whether there are alternatives to CommCor undertaking the court reporting/monitoring function to give magistrates confidence about participant compliance e.g. longer adjournment times to demonstrate support plan implementation.

Communication and promotion

Recommendation 10:

Develop strengthened relationships, including exploring the scope for formal partnerships with the legal aid sector.

Recommendation 11:

Develop an overall communication strategy to promote any CIDP rollout which is contemplated.

Recommendation 12:

Propose that courts develop an Easy Read version of the section 32 order template.

Data

Recommendation 13:

Review the information needed and develop a CIDP database tool/application to support the real-time, accurate and timely information capture for all participants, including capturing if this is the first diagnosis of cognitive impairment, logging multiple adjournments and incidence of section 32 applications heard prior to NDIS plan finalisation. This should include the provision of training in the use of the CIDP database tool for those responsible for data entry.

Recommendation 14:

Consider use of the PWI-ID[5] scale as a baseline and post-intervention measure to assess improvements in the personal wellbeing of CIDP participants.[6]

Program expansion

Recommendation 15:

Subject to resolution of the screening and assessment capacity issues, the section 32 diversion rate achieved by CIDP in its first 12 months of operation and the level of NDIS engagement rate for participants warrants consideration of a staged roll out of the CIDP to other parts of NSW.

[5] The Personal Wellbeing Index was developed in 2001 by Professor R.A. Cummins at The Australian Centre on Quality of Life at Deakin University

[6] The PWI-ID was trialled as part of the participant interviews for the evaluation and was readily understood

Introduction

WestWood Spice was engaged by the NSW Department of Justice to undertake a process evaluation and CBA of the CIDP. This report presents the findings and recommendations of the process evaluation.

The report is structured as follows:

- Section one — Overview of the CIDP — describes why CIDP is needed. It presents an introductory overview of the CIDP and its intended model of operation. There is more description of each of the model stages in the findings (Section three)
- Section two — Methodology — introduces the evaluation methodology (details of stakeholders who were interviewed are at Appendix A).
- Section three — Findings — has four major sections:
  - The profile of CIDP participants
  - CIDP process findings
    - Referrals and program promotion
    - Screening
    - Assessment
    - Support planning
    - Section 32 application and hearing
    - Monitoring/court reporting
    - Program exit
  - CIDP outcomes
  - Summary of CIDP strengths, barriers and opportunities
- Section four — Conclusions.

Section one: Overview of the CIDP

Why is CIDP needed?

People with a mental illness or cognitive impairment are over-represented in the criminal justice system. Much has been written about multiple contributing factors including disrupted family backgrounds, family violence, misuse of drugs and alcohol, unstable housing, lack of coordinated supports, limited early intervention and patchy access to the supports which are available.

In 2012, the NSW Law Reform Commission (LRC) Report 135 "People with cognitive and mental health impairments in the criminal justice system: Diversion" found that the legislative provisions to divert people with impairments into treatment and services under section 32 were underutilised as a strategy to prevent and reduce reoffending. Issues behind this underutilisation included lack of clarity around the definition of cognitive impairment, the challenges associated with identifying and assessing people, connecting offenders with the right services and maintaining that connection when problems arise, as well as ineffective breach and non-compliance reporting to the court.

As a result of the LRC recommendations, section 32 of the MHFPA was amended to make clear its applicability to people with cognitive impairment. Commencing on 28 August 2017, a specific definition of cognitive impairment[7] was included in the scope of people eligible for the diversionary options available under section 32. Section 32 is available for offences that can be finalised in the local court.

Contemporaneously, the introduction of the NDIS created a new opportunity to connect people with a cognitive impairment who have contact with the criminal justice system, to supports in the disability services sector.

CIDP provides an opportunity to test the use of section 32 for people who meet the definition of cognitive impairment now included in the MHFPA. Its goal is to increase the diversion of offenders with cognitive impairment and low-level offending away from the criminal justice system through supporting an application for diversion under section 32.

However, at the discretion of the magistrate, other pathways of diversion might be the outcome (See Appendix C for a definition of diversion and Appendix D for a listing of types of diversion).

[7] s 32(6) MHFPA: **'cognitive impairment'** means ongoing impairment of a person's comprehension, reasoning, adaptive function, judgment, learning or memory materially affect the ability to function in daily life and is the result of damage to, or dysfunction, developmental delay or deterioration of, the person's brain or mind, and includes (without limitation) any of the following:. It includes:

- intellectual disability
- borderline intellectual functioning
- dementia
- acquired brain injury
- drug or alcohol related brain damage, including foetal alcohol spectrum disorder
- autism spectrum disorder

Who developed CIDP?

The CIDP was jointly developed by the Department of Justice, NSW Health and the Department of Family and Community Services (FACS). Funding for the program has come from the NSW Government NDIS Transition Fund.

What is the purpose of CIDP?

The original CIDP proposal[8] envisaged that the pilot would:

- Improve access to the NDIS
- Allow Justice and Health to:
  - Better understand the prevalence of cognitive impairment in the criminal justice system
  - Identify the appropriate staffing and resourcing levels for the number of defendants accessing the CIDP
  - Confirm the value of the CIDP support workers
  - Test the CIDP model to ensure it operates as intended
  - Evaluate the impact and cost benefit of the CIDP

Who is eligible?

The CIDP targets adult defendants who:

- Have a cognitive impairment within the meaning of section 32 of the MHFPA.
- Are eligible to be considered for diversion under section 32 of the MHFPA.
- are before the Penrith or Gosford Local Court charged with a summary offence[9]

While eligibility for the NDIS is not a relevant factor when determining eligibility for CIDP,[10] it is likely that the person will have a cognitive impairment that will qualify them for an NDIS package and/or disability supports.

[8] CIDP proposal pp 18–19
[9] Summary offences are less serious offences e.g. road traffic offences, minor assaults, property damage and offensive behaviour
[10] P 14 CIDP Operational Manual

Why were Gosford and Penrith chosen?

CIDP is being trialled for two years from October 2017 in the Penrith and Gosford local courts to provide additional supports for adults with a cognitive impairment who come before the local court. Gosford and Penrith Local Courts were chosen as both were in Year 1 NDIS rollout sites. Each of these locations was expected to have capacity to accept new clients into the NDIS from the 2017/18 financial year.

What does the CIDP model look like?

Figure 5 below presents the visual pathway for the CIDP process as presented in the operational manual.

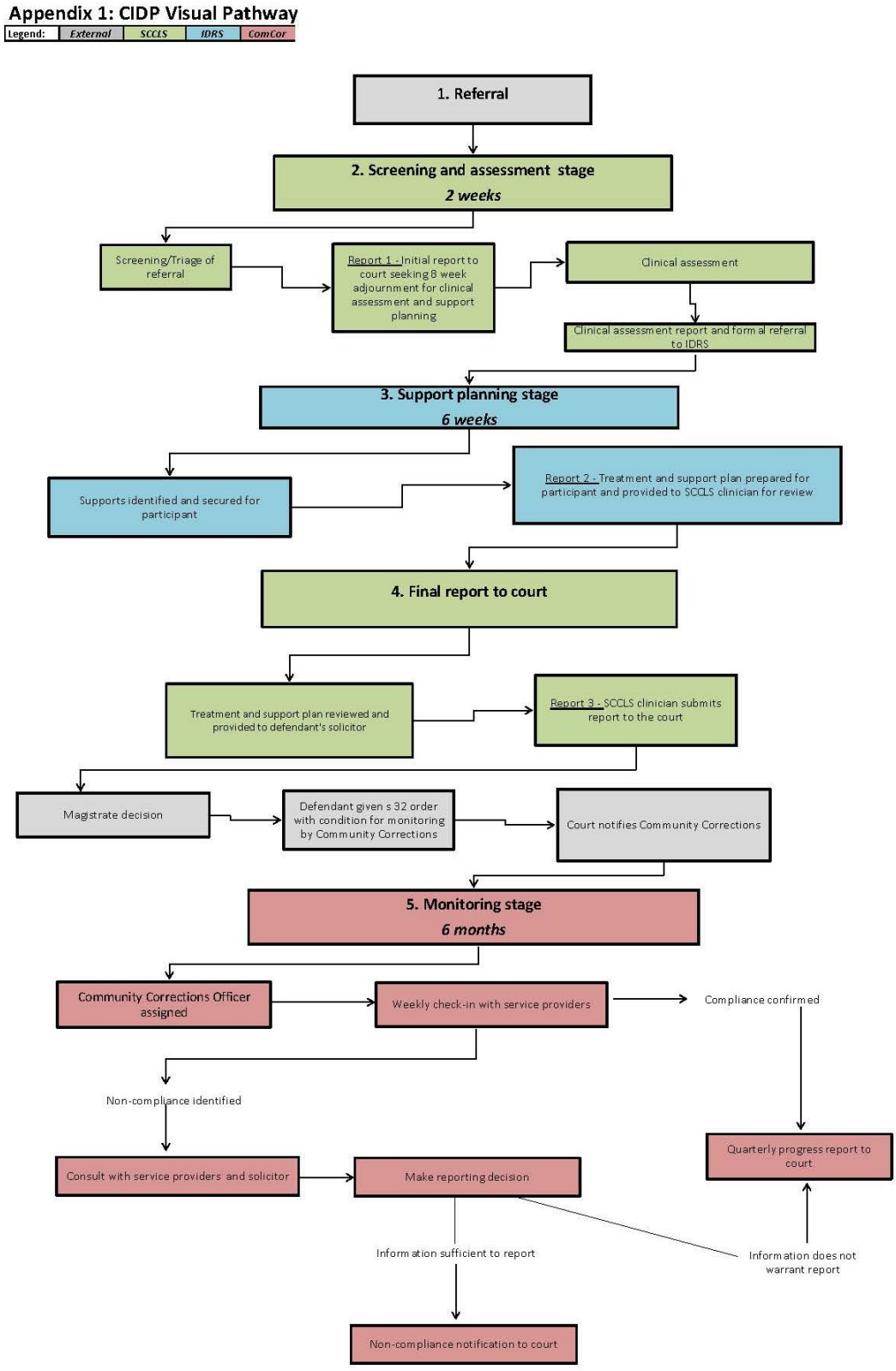


Figure 5: CIDP Visual Pathway

The CIDP model has three key elements:

1. **Screening and clinical assessment:** The CIDP process begins when someone is referred to the program for screening to check if they are likely to have a cognitive impairment. Screening is undertaken by a CIDP (JH&FMHN) neuropsychologist, employed by JH&FMHN as an extension of the State-wide Community and Court Liaison Service (SCCLS). Each local court (Penrith and Gosford) has one JH&FMHN neuropsychologist. Following a positive screen, an application is made to the magistrate for an adjournment of the person's matter to enable the JH&FMHN neuropsychologist to undertake more detailed assessment.[11] The JH&FMHN neuropsychologist provides a report to the magistrate ahead of the relisting of the matter. The report attaches a summary of the assessment results and the support plan prepared by the case manager (see below). This assists the magistrate to decide whether to make an order under section 32 of the MHFPA.
2. **Support planning:** Assessments[12] which confirm the cognitive impairment result in a referral of the individual to a CIDP case manager. IDRS, a NSW-based disability advocacy service and community legal centre is currently contracted to provide case management for CIDP. The case manager assists the defendant to access the NDIS and other support services, as appropriate, to meet their needs and goals. They develop a support plan for the individual that forms part of the application to the magistrate for diversion.
3. **Court reporting/ Monitoring:** At the discretion of the magistrate, Section 32 orders which are made may include a condition for monitoring by a CommCor officer. This option was included in the CIDP model[13] to give magistrates confidence to divert people they may not otherwise divert without the option of reporting compliance. The CommCor officer provides a written progress report to the court at three months into the diversion order and again at six months.

[11] The initial adjournment request was for eight weeks, but this was subsequently amended to ten weeks
[12] In practice, the evaluation found that case management is commencing at the point of a positive screen. See discussion later
[13] In its initial design it was anticipated that all section 32 orders would include monitoring

What are the roles of the CIDP partners?

The CIDP model is delivered through a multi-agency partnership. The contribution of each of these agencies is described in Table 2 below.

Table 3: CIDP partners and roles

Role	Partner
Overall project governance, design and oversight of evaluation	Department of Justice: Offender Strategy
Budget management for the Support planning and Court reporting function Liaison contact with the NDIA	Department of Justice: Diversity Services
Implementation of the court reporting function for section 32 orders where a magistrate has included monitoring. Budget management of the court reporting function	Department of Justice: Community Corrections
Provision of the screening and assessment function. Management and supervision of two court-based neuropsychologists and a 0.5 supervising psychiatrist Budget management of the screening and assessment function	NSW Health: Justice Health and Forensic Mental Health Network
Provision of the support planning function. Management and supervision of case managers at Gosford and Penrith	IDRS
Membership of the IWG. Advice on NDIS processes	NDIA
Membership of the IWG. Advice and liaison with NDIS Board, overall budgetary support	Department of Premier and Cabinet
Membership of the IWG. Advice on target cohort	FACS

CIDP governance

The oversight and monitoring of the CIDP is via a shared governance model of key stakeholders. An IWG meets bi-monthly with secretariat support provided by Justice (Offender Strategy). The terms of reference and membership are at Appendix B.

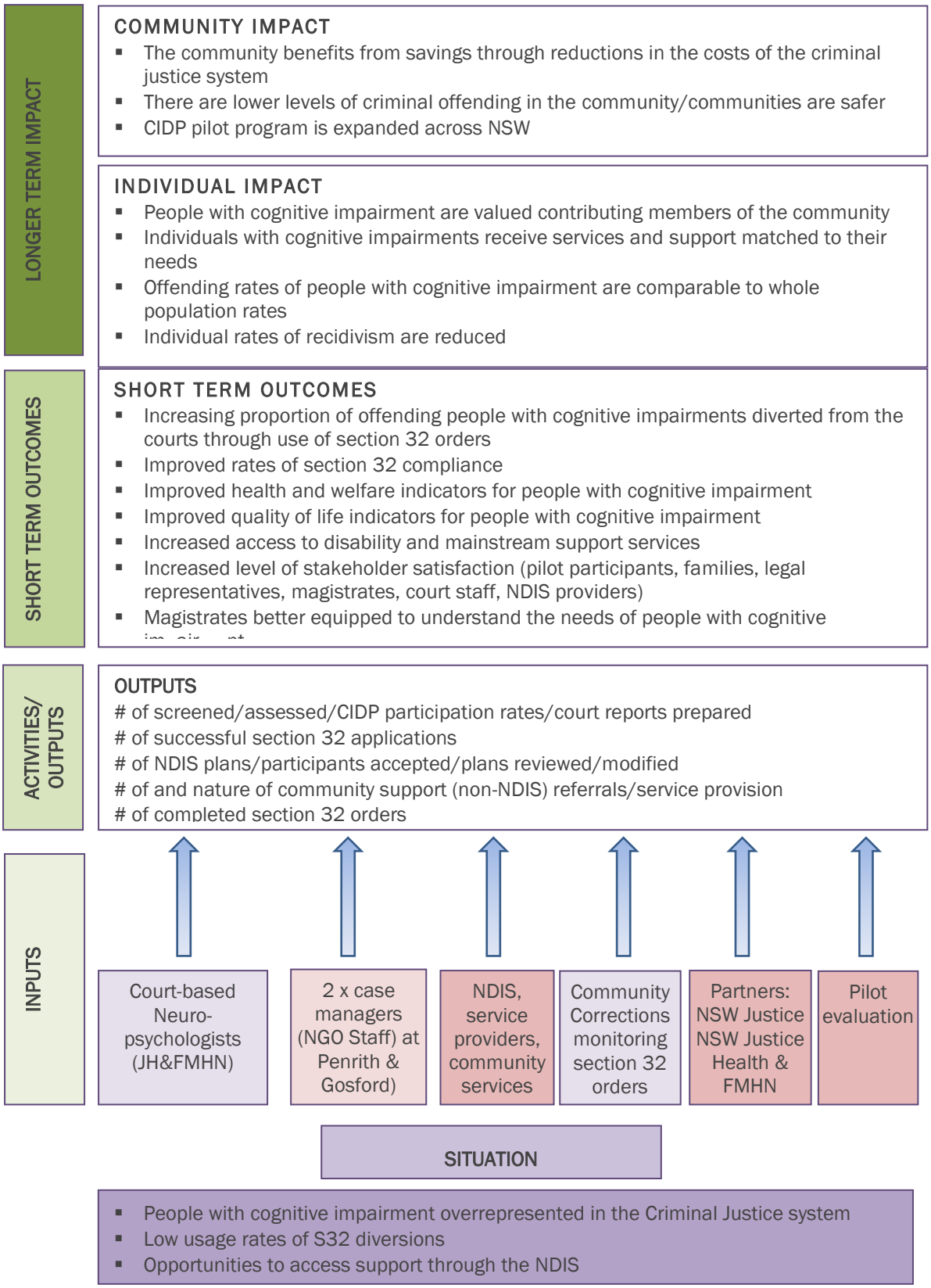
CIDP operational manual

There is an operational manual for the program. The Offender Strategy team is responsible for the manual. Decisions for any amendments are based on the experience of the program and the advice of the IWG. The manual is discussed later in this report in the context of the findings of the process evaluation which considered whether the program was implemented and delivered in line with the operational procedures across both local court sites.

Program logic

A program logic for CIDP was developed by WWS with input from the IWG during the development of the evaluation plan.

Figure 6: Program logic



Section two: Methodology

Evaluation objectives

The overall objective of the evaluation was to deliver an evidence-based answer to the question "Has the CIDP achieved its purposes and anticipated outcomes?"

The purposes and anticipated outcomes of CIDP are summarised in the table below.

Table 4: CIDP purposes and anticipated outcomes

○ CIDP Purposes	○ Anticipated outcomes	○ Measure and Data source
1. Screen and assess people for eligibility for section 32 diversion	Identification of people with a cognitive impairment who may be eligible for diversion	#'s of people screened as eligible for CIDP (CIDP database)
2. Connect people with NDIS and other support services	Improved health and welfare outcomes for participants	Participant and family feedback; #'s/% of active NDIS plans, (Participant and family interviews and CIDP database)
3. Provide reports to support an application for section 32 diversion	Increased use of diversion for people with cognitive impairment	#'s/% of participants diverted from court (CIDP database)
4. Monitor compliance with section 32 orders made, as required	Reduce likelihood of further interaction of the person with cognitive impairment with the criminal justice system (reduction in reoffending rates)	# of breach reports (CIDP database)

Key evaluation questions

Table 4 below sets out the key evaluation question components. These represent a high-level summary of the evaluation framework variables described in the Department of Justice's CIDP Evaluation Framework Document 2017. While this report does not address the CBA element of the evaluation, the CBA questions have been included in the table for completeness.

Table 5: Key evaluation question components

○ Key evaluation questions	○ Measurement (and data source)
○ **PROCESS EVALUATION**	
Was the program implemented and delivered in line with operational guidelines[14] across both local court sites?	▪ Match of delivery to benchmarks set in the operational manual for each stage[15] (CIDP data set and stakeholder interviews)
Were there any barriers or facilitators that impacted on the program's implementation and delivery? What were they?	▪ Stakeholder qualitative feedback (Participant and other stakeholder interviews)
Did the program achieve its objectives and aims?	▪ Numbers screened and assessed as eligible ▪ Numbers granted section 32 diversions (CIDP data set) ▪ Stakeholder feedback about improved health and welfare outcomes for participants (Participant, family and case manager interviews) ▪ Reduced reoffending (long-term outcome) (Data supplied by IDRS)
Recommendations for improvement?	▪ Stakeholder feedback (Stakeholder interviews)
○ **COST-BENEFIT ANALYSIS**	
What savings are generated for every dollar spent on the program?	▪ $ saving figures
What are the early health and welfare and reoffending outcomes for participants against costs to government?	▪ NDIS access rates and plan $values ▪ Stakeholder reports of health and welfare benefits (Participant, family and case manager interviews)

The evaluation was undertaken using a mixed methods approach. Quantitative data was sourced from the CIDP excel data sheets tracking program participants which were completed by Justice Health, IDRS and CommCor. There were several shortcomings with this data (see data limitations below).

Qualitative data was collected directly from a sample of CIDP participants, family members and other stakeholders.

A list of the stakeholders consulted is at Appendix A.

[14] Operational guideline benchmarks able to be assessed are detailed in the process descriptions for each stage of the model in the findings
[15] The CIDP data set captured selective benchmark data only

CIDP evaluation participants

Participants invited to contribute to the evaluation were drawn from the pool of 79 CIDP individuals who had been assessed as eligible for the program in its first 12 months of operation.

- Twenty CIDP participants consented to be interviewed for the evaluation (18 interviews conducted face-to-face at Penrith and Gosford local courts over two days; another two participants interviewed by phone.)
- Interviews followed the following format:
  - Presentation and discussion of an Easy Read participant information sheet (in line with ethics approval) (Appendix G)
  - A copy of the information sheet given to the participant to keep
  - Participant invited to sign Easy Read consent form
  - Participants were asked selected questions matched to their stage in the program. These questions were drawn from a range which covered all stages of the CIDP process.
  - Administration of the Personal Wellbeing Index (PWI-ID), an adaptation of the standard PWI questions for use with people with an intellectual disability. The scale was easily understood and completed by all but two of the evaluation participants.
  - At the end of each interview, individuals received a $50 gift card as a "Thank you" for assisting the evaluation
  - For individuals interviewed by phone, the participant information sheet was discussed and later sent through their case manager to the person for written consent, along with their gift card

Where appropriate, evaluation participants were asked for consent to contact family member/s. This yielded interviews with six family members. Relationships included parent, child, grandparent and spouse. Questions explored with family members were:

- What difference has being in CIDP made for the participant? (Health, happiness, community connections, what they are doing/work/study?)
- Has the CIDP made any difference to your confidence about the likelihood of the participant reoffending?
- Are there any other comments or feedback you would like to give us about the CIDP?

Other stakeholder input

The main data collection method for other stakeholders was face-to-face interview, with phone interviews undertaken where face-to-face was not feasible.

A survey targeted at Legal Aid, the Aboriginal Legal Service, police prosecutors and court registrars had a low response rate with three responses received from ten invitations. Follow-up interviews were completed with two of these three respondents.

A note on the Personal Well-being Index (PWI)[16]

PWI is the average level of satisfaction across seven aspects of personal life: health, personal relationships, safety, standard of living, achieving in life, community connectedness, and future security. The PWI has been adapted and validated with adults, children, and persons with an intellectual or cognitive disability.[17] The version of the PWI for people with an intellectual or cognitive disability (PWI–ID) has modified the questions to ask about happiness instead of satisfaction.

The participant interviews included administration of the PWI-ID. While there was no opportunity to repeat the scale, it proved to be readily understood. If a pre- and post-protocol to use the PWI-ID for CIDP participants can be developed, it will provide useful information about changes in participant subjective wellbeing following CIDP participation.

Data limitations

Health and welfare outcomes

The measurement of health and welfare outcomes was a challenge for the evaluation. As discussed above, the PWI-ID was tested with participants but, as there was no baseline administration, the results are not reported.

Qualitative feedback was sought directly from participants, including reported life changes, new goals, activities and connection to services. This was corroborated by a small number of family member interviews, together with observations reported by case managers and other stakeholders. This data is essentially qualitative and subjective.

Quantitative information was available about the number of participants connected to the NDIS and the number of active plans which resulted.

The CIDP data set contained a field to indicate other supports engaged, but only one type of support could be selected for an individual participant.

[16] The Personal Wellbeing Index was developed in 2001 by Professor R.A. Cummins at The Australian Centre on Quality of Life at Deakin University. Australian Unity, partnering with Deakin University, has been using PWI with a representative and validated sample of the Australian population to measure Australians' well-being since 2001. Scored out of 100, the average figure for Australians is available for each survey and across 17 years (2002–2018). This allows for a comparison to be made between the Australian population and any sub-group which is measured. The annual sample size is approximately 2,000

[17] http://www.acqol.com.au/instruments;
https://www.australianunity.com.au/media-centre/wellbeing

CIDP data set

There were major difficulties with the origin data excel spreadsheet set up to collect quantitative CIDP data. This included overwriting of fields to update participant status as they progressed through the program, the large number of data items and lack of recording.

Significant work was undertaken by Offender Strategy and the IWG to strengthen the quantitative data collection for the program during the period of the evaluation. This included streamlining the number of data fields from 105 columns to 39 and tracking the progress of individuals along their CIDP journey, rather than snapshot reporting.

This revised data set has been used to report on the quantitative outcomes of the program.

Data covered program commencement (16 October 2017) to 6 November 2018.

Functionally, we consider this data to represent the first 12 months of the pilot.

Statistics were captured for 118 screened individuals; both those determined eligible (79) and ineligible (35). For ineligible individuals, information was limited to referral source, basic demographic data (age, gender, Indigenous status, date of screening and outcome (not eligible)).

Amongst the eligible participants, while most participants had complete data, there are some limitations and inconsistencies in the new dataset, particularly relating to dates and blank fields:

- Inconsistent dates or blanks e.g. date of consent preceding date of referral. Approximately 20% of completed matters had missing or inconsistent dates.
- Some date fields contained multiple dates e.g. draft support plan submitted to JH&FMHN[18]
- Missing data in some other fields. e.g. primary diagnosis/comorbidity information for half of the Penrith participants
- The field for “other supports engaged” was limited to a choice of one type of support

Additionally, separate information has not been collected about the number/duration of adjournments for each individual matter. From the comments field, and elapsed time calculations made on the data, it appears that for some, the pattern of adjournments is more complex than the single adjournment envisaged in the model.

Ethics approval

Ethics approval was sought from the Bellberry Human Research Ethics Committee and received on 8 October 2018. (Application number 2018-08-644)

[18] This is because multiple versions of support plans were submitted in instances where a s32 hearing was expected but resulted in further adjournments

Section three: Findings

> *Life was getting a bit hopeless. It's far from hopeless now (CIDP participant).*

Overview

There are 4 major sections in the findings:

1. The profile of CIDP participants
2. CIDP process findings
3. CIDP outcomes
4. Summary of CIDP strengths, barriers and opportunities

3.1 CIDP participant profile

The CIDP data captured information on 118 screened individuals. Screened numbers are greater than participant numbers as some of the individuals who were screened were found to not have a cognitive impairment.

Eligible participants are the subset of those screened who proceeded to assessment as they were considered likely to have a cognitive impairment. The CIDP operational manual considers a person to be a CIDP participant when they consent to the clinical assessment.[19]

Amongst the 118 people who were screened for the program in its first 12 months of operation (70 Penrith and 48 Gosford), 79 or 67% were deemed eligible across the two trial sites.

Gender

Gender information is available for all screened referrals, both ineligible and eligible.

Most people referred to the program are male (85%).

Table 6: Gender of CIDP referrals

Gender	Penrith	Gosford	Total
Male	58 (83%)	42 (88%)	100 (85%)
Female	11 (16%)	6 (12%)	17 (14%)
Not specified	1 (1%)	-	1 (1%)
Total	**70**	**48**	**118**

Age

The age range of eligible participants at Penrith was 19–57 years old (average age 27.8 years) and at Gosford 19–72 years old (average age 32.7 years).

As can be seen from the table below, more than half of participants are under 30 years of age. The largest category of eligible participants is aged in their 20's. Individual dates of birth showed that almost two-thirds of these were in their early 20's.

[19] P 19 CIDP Operational Manual

Table 7: Ages of eligible participants

	Penrith		Gosford		Total	
Under 20	5	11%	3	9%	8	10%
20–29	22	50%	15	43%	37	47%
30–39	6	14%	8	23%	14	18%
40–49	9	20%	3	9%	12	15%
50–59	2	5%	4	11%	6	8%
60+	0	0%	2	6%	2	3%
Total	**44**	**100%**	**35**	**100%**	**79**	**100%**

Indigenous status

Aboriginal people were significantly overrepresented amongst the participant group (32%) compared to the NSW population (2.9% in 2016 Census).[20]

The proportion of Indigenous participants is similar in both Penrith and Gosford (30% and 34% respectively).

2017 ABS data[21] indicates that Indigenous Australians represent 28% of the prisoner population, so the incidence of Indigenous participants in CIDP is not surprising. The high Indigenous numbers suggest that there are no barriers to Aboriginal people being referred to the CIDP. Anecdotally, it was reported that the Aboriginal Court Liaison officer was a strong source of referrals. (See

> *I thought it wouldn't help at all, I knew I'd done wrong (CIDP participant)*

> *I didn't want to do it … I didn't want to be disabled … [Neuropsychologist] told me it was CIDP or prison … it was a wake-up call (CIDP participant).*

later in the report).

Table 8: Count of Aboriginal participants

Aboriginal status	Penrith	Gosford	TOTAL
Aboriginal	13	12	25
Non-Aboriginal	20	21	41
Unknown	11	2	13
Total	**44**	**35**	**79**

Table 9: Proportion of Aboriginal participants

[20] http://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/1?opendocument
[21] http://theconversation.com/three-charts-on-australias-booming-prison-population-76940

Aboriginal status	Penrith	Gosford	TOTAL
Aboriginal	30%	34%	32%
Non-Aboriginal	45%	60%	52%
Unknown	25%	6%	16%
Total	100%	100%	100%

Primary diagnosis

A primary diagnosis[22] was available for all Gosford eligible participants and almost half of the Penrith participants (19).[23] The percentages shown in the total column below have been based on the total numbers where a diagnosis is known (n=54).

The most common cognitive impairment is intellectual disability with more than half of eligible participants (57%) having this as their primary diagnosis. A further 20% of individuals have borderline intellectual functioning. The next largest category is acquired brain injury at 15%.

Table 10: Primary diagnosis

Diagnosis	Penrith	Gosford	Total[24]
Acquired brain injury	2	6	8 (15%)
Autism spectrum disorder	–	3	3 (6%)
Borderline intellectual functioning	2	9	11 (20%)
Intellectual disability	15	16	31 (57%)
Drug or alcohol related brain damage, including foetal alcohol spectrum disorder	–	1	1 (2%)
Not identified/ blank	25[25]	–	25
Total	**44**	**35**	**79**

Comorbidities

Amongst the Gosford group, the majority, 27 participants (78%) were diagnosed with one or more comorbidities.

Over half of these (15 participants) had a mental illness or condition, a quarter (seven participants) had drug or alcohol addiction and five had both comorbidities.

Comorbidity data was available for 21 individuals from Penrith. Eighteen of these (85%) had at least one comorbidity. Four had drug or alcohol addiction issues, four had a mental illness or condition and 10 had both. The absence of comorbidity information for

[22] The CIDP involves clinical assessment of participants. As a result, it is necessary to use clinical terms at times in this report, such as 'primary diagnosis' and 'comorbidity'. WestWood Spice acknowledges this language sits outside a social model of disability
[23] Data fields were incomplete/ participant was still awaiting assessment
[24] Missing data/pending assessment has been excluded from the % calculations
[25] This number includes those with assessment pending (two), and four who were awaiting previous assessment data. One participant had not attended their assessment appointment. Drug and alcohol comorbidities were recorded for seven, one secondary diagnosis was mild intellectual disability, one an unidentified medical condition and two had mental health mentioned

23 Penrith individuals means any conclusion needs to be qualified. However, even assuming none of these individuals had a comorbidity, across both sites at least 40% of eligible CIDP participants have a mental health comorbidity and a third have some issues with either alcohol or drug addiction.

Multiple diagnoses and comorbidities add to the complexities of participant needs.

Impact of comorbidities reported by participants

Participants spoke about multiple life challenges in interviews, including mental health, substance use, trauma and other health issues. NDIS and CIDP plans which included links to mental health and substance use services were highly valued, with people reporting they had not been connected to these supports at the time of referral into the program.

During interviews, participants indicated the impact of multiple comorbidities on their ability to engage with services. One participant reported being unsure of his NDIS status because of a recent hospitalisation for a neurological health issue. A family member felt an employment service dropped their involvement with her son because his psychiatric diagnosis was disclosed.

Several participants interviewed indicated trauma responses as a continuing challenge and area of need. One participant talked about trauma from child sexual assault and domestic violence as, "things that bring me to the point of drinking and drugging". The participant felt CIDP was likely to assist in "issues I've never addressed". Trauma in a participant's background adds to the complexity of their support needs, with service providers needing a trauma-informed skill and knowledge base to provide appropriate service to these individuals.

Custody status at time of referral

Table 11 below shows custody status at the time of referral.

Table 11: Custody status at time of referral

Custody status at time of referral	Penrith (All)	Penrith (Eligible)	Gosford (All)	Gosford (Eligible)
Fresh[26]	5	2	3	1
Out of Custody (OOC)	32	26	40	33
Remand	18	9	4	1
Blank	15	7	1	–
Total	**70**	**44**	**48**	**35**

The most common custody status, across the whole referral cohort and those deemed eligible is out of custody (OOC). For the Penrith group, approximately 20% of eligible participants were on remand at the time of referral compared to 3% at Gosford. Possible reasons are that there are more potential participants (i.e. on remand) every day at Penrith. Part of the screening process is to check in with corrective services on several occasions (usually three or four times) throughout the day for any fresh custodies — some of these people may also end up being remanded into custody. It was reported that there was a very good relationship between the mental health nurse and the "cells" which possibly contributes to picking up more people.

[26] in this context "Fresh" means that the participant has been presented to the court by police to have bail determined by a Magistrate. Generally these participants are newly charged

3.2 CIDP process findings

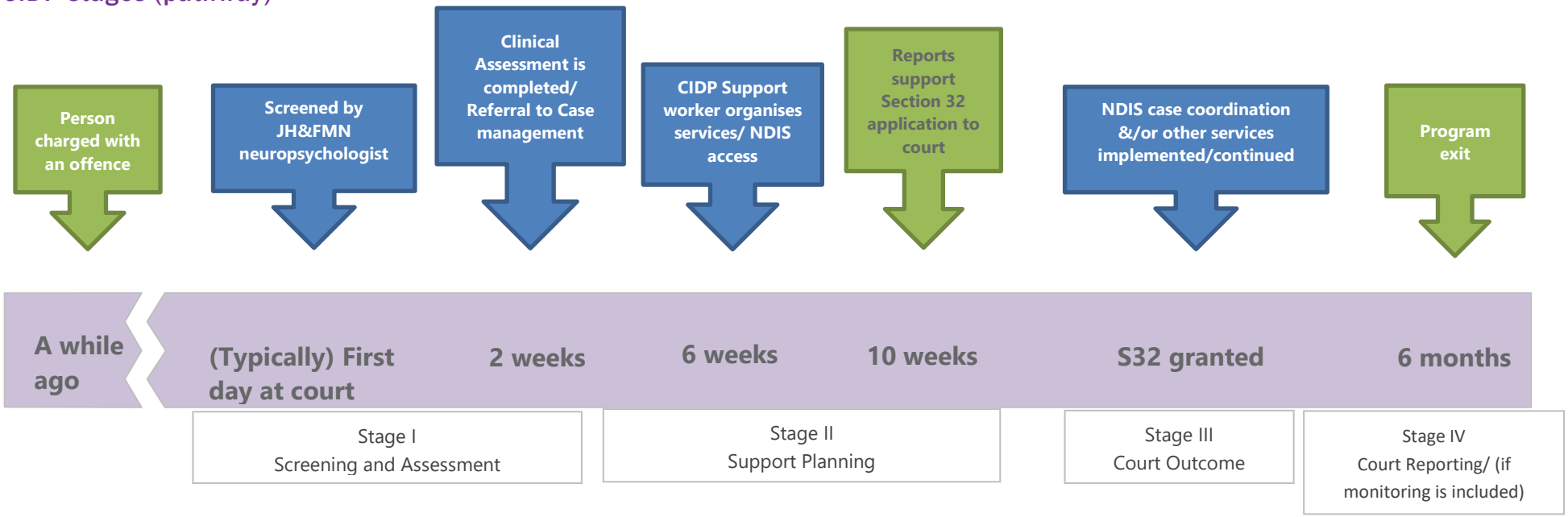
Figure 7 below shows in diagrammatic form the pathway of the stages experienced by a CIDP participant going through the CIDP process.

The findings about the process are mapped to each of these stages as shown below.

○ **Process finding heading**	○ **CIDP stage**
Referral process and program promotion Screening Assessment	Stage 1 — Screening and Assessment
Support planning	Stage 2 — Support Planning
Section 32 application and hearing	Stage 3 — Court Outcome
Monitoring/Court reporting Program exit	Stage 4 — Court reporting (if monitoring is included) and program exit

For each heading, there is a discussion of the theoretical process in the CIDP model and what the evaluation found in practice. Where challenges and strengths have been identified, these follow, together with any feedback obtained about participants' experience.

CIDP stages (pathway)



All CIDP participants will not progress to Stage IV of the pathway. This is because a decision to include monitoring as a condition under section 32 is a discretionary decision of the court.

Figure 7: CIDP Pathway

STAGE 1: Referrals and program promotion

A person's contact with CIDP begins when they are referred to the program for screening for cognitive impairment.

The model process

Referrals to CIDP are made by contacting the SCCLS clinician/CIDP neuropsychologist at the relevant pilot site. Referrals can be made by email, phone or in person.[27]

There is no referral form, but it is a requirement that the person's criminal charge sheet is provided.

The practice

Anyone can make a referral to the program at any time. Referrals are being received in line with what was envisaged in the manual: "It is anticipated that the SCCLS will receive most referrals on the day of the defendant's first court appearance."

Solicitors account for more than half of the referrals to CIDP (55%) with the majority coming from Legal Aid (47%). Fifteen percent of referrals are from the Aboriginal court liaison officer or other court personnel and 10% of referrals came from IDRS. (See

" *I thought it wouldn't help at all, I knew I'd done wrong (CIDP participant)*

I didn't want to do it … I didn't want to be disabled … [Neuropsychologist] told me it was CIDP or prison … it was a wake-up call (CIDP participant).

below).

Referral sources and numbers

Table 12: Referral sources

Referral source	Penrith	Gosford	Total
Legal Aid solicitor	33	23	56 (47%)
IDRS	10	2	12 (10%)
Aboriginal Court Liaison officer	2	7	9 (8%)
Other court personnel	1	7	8 (7%)
NGO	4	3	7 (6%)
Private solicitor	5	1	6 (5%)
Magistrate	5	–	5 (4%)

[27] P 19 CIDP Operational Manual

Other treatment provider(s)	1	1	2 (2%)
Family/friend/relative	1	–	1 (1%)
JH&FMHN professionals	1	–	1 (1%)
Blank	4		4 (3%)
Total	**70**	**48**	**118**

Challenges

- The number of referrals to the program are significantly less than the estimates of the number of people who might be the potential pool for CIDP participants in the initial proposal

These estimates were based on assumptions about the proportion of the criminal justice defendant population who have a cognitive impairment, one derived from general population incidence and the other from criminal justice population data. The CIDP Support Planning/case management function used a figure at the higher end of these numbers and assumed 50% would consider making a section 32 application.

Table 13 below shows these different estimates and the comparison with actual referral numbers. It should be noted that this differential does not consider the set-up time taken for a new program.

Table 13: Potential annual CIDP numbers x estimate source

Source of #	2.2% pop with cognitive impairment	8.8% CJ pop with cognitive impairment	CIDP NGO support agency tender	IDRS tender 50% consider section 32	Actual CIDP Referrals received in first 12 months of service
Penrith	76	304	352	176	70
Gosford	47	213	212	106	46
Total	123	517	564	282	118

Other variables which impact on referral numbers include individuals appearing without legal representation, lack of recognition of cognitive impairment by potential referrers and lack of knowledge about the program (see promotion point below). Better guidance for referral sources about likely indicators of a cognitive impairment would help increase their awareness of potential participants. Indicators could include receipt of the Disability Support Pension, low levels of literacy and poor school history.

- The lack of a formal referral process and documentation may mean the actual number of referrals have not been captured

This would seem to be the case, as the evaluation identified that the two JH&FMHN neuropsychologists have reached their capacity for screening and assessment. A position of a supervising psychiatrist was filled from January to August 2018, with clinical supervision responsibilities assumed by the Clinical Director of SCCLS once the

incumbent left.[28] The initial CIDP proposal envisaged four Clinical/Forensic Psychologists to deliver CIDP. It was not clear why this had been changed.

- There has been limited promotion of the CIDP

The evaluation did not find any publicity posters or pamphlets about CIDP in either of the local courts, or other strategies to promote the program. There appeared to be two main reasons for this:

1. The capacity ceiling of the JH&FMHN neuropsychologists described above
2. The program's pilot status.

Strengths

- The CIDP model allows for anyone to make a referral. As Table 12 above shows there are a wide variety of referral sources, though at this stage of the program numbers from some sources are low.

Participants' experience

Participants told us they hadn't heard of the CIDP prior to their referral and about one in five were doubtful it was real or could be of benefit.

> *I thought it wouldn't help at all, I knew I'd done wrong (CIDP participant)*

> *I didn't want to do it … I didn't want to be disabled … [Neuropsychologist] told me it was CIDP or prison … it was a wake-up call (CIDP participant).*

Others were enthusiastic:

> *Lit up my eyes [when I thought about what was possible] (CIDP participant).*

[28] This involvement was not part of the original model

STAGE 1: Screening

The model process

The manual envisaged screening taking place on the day of referral, which is typically the day the matter is first listed. This means screening would mostly occur at the local court. The purpose of screening as described in the manual is to provide an initial identification of a cognitive impairment (CI) and is the first step in considering whether a referred defendant is eligible for CIDP. If identification is positive for CI, the JH&FMHN neuropsychologist advises the defendant's solicitor and prepares an initial report to the magistrate confirming their clinical opinion that the defendant has a cognitive impairment. The report requests that the magistrate consider an adjournment[29] to complete assessment, support planning and associated reports.

The practice

The process of screening is working as envisaged in the manual. The JH&FMHN neuropsychologist uses a combination of clinical interview, review of collateral information that might be available and brief screening assessment tools to check for CI. Some of the screening tests include:

- Test of Premorbid Function (TOPF — part of Advanced Clinical Solutions battery)
- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
- Peabody Picture Vocabulary Test
- Wechsler Adult Intelligence Scale — fourth edition (WAIS-IV; Information subtest and Vocabulary subtest).

Screening data

Using the CIDP data set,

[29] Initially an eight weeks adjournment requested, later increased to ten weeks

Table 14 below provides a picture of the numbers screened and the numbers deemed eligible in the first 12 months of the CIDP.

Table 14: Numbers screened and numbers eligible by gender and location

○ Status	○ Penrith		○ Gosford		○ Total
	Screened Eligible	Screened ineligible	Screened Eligible	Screened ineligible	
Male	34	24	31	11	100 (85%)
Female	9	2	4	2	17 (14%)
Not specified	1		–		1 (1%)
Sub -Total	**44**	26	**35**	13	**118 (100%)**
TOTAL SCREENED	**70**		48		**118**
% eligible	62%		73%		67% (79 people)

The figures show a slightly higher proportion of referrals screened at Gosford were deemed eligible (73%) when compared with Penrith (62%), Overall, 67% or two thirds of people screened for CIDP were deemed eligible for the program based on a likely cognitive impairment. In all instances, these individuals consented to proceed to assessment/ participate in CIDP.

Challenges

- The process evaluation did not investigate the best tools and resources to undertake the cognitive impairment screening, but exploration of this may enable some program efficiencies

STAGE 1: Assessment

The model process

The adjournment request for those individuals screened as eligible was initially eight weeks. This comprised two weeks for the JH&FMHN neuropsychologist to undertake further clinical assessment and complete the assessment report. There was a further six weeks allocated for a support plan to be developed by the IDRS case manager. The model envisaged referral to IDRS at the two-week point when the assessment report would be available.

The outcome is to provide the reports needed to support an application for section 32 diversion under the CIDP[30] when the adjourned matter is relisted and support access to the NDIS. (See discussion below about length of adjournment).

The assessment is to confirm that the person has a cognitive impairment within the meaning of section 32 of the MHFPA. The model envisaged that assessment would take place on the same day as screening, or where necessary within one week of screening.

Originally the model included provision of a part-time clinical psychiatrist to oversee the clinical work of the JH&FMHN neuropsychologists.

The operational manual gives discretion to the JH&FMHN neuropsychologist to determine whether existing reports provide enough evidence of a cognitive impairment or whether a full neurological assessment is required

The practice

Formal testing

Previous assessments (e.g. school records) were used for eight participants from the Penrith cohort. According to the CIDP database information,[31] three Penrith participants' assessments were still to be confirmed and another had not shown up. The remaining six had various reasons for no assessment, including one participant whose application for adjournment on the day of screening was rejected by the magistrate, two who were second referrals into the program, and one referred to CIDP following an appeal to the District Court.

The process of full neurological assessment is guided by the clinical judgement and decision-making of the JH&FMHN neuropsychologist and the collateral information available. Test choice is determined by the disorder being investigated. Where testing uncovers further difficulties, more investigation/testing is carried out. An Adaptive Behaviour Assessment (ABAS) is universally included. Feedback from the NDIA confirms that the ABAS assists those with mild intellectual disability who might otherwise struggle to meet NDIS eligibility.

[30] Although other diversion outcomes may result at the discretion of the magistrate
[31] As at 6 November 2018

The suite of neuropsychological tests includes:

- Advanced Clinical Solutions
- Boston Naming Test
- California Verbal Learning Test (CVLT-II)
- Delis Kaplan Executive Function System (DKEFS)
- Depression Anxiety & Stress Scale (DASS)
- Expressive Vocabulary Test
- Hayling and Brixton Tests
- Peabody Picture Vocabulary Test
- Rey Auditory Verbal Learning Test (RAVLT)
- Rey Complex Figure Test (ROCFT)
- Sydney Language Battery (SydBat)
- Symbol Digits Modality Test (SDMT)
- Test of Everyday Attention (TEA)
- Test of Memory Malingering (TOMM)
- Wechsler Memory Scale (Third and Fourth Editions)
- Wechsler Adult Intelligence Scale (Fourth Edition)
- Wisconsin Card Sorting Test (WCST)

The CIDP assessment process includes a risk rating for participants, indicating a participant's risk to themselves and others, based on the participant's diagnosis. Multiple diagnoses appear to increase the likelihood of a higher risk assessment and could indicate greater complexity for case managers involved, and the need for greater supervision of supportive and clinical relationships.

All CIDP cases are reviewed by the Clinical Director of SCCLS as a result of recruitment difficulties in filling the Clinical Psychiatrist position to oversee the clinical work for CIDP.

Challenges

- Adjournment period

As described above, the operational manual envisaged an initial adjournment period of eight weeks.

In July 2018, the IWG agreed to extend the adjournment period to ten weeks. The rationale was to allow time for solicitors, participants, prosecutors and magistrates to process information in the assessment reports, by providing them two weeks before, rather than on the day, of the hearing. CIDP materials provided to the court include the clinical reports and support plan. In practice, it was found that the reports/support plans were not always provided two weeks in advance of court dates and even where they were provided in advance, the magistrate/solicitors did not read them until the morning of the hearing date.

Further investigation is needed to be confident about the appropriate adjournment period to best meet the needs of CIDP participants and the courts. The CIDP database provides for the recording of date of screening and date of court outcome. This enabled some testing of the average time from screening to court outcome. Valid date ranges[32] were available for 19/24 completed Penrith matters and 18/29 matters at Gosford. Data from Penrith indicated an average elapsed time of 12 weeks and for Gosford, 14 weeks prior to July 2018 and 10 weeks after July 2018 (six cases). The database does not currently record information about the number of adjournments required for each individual, but case manager advice indicates that more than one adjournment is common.

Legal Aid feedback suggested that the CIDP process is a more efficient, effective and timely process of seeking diversion. This was in comparison with the non-CIDP situation, where in the absence of access to the formal assessment reports and without a support plan, matters can be adjourned (possibly repeatedly) for lengthy periods of 12 months or more.

While this suggests the CIDP ingredients make a section 32 application faster and easier to make, the appropriate length of adjournment warrants further testing. In a couple of cases, magistrates reported they used an extra adjournment as a mechanism to test the implementation of the support plan when the section 32 application was heard.

- Timing of assessment

As mentioned above, the operational manual assumed that assessment would take place directly after screening. However, this did not happen for most people. Only 10% of participants screened proceeded to assessment on the same day as their screening.

While JH&FMHN neuropsychologists beginning assessments on the same day as screening has the theoretical advantage of a "captive audience", in practice, the neuropsychologists reported that this was difficult from a practical perspective.

For some participants, it is their very first experience of a day at court; for all, the day at court has been long and stressful. As a result, participants are less likely to be engaged in the testing, unlikely to be performing at their best and this could skew results. Based on the experience of implementing the assessment stage of the model, the benchmark of same day screening and assessment now appears inappropriate, with a delay to assessment providing a more appropriate testing environment for participants.

As can be seen from Table 14 below, most people who received a formal assessment completed this on a different day (or days) from the screening date. No Penrith participants were screened and assessed on the same day, while from Gosford only eight were.

[32] The other 15 fields were either missing a date, or the date of outcome was earlier than the date recorded for screening

Table 15: Assessment numbers and patterns

Assessment	Penrith	Gosford	Total
Screened and assessed on the same day	0	8	8
Two assessment dates	2	3	5
Single assessment on a different date from screening	22	22	44
Previous assessment data used	8	–	8
No show	1	–	1
TBC	3	–	3
Other	6	2	8
NA	2	–	2
Total	**44**	**35**	**79**

Apart from two individuals, all Gosford participants were formally assessed. One of these two was granted a section 32 at their first court appearance so did not require the assessment step. The second participant was deemed unfit to plea. Across both sites, most participants completed their assessment in a single session with only five participants requiring two sessions.

- Any growth in demand will outstrip supply unless capacity issues are addressed.

Although the process evaluation did not investigate whether the JH&FMHN neuropsychologists need to be the entry point into the program, there is value in investigating whether other health professionals and/or other arrangements could serve as the entry point at a lesser cost/effort to increase capacity for clinical assessment e.g. a CIDP panel of psychologists, priority testing using validated assessment tools for NDIS acceptance.

It should be noted that JH&FMHN do not support the outsourcing of comprehensive/ clinical assessments to a panel of providers as an alternative option to the current model as this is seen as potentially impacting on impartiality and not subject to the same supervision protocols.

Likewise, JH&FMHN do not support any reduction in the comprehensive approach to assessment as this will impact on the holistic nature of the assessment and management/treatment plan.

Strengths

- Flexibility in location of assessment

Typically, assessment took place in the JH&FMHN neuropsychologist's office at the relevant local court. However, the program has a flexible approach. One participant said the neuropsychologist made it possible for him to participate by meeting him at a court closer to where he lived, as he had trouble with transport.

- Feedback to participants

Although not part of the guidelines outlined in the operational manual, the JH&FMHN neuropsychologists developed a practice of talking with participants about the assessment findings. This feedback has played an important role in the participants' own understanding of their needs, particularly for those people who were unaware that they had a disability before they were assessed. Based on the direct reports of several participants, this increased self-knowledge appears likely to have contributed to their engagement both to the program generally and to specific supports which will be of benefit, for example, willingness to undertake anger management training.

This informal practice of making feedback available to participants has shown to be beneficial. The recommendations include making the provision of assessment feedback to participants a recognised feature of the model.

> *"[Neuropsychologist] brought a lot of understanding of what's going on in my brain that I didn't know … I got insight into myself … remind myself I'm not who I used to be. I have to adapt to before when I had a job and lived alone.*
>
> *Helped me to understand myself better. (CIDP participants)*

- Early referral to case management

Referrals are now commonly being made[33] to case managers at the point of a positive screen. We were told that this practice was adopted based on the observations of operational staff who found that case manager contact with the participant from the beginning of the process was very helpful in securing successful engagement with the participant.

Anecdotal feedback from one JH&FMHN neuropsychologist suggested that early engagement with case managers helped achieve 100% engagement with testing. In contrast, engagement levels where case managers had not yet become involved were estimated to be closer to 70%. This support to engage is especially helpful considering the finding above that only 10% of assessments take place on the day of screening.

- Assessments are cost-free to participants and undertaken by independent, impartial government clinicians

Legal representatives reported advantages of:

- timely access to testing (vs difficulties finding a private practitioner and the associated costs involved) reducing delays
- the independent status of the JH&FMHN neuropsychologist (vs a "hired gun"). This point of impartiality was also made by JH&FMHN
- Quality of reports. The assessments provided are comprehensive including Mental Health (MH) and Drug & Alcohol (DA) neuropsychological testing as determined by the clinician's judgement of the tester.

[33] This appeared to happen about 8 months into the pilot implementation

Participants' experience

A small number of participants didn't remember doing the assessment, but a majority could and about half commented it was very challenging.

> *The tests were long and hard … strenuous on brain … felt good doing it.*
>
> *[The test] made me feel stupid, agitated and overwhelmed and dumb … reminded me of school. (CIDP participant)*

Generally, although individuals found the assessment challenging, the experience had been improved by the positive and supportive approach of the JH&FMHN neuropsychologists.

> *[Neuropsychologist] broke it down so I understood .*
>
> *I was a bit embarrassed at not answering, but he [neuropsychologist] made me feel comfortable (CIDP participant)*

STAGE 2: Support planning

The model process

The CIDP operational manual envisaged a sequential process from screening and assessment to support planning; two weeks for completion of the assessment report and six weeks for case managers to develop a support plan to include in the application for section 32 diversion (accounting for the eight-week period of adjournment requested at the point of a positive screen). The JH&FMHN neuropsychologist was to make a formal referral to the case managers after the clinical assessment report was drafted and to provide it to the case manager.

"This referral commences the 6-week timeframe for securing supports during the adjournment period and for IDRS to support the CIDP participant according to their required KPIs."[34]

The original KPI list for IDRS contained seven measures (See Appendix I), six of which relate to timeliness of contact; with participants, with NDIS, with mainstream service referrals and providing a progress report to the JH&FMHN neuropsychologist within six weeks of the initial referral date. The seventh set a target of attendance at 90% of NDIS planning meetings. WWS understands that these KPIs are currently being renegotiated between IDRS and Diversity Services.

The practice

As noted earlier, there is a current practice of immediate referral to case management at the point of a positive screen. The process of support planning in general terms is as envisaged. Specific elements are covered in both the challenges and strength below.

Challenges

- The benchmark of two weeks for the completion of the clinical identification and assessment process, including the preparation of a clinical assessment report, is not being achieved

The CIDP database shows the following elapsed times in relation to screening, assessment and provision of the assessment report to case managers:

Table 16: Assessment benchmarks

○ Benchmark	○ Average days	○ Weeks (workdays)
Elapsed time between screening and assessment		
Penrith	15.5	3.3
Gosford	8	1.6
Elapsed time between assessment and report provided to IDRS		
Penrith	31	6.2
Gosford	17	3.3

[34] P 28 CIDP Operational Manual version 2.2 (19 March 2018)

This is mitigating the reality that the average timeframe for the completion of assessment reports and their provision to case managers is exceeding the two-week target (3.3 weeks in Gosford and 6.2 weeks in Penrith).

Part of this increase in timeframe is due to the separation of screening and assessment. Another contributor is the priority given to screening while a third is the time required to chase historical claims and reports about the participant (e.g. school records).

The benchmark of six weeks to finalise the support plan before relisting was challenging to measure.

The CIDP database did not lend itself easily to measuring average time to develop a support plan, with inconsistencies in referral dates and multiple dates for when a support plan was submitted to the JH&FMHN neuropsychologist. Notwithstanding this, intact data was extracted for ten Penrith participants and 15 Gosford participants with completed matters. At Penrith, the average duration was 9.47 weeks, with a range of 2.5 to 17 weeks. For Gosford, the figures were an average 6.77 weeks, with a range from 5 to 9.86 weeks.

Timeliness and speed for accessing the NDIS for a participant is influenced by the availability of the neuropsychology reports as they provide evidence of cognitive impairment which influences eligibility decisions made by the NDIA.

- Staff turnover, requiring ongoing education about CIDP

There was some frustration on the part of case managers about the impact of staff turnover.

> *"You start building that rapport with the legal understanding of the program. And then they're gone. (IDRS case manager)*

A barrier to success was turnover of personnel, which included both visiting magistrates and Legal Aid staff, requiring an ongoing need for education about CIDP. This could be ameliorated as more people become familiar with the program.

Strengths

- Hours of support available to participants

Case managers are providing more hours of support to their individual CIDP participants than initially estimated or envisaged as needed in the model. This has been a direct result of the capacity issues with the throughput of screened and assessed participants discussed earlier. The CBA found an average level of individual participant support provided at 80 hours. It is recommended that a review of the duration and intensity of support is conducted to identify learnings about the levels of engagement which have maintained diversion. This can guide future benchmarks for the duration of CIDP case management support.

- Working effectively with the NDIS

Although the design of the CIDP model was not explicit on the detail of the interface with NDIS, in practice this interface was reported to be a major strength of the program.

A local NDIS decision to maximise efficiencies saw the allocation of a dedicated NDIS planner for CIDP participants in both regions. While each of these planners had caseloads beyond CIDP, all CIDP participants accessed the NDIS through these individuals.

This worked well and underpinned the ability of case managers, working with both participants and planners, to get supports in place according to the court's schedule. The dedicated planner meant faster plan creation and strengthened on-the-job learning for the planner about the needs of people with cognitive disability involved in the criminal justice system. CIDP case managers provided input to the planning meetings.

A planner explained that she runs the planning meetings differently for CIDP participants to maximise their engagement. For example, she reported sitting with them rather than behind a desk and avoiding use of the computer during the meeting.

There was an additional dedicated point of contact where escalation was required to the National Access Team, which was important as plan approvals are managed centrally. Diversity Services played a role in creating these connections. Again, this appeared to have unfolded informally but was of major benefit to the program in meeting its timelines to finalise support plans to present to the courts.

An advantage of this focused attention on accessing the NDIS is that supports are getting to the participant quickly and there are key contact people in the NDIS if there is a need to return to update the plan to reflect changes in the participant's life. This strengthens the effectiveness of the case manager in providing a support plan to the participant.

The local planner explained the advantages of the neuropsychological assessment in assisting people to secure NDIS plan approval. The report is up-to-date, detailed and available to the planner to help prepare for the meeting. It is an important independent source of information, which is not from a service provider. Detailed independent assessment of the participant's skills and challenges can greatly assist to substantiate eligibility. The functional impact assessment is helpful for a participant with a mild or borderline intellectual disability who might otherwise struggle with demonstrating eligibility.

It was reported by a support coordinator that NDIS plans for CIDP participants are frequently written with six-month review periods. This recognises their unstable circumstances and the likelihood of setbacks. As with the creation of the plan, participants are likely to benefit from independent advocacy by the CIDP case manager in the review meeting.

Given the complexities of the CIDP participants, there was an informal understanding between CIDP and the NDIA that all NDIS plans written for a CIDP participant include support coordination. It may be that support coordination is needed for 12–24 months, or beyond, for some participants, depending on the capacity building that can be achieved with them. It was salutary that some participants entered CIDP with a current but inactive NDIS plan, so were missing out on supports because they did not have the capacity to activate it.

Some participants need time to transition from their CIDP case manager relationship to an NDIS support coordinator. One NDIS support coordinator indicated this could take between two weeks to two months.

- Effective partnerships

Project partners built strong relationships which helped deliver CIDP outcomes to participants. This embraced many aspects of operation:

  - Relationships between CIDP case management staff and the court-based neuropsychologists led to better participant engagement, case manager access to reports in advance of presentation to the courts and shared understandings about the participants' best interests
  - Magistrates were willing to seek the advice of the JH&FMHN neuropsychologists during the hearing of a section 32 application
  - NDIS support coordinators worked in tandem with CIDP case managers to facilitate a smooth and successful transition of case management
  - Diversity Services took a facilitative role in problem-solving system issues

> *[Diversity Services] are … really responsive, receptive, available, approachable, who've taken on doing stakeholder engagement at the levels that only they can because it's government to government. (IDRS case manager)*

> *… we're very reliant on those other service systems to do things in a timely manner, otherwise all we can present to the court is a wish list or a series of promises rather than these are the funded linked activities that are now occurring for this person. (IDRS case manager)*

- A holistic approach to the supports needed by a participant

The support plan takes a whole of life view to the services and supports which will meet the needs of a CIDP participant. This creates a unique role for the CIDP case manager.

This was best explained by a case manager directly:

> *Through this pilot we're developing a more specialised skill set in … supporting someone to access whole of life supports through an NDIS plan and then distilling that to see what we need. What aspects of that do we need to present to the court in order to meet the requirements for a solicitor to successfully argue for a diversionary order? … That's, I think, something that is unique about the function that we serve — being able to look at those very different systems and what the expectations and requirements of each are. Otherwise, you risk criminalising a person's disability by making all of the supports in their life part of the process. (IDRS case manager)*

Participants' experience

Participants told us the early interpersonal connection of both case managers and neuropsychologists' court-based assessment services gave them a sense that the CIDP was a serious program.

CIDP case managers helped participants apply to access the NDIS, to implement their plans and to seek review of their plans. Participants said case managers supported them to make appointments with NDIS and to go to the planning meeting.

> *I had been trying to get help for ages. Had all the stuff there but couldn't get it together … Would ring up and case worker would make time and tell me what happens … Doctor had already recommended [me for NDIS] and put in a letter. With [case worker] and [neuropsychologist] it went through heaps quicker. I would have had heaps more trouble by myself.*
>
> *I've got all the right people now. I was on the NDIS for three years…I didn't know how to use the plan.*
>
> *I have more support, I didn't have any before. I tried [NDIS] before but I wasn't getting money.*

Participants indicated that the relationship with their case manager was the most important part of their ability to engage with the program.

One participant said she felt connected to her case manager when he sent her text messages to check in on how she was doing. Another participant, who otherwise said very little in the interview, commented that it was important to him that his case manager had backed up what she said she'd do. A third had been particularly touched when his case manager bought him lunch.

One participant said the program had improved her family's relationship saying, "We have someone to talk to".

Others reported feelings of reduced stress and less anger, which also benefitted their relationships with others.

> *I cut friends who were a bad influence … I didn't know how to do this before.*
>
> *[Now I have] techniques for coping with sadness, anger and worries.(CIDP participant)*

A couple of participants were tearful when talking about the importance of their relationship with their case manager. Several participants were reluctant to accept a gift card for the interview, saying they wanted to participate in the evaluation as a way of saying "thank you" for the support.

> *I'm so glad I took the step to finally trust again.*
>
> *I'm satisfied, good, keep up, there's nothing too trivial. Little things that everybody's let go [CIDP helps with].*
>
> *[Case worker] is the best.*
>
> *[CIDP helps] managing, reminding, guiding, understanding.*
>
> *[Case worker is a] great help, bolsters my self-worth, [case worker] throws his energy into it, cares about work and people.*
>
> *[Case worker gives] confidence. Nothing could be better.*
>
> *It's a home base.*
>
> *If CIDP hadn't rocked up I wouldn't understand and would keep doing what I was doing.*
>
> *I feel like I am getting heard, my voice counts.*

STAGE 3: Section 32 application and hearing

The model process

The JH&FMHN neuropsychologist prepares a final report to the magistrate for the section 32 hearing. The report confirms the cognitive impairment of the CIDP participant and attaches the support plan which has been provided by the IDRS case manager. As appropriate, the report recommends support in the community.

The practice

The court hearing is working as envisaged in the manual.

Magistrates noted that reports are well structured. The reports cover many aspects of the person's support needs and the involvement of the case manager means that recommended referrals have happened or will happen. A magistrate commented that if he decides not to make a section 32 order, he has information about how best to help the participant with other options.

The JH&FMHN neuropsychologist and the IDRS case manager are present at the court appearance to answer any questions the magistrate may have.

The case manager also provides on the spot support for the CIDP participant in the hearing. They help explain the court outcomes so they can be understood by the participant.

Diversion before a finalised NDIS plan

In June 2018, the IWG agreed that the JH&FMHN neuropsychologist and the IDRS case manager could release their reports in time for an adjourned hearing for a section 32 application, notwithstanding that a participant's NDIS plan was still to be approved. There was no data to indicate how often this had occurred. For the future it is suggested that the incidence of this occurring be recorded and monitored, together with its impact on the outcome at court (e.g. did a further adjournment result?).

Challenges

- Understanding of section 32 obligations

Participants reported a mixed level of understanding about their legal status. None were aware of the role of CommCor, although a small number were subject to their monitoring.

Some participants knew about their section 32 conditions, others could not say what the court outcome was, and for those with a sentencing date pending, some appeared unaware that diversion was a possible outcome.

One participant talked about feelings of shame at committing a crime against a vulnerable person:

> *I have big regret for that crime and I have to live with that.*

Others said:

> *Section 32 was so scary, didn't think I would get it, I had 10 pending charges.*
>
> *I am more aware of why I did what I did.*
>
> *Section 32 … I didn't understand what it was … just heaps of numbers.*

It was noted that although case managers provide support to participants at court, they are unable to go through the actual, final orders with the participant because the order is received later by the participant by post. This reduced the opportunity for immediacy in explaining details.

An easy read version of the section 32 template would also assist.

Strengths

- High quality of Section 32 applications

One magistrate described CIDP section 32 applications as well structured, so unlike non-CIDP section 32 applications he doesn't have to "fill in in the blanks". Reports provided by the JH&FMHN neuropsychiatrists are logical and from a trusted source; they make his decision-making process easier.

- CIDP presence in the hearing

The presence of the JH&FMHN neuropsychologist and IDRS case manager at court strengthens the program, as they can respond to questions from the magistrate arising from the assessment report and support plan.

- Confidence about avoiding future criminal justice contact

Most evaluation participants expressed confidence about not getting into trouble again, although several expressed concern about the consequences of losing their CIDP case manager and the role the case manager plays in helping them to stay out of trouble.

Participants' experience

Court support

Participants talked about their difficulties at court, finding the experience complicated. Some participants were unable to say whether they had legal representation, what they were charged with or what the outcome was.

Participants described feeling 'terrified' and having anxiety about court.

> *I don't really know what to expect, my life was in someone more intelligent than me's hands.*
>
> *When you give statements with brain injury, you're not sure if you got it right because of your memory.*
>
> *I couldn't understand. The magistrate looks down [when talking] and I can't hear.*
>
> *Judges and lawyers talking too quick.*
>
> *Whole authority thing — your life's out of control, people you have to see, forms, general distress, makes you sicker.*
>
> *Large crowds. I feel anxious.*
>
> *Waiting around at court is the hardest thing.*
>
> *I thought I would have house arrest or prison sentence … I was sitting in the court shaking.*
>
> *There's not enough help for disability people, lots of people don't get it, especially judges and brain injury.*

Participants said that having support at court from their case manager was very helpful.

> *[The] sense of support [from CIDP] was huge, otherwise you're alone and ready for gaol.*
>
> *Someone by your side. You don't want to be alone at court.*
>
> *Support to explain, keep on top of things.*
>
> *Judge explains situation and [case manager] describes it in another way.*
>
> *Scary by yourself. If you go to gaol who's to know? … Not as stressed with someone else for support. If I don't understand she'll put it in words I can understand. I don't understand the judge.*
>
> *[Case worker] went through the support plan. Helped me understand what was going to happen in court.*
>
> *Now I'm in the program, they don't make me wait all day at court — I get restless — they try to get done in the morning.*

Stage 4: Court reporting/Monitoring

The model process

The court is to notify CommCor when a magistrate makes a section 32 order which includes a monitoring condition. The assigned CommCor officer (CCO) does not have any direct contact with the participant.

CommCor tasks include:

- generating a record for the participant on the CSNSW database if they have no prior contact with Corrections (See Appendix E for information about the MIN)
- weekly contact with the service provider delivering supports under the support plan
- provision of three-month and six-month written progress reports

Where non-compliance is identified, the CCO is responsible for the final decision about whether or not to report the compliance to the court's registrar. (If it is reported, the magistrate then has discretion about whether to recall the participant to court as a result of non-compliance.)

The operational manual provides a range of questions which the CCO may consider.

- Has the defendant been engaging regularly with the CIDP case manager and as required with the NDIS support coordinator (if applicable)?
- Has the defendant selected relevant service providers and have they been engaging regularly with them?
- Has the defendant been regularly attending appointments, if not, are there any medical issues to explain this?
- Has the CCO made referrals or provided any assistance required to ensure the defendant accesses appropriate interventions and the defendant has continued to disregard these referrals?
- If the defendant has displayed repeated non-attendance at appointments without good reason, have they been issued a verbal and written warning?

The practice

For the first seven months of the program, no section 32 orders were made which included monitoring as a condition. There was a view that perhaps monitoring was not needed in the model.

Around May 2018, the JH&FMHN neuropsychologist reports were modified to include a prompt sentence (below) to magistrates about the option of monitoring:

"As part of the CIDP, there is an option for Community Corrections to monitor Mr XXXX's engagement with the service providers associated with his support plan."

After the first seven months of the program's roll out, it was the IWG's view that the monitoring function was not being utilised and therefore maybe that was the reason why magistrates were not ordering more section 32 orders. To boost more diversions and to simultaneously increase magistrate confidence, this "prompt" as an optional function available to a CIDP client was introduced into the neuropsychologists' reports.

The prompt was effective as of 40 orders made in both courts between October 2017 and November 2018[35], nine have included monitoring.

Table 17: Monitoring status of section 32 orders

Court outcome	Penrith	Gosford	Total
Section 32 without monitoring	16	15	31 (78%)
Section 32 with monitoring	6	3	9 (22%)
Total	**22**	**18**	**40**

As Table 16 shows, nine of the 40 section 32 orders made in the first year of CIDP include monitoring (22% or approximately one in five orders). It is unclear whether this rate will increase.

CommCor confirmed their role in line with the operational manual.

- they do not directly contact the participant
- typically follow-up is being made fortnightly rather than weekly or as decided in consultation with the service provider(s)

CommCor ask only two question:

1. Did the client turn up to the appointment?
2. Are you satisfied with the client's engagement with the service?

Challenges

- There is no direct engagement between CommCor and the participant

The CIDP process is unlike the usual CommCor model, which involves a frequent and regular pattern of client contact with the attendant opportunities this creates to develop rapport and a detailed understanding of the individual's circumstances.

- There is no CommCor access to the participant's CIDP reports, so no opportunity to contextualise the section 32 order.
- Copies of the orders from the court are not always received in a timely fashion and there was no established process in the operational manual for this.

[35] To February 2019, there have been 11 orders with monitoring

- Insufficient information provided to monitor orders, especially contact details of service providers identified in the support plan (e.g. phone, email, contact person's name). In some circumstances, a person mentioned on the order had changed jobs or there was a change in the service provider by the time CommCor received the order.
- There is also inconsistency in the language used by magistrates in the orders, which is confusing for CCOs to follow up on; this is perhaps due to a lack of understanding regarding the function of monitoring in CIDP.
- There is difficulty in obtaining information about a participant's participation. Feedback from a magistrate indicated a dislike for naming a relative as the "responsible person" on the grounds that they may not have all the information needed and were unlikely to secure compliance of the participant. Magistrates reported that the best "responsible person" will know what is going on in the participant's life and will be willing to give that information to the courts. In the community, this role is hard to fill. The NDIS support coordinator is likely to be the person who best tracks the participant's progress, but they operate from a position where the participants' decision to engage in services is voluntary and entirely their choice.
- There is unwillingness amongst service providers to engage with CommCor. CommCor told us that some service providers do not want to talk with them out of concern for negatively impacting their relationship with the participant. Where they do spend time communicating with CommCor, as an NDIS provider, there is the real possibility that the participant will be charged, in billable units, for this time.

STAGE 4: Program exit

The model process

A CIDP participant is free to withdraw their consent for participation in the program at any time.

CIDP stakeholders may exit a participant where careful consideration of factors indicates that they are no longer suitable for the program.

Factors to be considered include:

- where the participant does not turn up to clinical assessments, or continually misses appointments during the adjournment period
- where the person presents as drug or alcohol affected which prevents them from participating in screening and assessment
- where the defendant reoffends during the adjournment period. In these cases, the participant will be under fresh criminal charges and will be before the court. However, the CIDP may continue at the court's discretion (if the person is already subject to a section 32 order with monitoring condition completed by CommCor under CIDP) or the discretion of CIDP (if the person is remanded in custody and can no longer participate).

One of the clarifications made to the operational manual was that people who reoffend during the CIDP process are not automatically removed from the program.

The operational manual is silent on the exit point for program completion.

The practice

No CIDP participant withdrew their consent to participate in CIDP.

One person was exited from CIDP in December 2017 after multiple re-offences during the adjournment period meant he was no longer deemed suitable for CIDP.

Comparable Penrith figures were 12 exits and 20.6 working days. Eleven of the 12 people exited had received a section 32 diversion and one person's court outcome was a custodial sentence.

There is a differential between the number of matters which have been finalised (with a court outcome) (n=53) and the number of formal exits from the program which have been recorded (n=19).

The original intention of the support planning function was to provide intensive short-term case management to coordinate the development of the support plan, rather than to deliver an ongoing case management service. However, partially because of the earlier engagement of case managers, and partially because of the capacity differential between the JH&FMHN neuropsychologists and the case mangers discussed earlier, CIDP participants are receiving significantly more than the original six weeks of support envisaged in the theoretical model. CIDP case managers described the duration of support as more like 6–8 months rather than 6–8 weeks. This has facilitated the smooth and gradual transition to NDIS support coordinators as appropriate and has enabled practical advice and support in accessing services to be given.

Challenges

- Exit data is unclear

The process and timing of exit from CIDP was not clear from the database. Exit dates were shown for seven Gosford participants, all of whom had received a section 32 order. Elapsed time between court outcome and exit date was 31 working days (6.2 working weeks).

- Different agencies have different practices

Exit from the CIDP is further confused as JH&FMHN may exit a client, while IDRS continues to work with the person. This raises the question of whether there are (or should be) multiple exit points from different program stages.

All of the above raises the question of what the most appropriate exit point for program participants is, and to what extent the additional benefit of case management should be included in the model going forward.

Strengths

- Case manager and participant rapport

The strength of the rapport and engagement which the case managers have brought to individual relationships has contributed to the outcomes being achieved. But this has made it more challenging for some participants when they need to exit the program. Managing for the exit from the program from the outset is needed.

Participants' experience

A number of the participants we interviewed told us they found it difficult to imagine ending their work with their CIDP case manager, becoming quite anxious and distressed talking about it, worried they would lose all they had gained. Some who had already exited continued to find it difficult to adjust.

> *[I was] not happy when she [case worker] finished, came out of nowhere.(CIDP participant)*

3.3 CIDP outcomes

The success of the CIDP is seen in the number of section 32 orders and other diversionary orders achieved, the number of NDIS plans and reactivations achieved as well as connections to other services. In addition, there are the qualitative outcomes in the lives of participants as reported by participants and their family members, case managers and service providers.

CIDP is achieving diversion

There are 53 finalised matters of which 46 resulted in a diversion from the courts. There were 40 section 32 orders, four bonds (sections 9, 10 and 12) and two matters where charges were withdrawn. This represents a diversion rate of 87%.

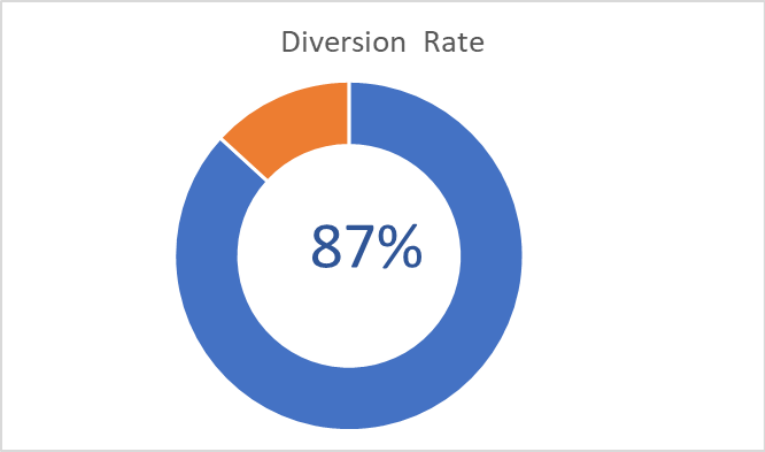


Figure 8: CIDP Diversion rate

In two matters, the JH&FMHN neuropsychologist did not recommend section 32, on the grounds the person may have been exaggerating their level of impairment. Nevertheless, both participants received section 32 orders.[36]

Table 18: Outcomes of finalised matters

Court outcome	Penrith	Gosford	Total
Section 32	22	18	40
Section 9 bond		2	–
Section 10 bond	1		
Section 12 good behaviour bond		1	
Imprisonment	1	1	–
Withdrawn/dismissed	–	2	–
Other		4	
Blank		1	
Total	**24**	**29**	**53**

[36] In one of these, the solicitor did not present the report from the JH&FMN neuropsychologist

CIDP is connecting participants with the NDIS and other services

Accessing NDIS and securing a plan

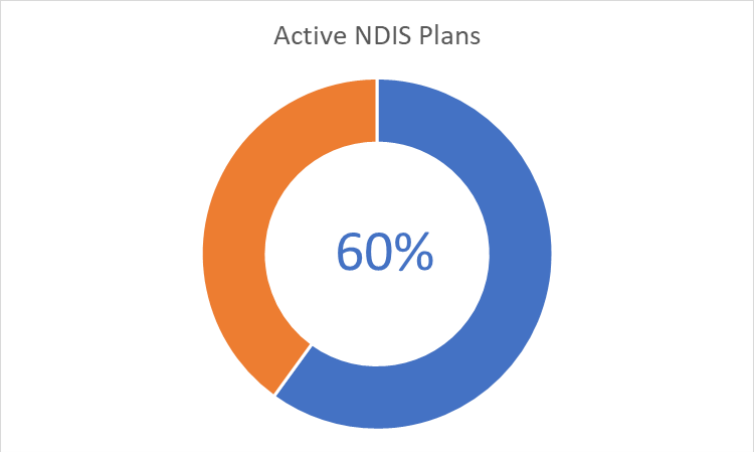


Figure 9: Proportion of eligible participants with an active implemented NDIS plan

At the end of the first 12 months, 46 of 76 participants (60%) had an active implemented NDIS plan (6 November 2018). Three participants were identified as not eligible for the NDIS — one over 65 years of age, one with Lifetime care and support from iCare, and one with Aftercare workers compensation.

NDIS status at the time of referral to case management is shown below. Of available data, we know 15% (12/76) had an active plan and 12% (9/76) had an NDIS plan but it was not implemented.

Table 19: NDIS status at time of referral

NDIS status	Penrith	Gosford	Total
Existing participant with an active and implemented plan	8	4	12
Existing participant with an active but not implemented plan	3	6	9
Not eligible for NDIS	2	1	3
NDIS eligible participant numbers	**42**	**34**	**76**
Total participant numbers	44	35	79

Connections to other services

CIDP case managers assisted participants to make connections with services, mostly through the NDIS, but also more broadly, as was the intent of the model. Most significant amongst these is the connection with housing.

Unstable housing and/or imminent homelessness were presenting characteristics of some participants. Access to stable housing was described as "life changing" for some participants. While it is not a direct cause of offending, it can have an impact on why a participant might offend or reoffend. Securing the basics, food, somewhere to live and be safe is the foundation. As one case manager said:

> *"It's hard for any of us to do any work, really, if we don't have the fundamentals. (CIDP case manager)*
>
> *Six months and we are managing to help people resolve a lot of crisis stuff and get support needs in place (CIDP case manager)*

Table 20: Other supports engaged

Support type	Penrith	Gosford	Total
Accommodation	4	5	9
Education	1	1	2
Employment	2	–	2
Health	3	1	4
Mental health	7	4	11
Legal Advice	–	1	1
Total	**17**	**16**	**33**

Table 20 shows the CIDP data set information about other supports engaged. Housing and support for mental health issues are the two most common support types accessed. As only one support was able to be entered per participant, this is an underreporting of services which have been engaged.

Participants report a range of benefits from CIDP participation

- Some participants received a clinical diagnosis for the first time in their life

Participants were better able to understand themselves.

> *I realise now I mucked up at school because of low IQ.*

- Participants expressed strong satisfaction with the program

Seven participants were specifically asked if they would recommend CIDP to someone in their situation and all said "yes".

> *Happier than I've been in a long time. Everything's going really, really good. As good as it gets. Very happy.*
>
> *CIDP — great for me and helped my life. Immensely. Especially [case manager] but everyone there helped me heaps.*

Other stakeholders expressed high levels of satisfaction with the program and corroborated its impact on participants. The program delivered a wide range of positive benefits to participants, helping them to connect to needed support and services and getting on with leading satisfying and productive lives. This includes the majority of people now connected to the NDIS and examples of connections to other services such as housing.

> *It's wonderful.*
>
> *It's really helped a lot of people who wouldn't have been helped otherwise Even if the matter is not dismissed, the person is in a better place because of the links to services. (Legal Aid)*
>
> *It's great, learning to get my shopping and to cook … A guy who comes on Tuesdays and Thursdays to help me take care of the unit … shows me how to live like an adult.*
>
> *I went to the beach for the first time in three years, it's only close.(CIDP participant)*
>
> We've only scratched the surface [of things I can now do].

Participants told us they achieved goals and set targets in these areas:

- TAFE course
- apprenticeship
- paid employment
- drug and alcohol counselling
- appointments with psychologist
- appointments with psychiatrist
- financial counselling
- victim's compensation
- quitting smoking
- quitting drinking
- living independently with own keys to own accommodation
- being helped to be wait listed for accommodation
- finding a private rental and successfully managing a tenancy
- applying for and receiving the Disability Support Pension
- physical health issues

- community mental health services
- imagining having a family in the future
- bushwalking
- getting a driver's licence
- dealing with financial issues
- gym membership and exercising
- support with housework
- shopping support
- gardening and garden maintenance
- hanging out with more 'positive people'
- volunteering at an animal shelter
- learning housekeeping, shopping, budgeting
- help with writing a shopping list and doing grocery shopping

Participants described the impact of CIDP in ways that went beyond the immediate issue of contact with the criminal justice system. They talked about receiving help with problems they had struggled with for years as well as their experiences of life and exclusion: of access to support, of positive involvement with the community and their feelings of hope for the future.

“ It’s sad to say I had to get into trouble to get support.

[CIDP is] there to help us bring what’s left together.

[CIDP is a] light at the end of the tunnel. They don’t get credit for what they do, it’s worth more than they get, worth more than gold.

I used to be isolated, now I go to the beach … [Case manager helps with issues … I used to hide away, I wanted to be alone. Now I enjoy being out with mates.

Case manager] helps me to cope with problems rather than get into trouble … [case manager] knows disability, how to talk with you.

I’m a better person.

Didn’t have a network and now I have people I can ring up about various things. It’s almost hard to say — a foolscap page of people.

It’s changed my mind about violence.

Any kids with disability in Australia and involved with courts. IDRS is the best place you can reach.

It’s very great.

It’s all about trying really.

If I didn’t get in … [I] get sick in the guts thinking about it.

It’s been amazing … 101% the best thing ever … it was that bad. It saved my life.

Family members reinforced the positive impact of the program on participants' health and welfare. In all, six relatives were interviewed.

> *It saved his life. He is not a mess any more. (Parent)*

Key themes included the importance of the case manager relationship and its impact on the participant and their motivation to avoid reoffending and the access to services which wouldn't otherwise have been easily obtained.

One family member commented that her son's experience with the program gave him an understanding of his limitations, the law and the social skills to behave.

She also commented that everyone, including magistrates, Legal Aid, neuropsychologist, caseworker, had treated him with respect…

> *It's changed his view of himself. (Mother)*

Impacts for family members themselves included having someone to help, a source of advice and ability to focus on their primary role as a parent

> *It's good for us. It gives us someone to talk to. We can find out what's happening. (Grandparents)*

3.4 Summary of CIDP strengths, barriers and opportunities

The evaluation identified a range of strengths in the delivery of CIDP. Some of these are intrinsic to the theoretical model; some are the result of divergence in how the CIDP has been implemented in practice.

There are some aspects of service delivery which could be enhanced. The table below summarises the strengths, barriers and opportunities presented by CIDP today. These have informed the recommendations found in the Executive Summary.

Table 21: Strengths, barriers and opportunities of CIDP

Strengths	Barriers	Opportunities
Screening and assessment: ▪ Practice of JH&FMHN neuropsychologists providing direct feedback to participants helps them understand assessment results ▪ Clinical assessments are free of charge to CIDP participants ▪ (Early) referral to case management at the time of screening shortens the time taken to access supports and facilitates participant engagement Support planning: ▪ Case managers expedite access to the NDIS/ reactivation of NDIS plans ▪ NDIS acceptance of borderline intellectual disability from the ABAS functional assessment assists establishment of NDIS eligibility ▪ Dedicated NDIA support planner in each location streamlines NDIS engagement ▪ Holistic approach of the support plan to meeting the needs of CIDP participants enhances welfare outcomes e.g. stable housing ▪ Strong relationships between case managers and participants underpin participant motivation to succeed Court processes: ▪ Lawyers have comprehensive evidence to support a section 32 application ▪ Lawyers report a reduction in adjournments saving court time ▪ Local court decisions to have separate list days improving court experiences of participants	▪ Staff turnover amongst key stakeholders, requiring ongoing education about CIDP ▪ Informality of referral processes for screening and lack of associated data capture ▪ Assessment on the same day as screening is difficult for participants ▪ Bottleneck with neuropsychologists limiting program capacity ▪ Monitoring — difficulties obtaining updates on participants' engagement with service providers ▪ No clear agreed program exit point/ exit planning– impacts stress of transition for participants	▪ Better program communication and associated promotional material ▪ Quality assurance: (1) Improved Data collection processes and content, including potential to manage data on a dedicated system rather than excel sheets (2) Regular review of CIDP policies & practices based on feedback and data ▪ Investigate if screening can be performed elsewhere/ by others giving the JH&FMHN neuropsychologists increased capacity for assessments. ▪ Investigate alternatives to the current clinical assessment component of the model e.g. panel of psychologists ▪ Identify key assessment tools which can be used to reduce time delays in reports being made available to the NDIS ▪ Participants have benefited from the support role/ case management function providing more hours of support than originally envisaged ▪ Opportunity for the case manager to explain the section 32 orders and conditions to the participant after sentencing ▪ Review who undertakes the function of monitoring and how it is delivered and made meaningful for the participant ▪ Include exit planning as part of early engagement with participants

Section four: Conclusions

The CIDP set itself a challenging task: boosting the rates of diversion from the criminal justice system for a cohort of complex and challenging individuals, some of whom have significant histories of offending.

There were many elements to coordinate; identification and assessments by neuropsychologists employed by JH&FMHN, case management and support planning by IDRS and activation of the NDIS, working with the courts and legal systems to make a section 32 application, development of support plans and possible monitoring by CommCor. Participants have complex needs and the pathway to success has been bumpy for some, with setbacks along the way.

Twelve months in, the process evaluation can point to both the numbers of section 32 orders that have been made (40) and the transformational reports of participants to indicate the success of the program.

Our conclusions are:

CIDP is achieving diversion

- CIDP is boosting the level of diversion from the criminal justice system with 87% of finalised matters resulting in a diversion.

People with cognitive impairment eligible for diversion are being identified

- Two-thirds of individuals recorded as screened for CIDP in its first 12 months of operation were deemed eligible for the program

CIDP is providing participants with a clinical diagnosis

- Nineteen of the 79 participants (almost 25%) received a clinical diagnosis for the first time in their life

Participants are being supported to access the NDIS

- 60% of NDIS eligible participants now have an active implemented plan
- Neuropsychology/clinical assessments, in particular, the functional assessments which are undertaken, provide a body of evidence which streamline NDIS eligibility considerations and provide planners with information about support needs

CIDP is improving the health and welfare of a cohort of people with a cognitive impairment and complex needs

- Participants who have previously missed out on services are now receiving support
- Participants can access a range of services to build a network, rather than single source of support
- Participants report feeling respected and valued in a way not previously experienced.

CIDP is reducing the likelihood of further interaction with the criminal justice system

- In the period covered by the evaluation, amongst the nine participants who had monitoring included, no breaches of their section 32 orders were reported.

There are several ways in which the implementation of the model has diverged from its theoretical model and these have strengthened the program.
These include:

- Screening and assessment undertaken on different days
- Feedback to participants about the results of their clinical assessments
- Referral for case management support at the time of screening
- Dedicated NDIS planners

References

Cognitive Impairment Diversion Program (Pilot) Operational Manual Version 2.2 (19 March 2018)

NSW Law Reform Commission Report 135 (2012) 'People with cognitive and mental health impairments in the criminal justice system Diversion'.

Clift, K. (2014). *Access to the National Disability Insurance Scheme for People with Intellectual Disabilities who are involved in the Criminal Justice System.* Research and Practice in Intellectual and Developmental Disabilities 1(No 1): 24–33.

Richardson, E. and B. McSherry (2010). *Diversion Down Under — Programs for Offenders with Mental Illnesses in Australia.* International Journal of Law and Psychiatry 33: 249–257.

Appendix A: List of stakeholders[37] consulted

Stakeholder category	Details
Face-to-face interviews:	
Department of Justice: Offender Strategy	▪ Shanna Satya*, Director ▪ Rebecca Sobczak*, Manager ▪ Ruchika Nigam*, Policy and Projects Officer
Diversity Services	▪ Yasmin Hunter*, Manager ▪ Nikki Aquiatan*, Senior Project Officer
Community Corrections	▪ Alexandra Young *, Manager, State-wide Reforms ▪ Vedrana Pecer, CommCor Officer (CIDP Program Coordinator)
NSW Health: Justice Health Statewide Community and Court Liaison Service (SCCLS)	▪ Joshua Barber, Clinical Neuropsychology Registrar, Penrith Local Court ▪ Dr Matt Conroy, Clinical Neuropsychologist, CIDP, Gosford ▪ Carolynn Dixon*, Operations Manager, Statewide Community & Court Liaison Service ▪ Professor David Greenberg*, Clinical Director, SCCLS
IDRS	▪ Janene Cootes*, Executive Officer ▪ Benjamin Garcia-Lee*, Manager CIDP ▪ Michael Baker, Justine Taggart, Charlotte Rider & Jillian McCarthy*, IDRS Penrith and Gosford Case Managers
CIDP Participants	Interviews at Penrith and Gosford completed with: ▪ 20 CIDP Participants ▪ 6 family members
Gosford and Penrith Local Courts: Magistrates	▪ Magistrate Hiatt, Penrith ▪ Magistrate Maiden, Gosford
Registrar	▪ Julia Gahan, Deputy Registrar, Penrith Court
NSW CID	▪ Jim Simpson, Senior Advocate
Phone interviews:	
NDIA	▪ Jennifer Pospelyj* Regional Director, Nepean Blue Mountains Region ▪ Nicky Cahill, Team Leader, Local Operations Penrith
Legal Aid	▪ Sarah Ellison, Senior Criminal Solicitor, Penrith Office ▪ Ian Le Breton, Local Court Practice Manager, Gosford
NGO support organisation: Ability Options	▪ Daniel Palffy, Support Coordinator, Sydney Region
Survey for Legal Aid, ALS, ODPP, Police Prosecutors, Court Registrars	
	15 surveys sent, 3 completed

[37] IWG members indicated with *

Appendix B: CIDP IWG terms of reference

Revised terms of reference

On 4 October 2016, the NDIS Board endorsed the use of the NDIS Transition Fund (following approval by the Treasurer and Minister for Disability Services) to fund the CIDP. The aim of the CIDP is to increase the use of diversion options in two Local Courts (Penrith and Gosford) by improving the capacity of the justice system to assess, support and monitor people with a cognitive impairment.

This project will expand court support services to people with cognitive impairment, as recommended by the NSW Law Reform Commission in the Report — People with cognitive and mental health impairments in the criminal justice system: Diversion in 2012. This support may include assistance to lodge an access request with the National Disability Insurance Agency.

The project will also increase the capacity of NSW Community Corrections to monitor the implementation of diversion plans under section 32 of the MHFPA with the aim of increasing judicial confidence that section 32 orders will be enforced.

Objectives

The key objectives of the CIDP IWG are to:

- Undertake key actions to operationalise the CIDP
- Monitor and oversee the delivery of the CIDP
- Evaluate the CIDP
- Report to the NDIS Steering Committee on the delivery of the CIDP

Chair and Secretariat

The IWG will be chaired by Justice Strategy and Policy. Secretariat support will be provided by Justice (Offender Strategy).

Meetings

IWG representatives may be involved in out of session meetings to resolve issues related to their agency.

Membership

The CIDP operates under a shared governance model with an external escalation procedure. The CIDP IWG oversees the implementation and monitoring of the program. All major decisions about the design and implementation of the CIDP are approved by quorum of the IWG.

The CIDP IWG absorbs the responsibilities of the CIDP Control Group, which was dissolved in December 2017.

The CIDP IWG consists of the following agencies which each have their own role in the implementation of the program:

Agency	Responsibilities	Contact
Offender Strategy, Department of Justice	▪ Primary responsibility for coordinating agency involvement in the CIDP. ▪ Primary responsibility for coordinating the evaluation of the CIDP. ▪ Jointly supervises the rollout of the program. ▪ Chairs the IWG. ▪ Provides secretariat support for the IWG. ▪ Coordinates and monitors communication and engagement strategies for the CIDP. ▪ Coordinates the resolution of minor issues in consultation with affected agencies.	▪ Rebecca Sobczak Manager, Offender Strategy ▪ Ruchika Nigam Policy and Projects Officer
Diversity Services, Department of Justice	▪ Primary responsibility for the contract management of the IDRS. ▪ Coordinates the IDRS' delivery of support services. ▪ Escalates issues and concerns raised by the IDRS.	▪ Yasmin Hunter, Manager, Diversity Services ▪ Nikki Aquiatan, Senior Project Officer
Justice Health & Mental Health Forensic Network	▪ Jointly supervises the rollout of the program. ▪ Primary responsibility for the coordination of screening, assessment and reports to the court on mental health and cognitive impairment matters for CIDP participants. ▪ Identifies and manages implementation and policy issues relevant to the clinical screening and assessment of participants.	▪ Professor David Greenberg, Clinical Director, SCCLS ▪ Carolynn Dixon, Operations Manager, SCCLS
Community Corrections, Department of Justice	▪ Primary responsibility for the coordination of monitoring and reporting back to the court for CIDP participants. ▪ Identifies and manages implementation and policy issues relevant to the monitoring and reporting back to the court for CIDP participants.	▪ Alexandra Young, Manager, Major Reforms, Strategic Operations ▪ Monika Klimoski, A/Project Officer, Major Reforms, Strategic Operations
Department of Premier and Cabinet	▪ Advisory role in the development and implementation of the CIDP. ▪ Jointly monitors the expenditure and implementation of the project. ▪ Escalates and resolves issues critical to the success of the project with the NDIS Steering Committee, where required. ▪ Provides updates on the CIDP's implementation to the NDIS Board. ▪ Develops advice on the business case for expanding the project for Cabinet, if required.	▪ Stephen Beverley, Principal Policy Officer, Social Policy Group

Department of Family and Community Services	▪ Advisory role in the development and implementation of the CIDP. ▪ Provides expert advice on the cohort and their interface with the criminal justice system.	▪ Anna Edwards, Director, Community Justice Program (CJP)
National Disability Insurance Agency	▪ Provides advice to the CIDP IWG as required. ▪ Advisory role in the development and implementation of the CIDP. ▪ Identifies policy issues relevant to the interface between the CIDP and the NDIS and reports back to the IWG. ▪ Provides expert guidance on the types of information required within the SCCLS clinician's reports to streamline participant access to the NDIS. ▪ Coordinates priority access of CIDP participants to the NDIS. ▪ Coordinates the provision of a support coordinator to each CIDP participant.	▪ Donna Weekes, Director — NSW/ACT, Community and Mainstream Engagement ▪ Jennifer Pospelyj, Director, Nepean Blue Mountains Region
Intellectual Disability Rights Service	▪ Provides advice to the CIDP IWG as required.	▪ Benjamin Garcia-Lee, Manager, CIDP (IDRS) ▪ Janene Cootes, Executive Officer, IDRS

Escalation procedure

1. **Local level** — Any agency can resolve an issue at a local level, only if it is a minor operational/other issue with no impact on the CIDP model endorsed by the IWG. The resolution of all issues at the local level should be recorded for the purpose of the process evaluation.

↓

2. **Offender Strategy** — Offender Strategy will coordinate the resolution of minor operational/other issues between agencies that cannot be resolved at point 1.

↓

3. **CIDP Implementation Working Group** — The CIDP IWG will consider issues that cannot be resolved at points 1 and 2.

↓

4. **Deputy Secretary** — Relevant Deputy Secretaries/Assistant Commissioners of NSW government agencies represented on the IWG will consider issues that cannot be resolved at point 3.

↓

5. **NDIS Steering Committee** — The NDIS Steering Committee will consider issues that cannot be resolved at point 4. Issues and resolutions will be reported within progress reports to the NDIS Steering Committee.

Appendix C: What is diversion?

The 2012 NSW Law Reform Commission (LRC) Report "People with cognitive and mental health impairments in the criminal justice system: Diversion" described diversion broadly defined as:

"measures to divert the offender out of the criminal justice system and into treatment or rehabilitation."

The report adopted an even broader definition, suggesting that diversion could refer to:

any "alternative" processing option which can occur at any stage of the criminal justice system.[38]

[38] P26 NSW Law Reform Commission Report 135 (2012) "People with cognitive and mental health impairments in the criminal justice system Diversion"

Appendix D: Types of diversion

Section 32 diversion

Section 32 of the MHFPA is the core of diversionary practice in NSW.

Under section 32(2) the magistrate may do any one or more of the following:

(c) adjourn proceedings,
(d) grant the defendant bail in accordance with the *Bail Act 2013*,
(e) make any other order that the magistrate considers appropriate

(3) the magistrate may make an order dismissing the charge and discharge the defendant:

(a) into the care of a responsible person, unconditionally or subject to conditions, or
(b) on the condition that the defendant attend on a person or at a place specified by the magistrate:
    (i) for an assessment or treatment (or both of the defendant's mental condition or cognitive impairment,
    or
    (ii) to enable the provision of support in relation to the defendant's cognitive impairment, or
(c) unconditionally.

Other types of diversion

In addition to section 32, the other diversion orders which might be made include:

- MHFP Act 1990
  - Section 33
- Criminal Procedure Act
  - Dismissal of matter if matter withdrawn
    (1) If a matter is withdrawn by the prosecutor, the matter is taken to be dismissed and the accused person is taken to be discharged in relation to the offences concerned.
    (2) The dismissal of a matter because of its withdrawal by the prosecutor does not prevent any later proceedings in any court for the same matter against the same person.

- Crimes (Sentencing Procedure) Act 1999
  - Section 12 — A good behaviour bond is an order from a magistrate that a person be of 'good behaviour' for a specified amount of time, with or without other conditions. The bonds allow an offender to be released into the community rather than serve time in jail. The conditions of the bond must be accepted by the defendant, who signs the bond as a promise to comply with it.
  - Section 9 — empowers the court, following a conviction, to direct an offender to enter into a bond to be of good behaviour for a specified period.
  - Section 10 — If a Court is satisfied that it would not be expedient to punish a person, or if it is satisfied that it would be more expedient to require a defendant to enter into a good behaviour bond, then it may make a section 10 order.

Appendix E: Master Index Number (MIN)

A MIN is a six-digit identity number given to an inmate when they are first incarcerated. They retain this number for all subsequent incarcerations. This number will be on an inmate's ID card and all other department records. A MIN does not change even if an inmate changes correctional centres. A MIN can be linked with or used when:

- Linking phone numbers of family/friends to the inmate for contact when in custody
- Organising inmate dental appointments
- Receiving mail at a correctional facility
- Making enquiries at a correctional facility

A MIN will not reveal an offender's entire criminal history, it will only reveal convictions which led to contact with Corrective Services. A MIN is used to manage information about an offender.

Appendix F: Case studies

IDRS shared these case studies of CIDP participant experiences and outcomes

- Ricky[39] has a significant criminal history and an acquired brain injury. His brain injury means he has trouble regulating his emotions; as a result, he has been banned from many services and has spent significant amounts of time in prison. Following discharge from his initial inpatient brain injury treatment, Ricky did not receive any formal supports and had difficulty coping with Centrelink Newstart job seeking requirements. Through his involvement in CIDP case management, Ricky received section 32 orders for a number of outstanding offences. He now has the Disability Support Pension, access to the NDIS and a support coordinator with a suite of funded supports. His contact with the criminal justice system has decreased significantly.
- Jim has Huntington's Disease and was referred to CIDP following an allegation of sexual assault in a public place. This was his first contact with the criminal justice system. When he was charged, Jim was not in supported accommodation and did not have a NDIS plan. After participating in CIDP, he was granted a section 32 order, received a substantial NDIS package including supported accommodation, and now has the supports in place he will need as his condition deteriorates.
- Lara was charged with a series of offences related to dishonesty, which involved serious breaches of trust. Lara was facing jail time for her offences. Prior to entering CIDP Lara was assessed to be at high risk of reoffending by a consultant psychiatrist. Through participating in CIDP she is now working in a position of responsibility, is drug free and has not reoffended. When asked by her solicitor why she has not reoffended she stated, "because now I have too much to lose".
- John is an Aboriginal man with an intellectual and physical disability who was living on his own with no formal and extremely limited informal support. As a result of the number of assaults he had received throughout his life John was very cautious about going out in the community. The sitting magistrate felt John was not suitable for a section 32 because of his drinking and violent behaviour towards police. CIDP supported John through his court case and he eventually received a Community Corrections Order. Even though he did not receive a section 32 order, with CIDP case management support, John's NDIS was approved and he now receives one-on-one support twice a week. He uses this time to do his grocery shopping, difficult chores around the home and attend appointments. John is now enjoying regular social outings. He regularly tells his case manager how much his life has changed in just a few months, how it makes him feel valued. The support has given him confidence not only in the community but in dealing with people in general. John feels more optimistic about his future and more able to navigate the challenges of daily life on his own.

[39] Names have been changed

- **Bill** was referred to CIDP and was homeless and living on the trains. He was under a Community Treatment Order (CTO) for his chronic schizophrenia. He had 11 charge sequences in the 12 months before his referral. He has been a CIDP participant for six months and had three new charges during this period, all of which were dismissed under section 32. With the support of his case manager he has secured permanent housing, is no longer on a CTO and is now receiving disability related supports from the NDIS.

Appendix G: Easy Read participant information sheet

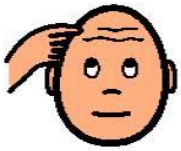
Cognitive Impairment Diversion Program (CDIP)
Information sheet

This information sheet tells you about the **Cognitive Impairment Diversion Program (CIDP)** evaluation.

You can ask for help to read this information sheet.

Evaluation means taking a close look at a program to decide if it works well or not.

What is the CIDP?



The CIDP is a way for people with disability to:

- Get support instead of going to jail
- Access the National Disability Insurance Scheme (NDIS)
- Connect with support services

The CIDP is run by the NSW Department of Justice.

Evaluation

WestWood Spice is helping the NSW Department of Justice find out how well the CIDP works.

They want to find out if the CIDP can work better.

WestWood Spice is not part of the government.

WestWood Spice would like to find out if the CIDP has helped you.

They would like to talk to you:

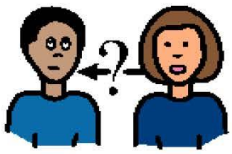
- face to face

or

- on the phone

They would like to talk to you for about 30 minutes.

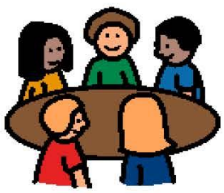
What questions will they ask?



WestWood Spice will ask you questions like:

- Have things in your life changed because of the CIDP?
- Do you think the changes are good or bad?
- Has the CIDP helped you with court?
- What do you think of the services you are getting?
- What could make CIDP better?

Support person



You can ask someone you trust to be with you when you talk to WestWood Spice.

Your support person could be a friend, advocate or family member.

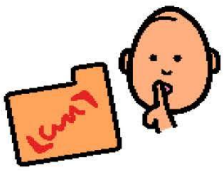
Your CIDP support worker cannot be your support person for the evaluation.

Your privacy

WestWood Spice will only talk with you about the CIDP.

They will keep what you tell them safe and private.

They will use what you say about the CIDP to write a report.



Your name will not be in the report.

The report will be about how the CIDP is working.

It will give your ideas for improvements.

It's your choice

You do not have to speak to WestWood Spice.

You can also change your mind and stop during the conversation if you want to.

You will not get into trouble if you decide not to talk to WestWood Spice.

Your family

WestWood Spice may also like to talk to your family.

You can decide if you agree that WestWood Spice can talk to your family.

You can say YES or NO on the consent form.

Consent means you agree to talk with WestWood Spice about the CIDP.

If you decide to talk to WestWood Spice:

- You will need to sign a consent form and give it to your CIDP support worker (NAME).
- WestWood Spice will give you a $50 Coles/Myer gift card to say thank you for your time.

If you consent, your CIDP caseworker will

organise for you to meet with WestWood Spice at the IDRS offices.

Gosford: 4 Karalta Lane, Erina NSW 2250

Penrith: Suite 105, 114-116 Henry St, Penrith 2750

Who can I talk to for more information about the CIDP evaluation?

You can ring BEN at IDRS on 0427 462 208

You can email:

cidp@justice.nsw.gov.au

suewarth@westwoodspice.com.au

Ethics Review Ethics review means:

- Checking that the project is safe
- Checking your personal information is kept confidential
- Checking that you are asked to give your consent

An independent committee called the Bellberry Human Research Ethics Committee has approved this evaluation.

If you have any concerns or complaints you can ring the Operations Manager Bellberry Limited on 08 8361 3222

Appendix H: Participant consent form

Cognitive Impairment Diversion Program (CIDP) Evaluation

Consent Form

Project Evaluators:

- Susan Warth, Principal Consultant, WestWood Spice
- Justine O'Neill, Associate Consultant, WestWood Spice

Name of CIDP participant (print): .....

I agree:

- ☑ I have been told about the evaluation project and why it is important
- ☑ I understand the explanation
- ☑ I have been given a copy of the evaluation information sheet
- ☑ I have been able to ask questions and get answers about the evaluation
- ☑ I agree to take part in the CIDP evaluation
- ☑ I understand my information will be confidential
- ☑ I understand that I can withdraw at any time

YES/NO You may contact my family

Signature: .....

Date: .....

I confirm I have discussed the evaluation project with

..... (Name of participant)

and I believe they understood the explanation.

Name of Principal Investigator / Co- Investigator:.....

Signature: .....

Date: .....

WestWood Spice is contracted to the NSW Department of Justice to evaluate the CIDP program.

Appendix I: IDRS original KPIs

1. The CIDP support worker attempts to contact at least 90% of defendants within one business day of receiving the referral from the SCCLS.
2. The CIDP support worker submits an NDIS Access Request Form within five business days of receiving the assessment report from SCCLS (if no additional report is required) for at least 90% of CIDP participants who agree to test their NDIS eligibility.
3. At least 90% of CIDP participants who have an existing NDIS plan, have a plan review lodged within seven business days of the Provider receiving a copy of the existing plan, if the Provider identifies that there has been a change in the person's circumstances and the participant consents.
4. The CIDP support worker attends at least 90% of NDIS planning meeting/s with the participants (with their consent) except when a more appropriate representative is able to attend.
5. When a plan is identified as being insufficient or inappropriate in meeting the needs of the CIDP participant, the review period has not expired and the participant consents, the Provider escalates the issue with the National Disability Insurance Agency and notifies SCCLS within five business days of receiving the plan.
6. At least 90% of CIDP participants are referred (if the CIDP support worker deems it appropriate and the CIDP participant consents) to a form of mainstream/community-based support service within seven business days of receiving the assessment report from SCCLS.
7. A progress report outlining the status of the CIDP participant's NDIS Access Request and NDIS planning, any NDIS Plan details, and any additional support services to which the CIDP participant is connected, is provided to the local SCCLS worker for at least 90% of CIDP participants within six weeks from the initial referral.