

18 December 2020

The Honourable Ronald Sackville AO QC  
Commissioner  
Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

By email to: [DRCenquiries@royalcommission.gov.au](mailto:DRCenquiries@royalcommission.gov.au)

Dear Commissioner

**Re: Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability**

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide input into the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

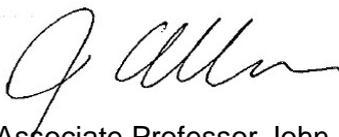
The RANZCP is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and is responsible for training, educating and representing psychiatrists on policy issues. The RANZCP represents more than 5100 qualified psychiatrists and 1800 trainees across Australia and New Zealand and is guided on policy matters by a range of expert committees, including the Section of Psychiatry of Intellectual and Developmental Disabilities.

The RANZCP recognises the important role of the Royal Commission in working towards a future where people with disability can be free from violence, neglect, abuse and exploitation. Stigma, discrimination, out-of-pocket costs, poor sector connectivity and inequitable access to mental health services are some issues of concern for psychiatrists in reference to people with mental health conditions and people with intellectual and developmental disability.

The RANZCP provides this submission with the aim of addressing gaps as discussed in the Interim Report, as well as providing practical solutions to the challenges facing this sector.

To discuss any of the issues raised in this letter and submission, please contact Rosie Forster, Executive Manager, Practice, Policy and Partnerships Department via [rosie.forster@ranzcp.org](mailto:rosie.forster@ranzcp.org) or by phone on (03) 9601 4943.

Yours sincerely



Associate Professor John Allan  
**President**

Ref: 2029



The Royal  
Australian &  
New Zealand  
College of  
Psychiatrists



Submission to the Royal Commission into Violence, Abuse, Neglect and  
Exploitation of People with Disability

December 2020

# Improve the mental health of communities

# Royal Australian and New Zealand College of Psychiatrists submission

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

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### **About the Royal Australian and New Zealand College of Psychiatrists**

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 6900 members including more than 5100 qualified psychiatrists and over 1800 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

The following RANZCP committees provided input into this submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability:

- Section of Psychiatry of Intellectual and Developmental Disability
- Section of Private Practice Psychiatry
- Faculty of Child and Adolescent Psychiatry
- Section of Perinatal and Infant Psychiatry
- Faculty of Adult Psychiatry
- Faculty of Addiction Psychiatry
- Practice, Policy and Partnership Committee
- Committee for Evidence-based Practice
- Community Collaboration Committee

These committees are made up of psychiatrists engaging with people with disability and community members with lived experience. As such, the RANZCP is well positioned to provide advice about this issue due to the breadth of academic, clinical and service delivery expertise it represents.

### **Key messages**

- All people with disability should be treated as individuals with respect and dignity.
- Many barriers still exist for people with disability in accessing mental health services.
- Systems should be co-designed to remove barriers, stigma and discrimination for people with disability such as health, transport, education, employment, housing and justice.
- Ensure all service providers are provided training and education to better support people with disability.
- Policy and service development should be co-designed to better meet the needs of people with disability, remove stigma and discrimination and address barriers to services and healthcare.

### Introduction

The RANZCP commends the establishment of the Royal Commission into the Violence, Abuse, Neglect and Exploitation of People with Disability (the Royal Commission). The Royal Commission is an important step towards recognising the stigma, discrimination and inequity faced by people with disability throughout society, in the past and contemporarily. Importantly, the RANZCP recognises the role of the Royal Commission in working towards a future where people with disability can be free from violence, neglect, abuse and exploitation.

The RANZCP welcomes the release of the Interim Report from the Royal Commission as the first step in highlighting the stories of people with disability, their family and carers and how change for a more inclusive society may be achieved.

People with disability should be treated with respect, dignity and always with acknowledgment of their individuality. Additionally, people with disability should have legal capacity on an equal basis with others in all aspects of life.[1] Violence, abuse, neglect or exploitation of people with disability is unconscionable and should not be tolerated under any circumstances.

The World Health Organisation describes disability as the interaction between individuals living with a health condition and the personal and environmental factors which are experienced as a result of that condition, such as stigma or inequitable access to services and support.[2] The RANZCP highlights the importance of recognising that there are many different types of disability that require consideration in their own right as they face different challenges.

People with disability comprise approximately 17.7 percent of the population in Australia.[3] Approximately 615,000 or two to three per cent have a severe mental health condition, a further 1.2 million people have a moderate mental health condition in Australia.[4]

While the precise prevalence of people with intellectual disability in Australia varies, suggested prevalence varies between 0.42% to as high as 3%.[5-7] The actual prevalence of intellectual disability and mental health conditions is difficult to say with certainty due to different definitions of intellectual disability and the separation of mental health from disability services; as a result, estimates of prevalence vary significantly.[8-11]

Likewise, prevalence of people with intellectual disability who also have a mental health condition is also difficult to estimate due to methodology problems [12] though suggestions in Australia estimate that the majority (57%) of people with intellectual disability also have a comorbid mental health condition.[13] An Australian Bureau of Statistics household survey in 2015 reported that 125,000 Aboriginal and Torres Strait Islander people identified themselves as living with a disability and 38,100 reported having a severe or profound disability requiring assistance or support in undertaking day-to-day tasks.[14, 15]

Though much progress has been made in calling attention to stigma around mental health, people with disability, including those with mental health conditions, continue to face difficulties with access, stigma and discrimination. These barriers negatively impact on an individual's right to enjoy a fulfilling life. Ensuring that all people with disability can fully engage with all aspects of the private and public sphere is critical in improving the health and wellbeing of people with disability.

The RANZCP provides this submission with the aim of highlighting any remaining gaps which were unaddressed by the Interim Report, as well as providing practical solutions to the challenges facing this sector. This submission, in response to the Royal Commission, will focus on people with mental health conditions, and people with intellectual and developmental disability, acknowledging the complexities of comorbidities of these conditions with other disabilities, including physical, sensory, and other types of disability.

### Summary of recommendations

#### *Ensuring access to mental health services*

- Establish an advisory body by Government that includes industry experts, consumers, families and carers so that the needs of people who have difficulty advocating for themselves are taken into account in policy development and implementation. This would include people with intellectual disability and people with mental health conditions
- Address the needs of people with disability, including intellectual disability, within all relevant health, mental health and disability frameworks and policy, including implementation.[16] (while recognising the diversity of need)
- Ensure all government advisory bodies consult with relevant expert, consumer and carer representation so that the needs of people with disability are taken into account which recognises the heterogenous nature of this group.
- Ensure accountability of the quality of care across all mental health services for people with disability, particularly people with intellectual disability.
- Develop specialist mental health services to address service gaps for people with complex and challenging behaviours. These will need to work collaboratively with the NDIS and criminal justice sector.
- Invest in accreditation of medical, nursing, psychology, allied health and support worker training at all tertiary and relevant training institutions. This should mandate specific competencies in the provision of culturally safe mental healthcare to people with disability and people with intellectual disability and include the use of augmentative and alternative communication.
- Improve the ability of services to engage with culturally and linguistically diverse (CALD) clients either through increasing the diversity of their own staff or through effective cultural competency training for staff at all levels.[17]

#### *Improving connectivity between disability and health supports*

- Communicate the responsibilities clearly of federal and state governments in the delivery of health and disability services to enable accountability in service provision.
- Address the needs of people with intellectual disability in specialist inpatient and community mental health services by developing services and projects which aim to address the mental health needs of people with intellectual disability.
- Establish routine data collections of service provision and outcomes in relation to people with disability, to allow for evaluation of effectiveness of service delivery, ensuring outcomes are routinely reported.
- Ensure a cohesive national approach is taken to address the needs of people with intellectual disability including adequate funding to ensure actions can be developed, coordinated and implemented appropriately.[16]
- Create ongoing linkage between state and federal datasets to enable examination of mental health outcomes and service use for people with intellectual disability.[16]

#### *Cost and financial barriers*

- Develop Medicare Benefits Scheme items which are specifically for people with intellectual disability to help improve their access to mental health services.

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### *Telehealth*

- Continue the expansion of telehealth services and access to other assistive communication technology for adults and children with disability to better ensure access to appropriate health care.

### *Emergency planning*

- Prepare a continuity or emergency plan to protect and support people with disability in the event of another emergency or disaster. This should include planning for appropriate schooling arrangements for children with disability and parents with disability and their families.

### *Advocacy and carers*

- Identify and address service gaps for advocacy especially for hard to reach populations including people in remote communities, people who identify as culturally and linguistically diverse and people who are homeless.
- Increase the number of, and funding for, advocacy services for people with disability in urban, regional and rural areas, and both broad and targeted promotion of these services once gaps have been identified by mapping to ensure people with disability have adequate advocacy services (particularly in hard-to-reach populations).[15]
- Ensure better monitoring of health and disability service providers to better safeguard the rights of people with disability against abuse, violence and neglect.
- Provide adequate access to respite for carers of people with disability especially those that care for people with complex and challenging behaviours.

### *Use of restrictive practices*

- Develop education and training across all sectors in supporting and engaging with people with disability, with extensive modules on listening to and providing support to people with intellectual disability or those who display challenging behaviour or non-verbal means of communication.

### *Over exposure of people with disability in the criminal justice system*

- Invest in a nationwide court diversion program for people with disability to ensure that appropriate alternative pathways are available, addressing over-representation of people with disability in the criminal justice sector.
- Develop appropriate community-based service models to meet the needs of people with disability detained in custody after being found unfit to stand trial.
- Ensure people with disability are identified while in, and transitioning out of, the criminal justice sector so they are able to get the support they need, facilitate reintegration and reduce recidivism.
- Ensure people with intellectual and developmental disability have access to additional models of care, and access to appropriate facilities while in the criminal justice system.
- Develop culturally appropriate models of care of Aboriginal and Torres Strait Islander people in the criminal justice system including appropriate early testing and screening for disability.

### *Stigma and discrimination*

- Ensure people with disability are well represented and involved in all levels of decision making and design across all sectors including transport, health, and housing. This will need to consider the different types of disability and how to include people with intellectual and developmental disability.

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- Ensure robust protections exist against stigma and discrimination for people with disability (including those with mental health conditions) including provision of appropriate resources for people with disability to challenge stigma and discrimination.

## *National Disability Insurance Scheme (NDIS)*

- Increase the number of, and funding for, advocacy services for people with disability in urban, regional and rural areas, and both broad and targeted promotion of these services.[15]
- Create Medicare Benefit Schedule-style items for health professionals to conduct assessments for NDIS purposes, to support more equitable access to the NDIS for people with disability and allow people with disability more choice in decisions which impact their NDIS journey.

### Ensuring access to mental health services

People living with disability have varying experiences and needs, often having higher health needs than the general population, and report difficulty in accessing adequate health care services with one in eight people with disability, aged under 65 years old, reporting they had no source of assistance to help them access health care.[18]

This is particularly concerning as generally, people with disability report poorer overall health and higher levels of psychological distress than people without disability.[19] AIHW data suggests adults with severe or profound disability are almost 12 times as likely as adults without disability to experience a 'very high' level of psychological distress.[19]

Barriers occur for a variety of reasons. People with disability may have difficulty in recognising or describing symptoms and be dependent on others to identify symptoms and take them to health services. Problems are often mistakenly attributed to the disability rather than considering other possibilities. Services may not wish to admit a person with disability due to concerns about their vulnerability, fears that hospital admission may exacerbate the issue and lack of appropriate treatment programs and facilities. Issues around consent or record access may impact on their ability to obtain care. Stigma, discrimination and exclusion are also a significant barrier to service access.

The RANZCP regards inequity in access to health services faced by people with disability as a human rights issue which must be addressed. The Convention on the Rights of People with Disabilities (CRPD) defines persons with disabilities as 'those who have long-term physical, mental, intellectual or sensory impairments which in interactions with various barriers may hinder their full and effective participation in society on an equal basis with others'.[20]

People with disability who identify as CALD are not a homogenous group, having a wide range of needs and experiences. It is estimated that people who identify as CALD access disability services up to two thirds less than Australian born people, though there is a similar rate of disability.[21] Language barriers may be a key factor impacting awareness and access to services.[22] Gaps in services and supports for people who identify as CALD remains an ongoing challenge for governments. In addition, people in offshore immigration centres with disability have unclear access to support services.

Compared to the general population, people with intellectual disability experience higher rates of mortality [23], mental illness [24] and common neurodevelopmental comorbidities [25] as well as other medical comorbidities such as epilepsy.[26] People with intellectual disability require more support than other people to navigate the health system and would be best undertaken by someone in a case management type role as a means to assist those who may need more support in providing informed consent.

The RANZCP recognises that a key barrier to equitable access is workforce education and training. Equipping the workforce to develop specialist skills in populations of relevance including those with intellectual and developmental disability is urgently needed to increase access and reduce barriers to healthcare. Unfortunately, many educational components for health professionals contain little education and training on providing healthcare to people with intellectual disability.[27] Most hospitals do not have specific guidelines, resources or training programmes to guide staff on how to interact with people with a disability or how treatment and management may need to be modified. The mental health needs of this population requires the development of appropriate policies that clarifies the roles and responsibilities of generic mental health services with additional training for clinical staff and access to expert advice and opinion. Any education and training on intellectual disability should include cultural safety and the use of augmentative and alternative communication as core elements. All training across sectors, must also work towards dismantling stigma and discrimination against people with disability. In the United Kingdom this is also helped by specialist models of care for people with intellectual and developmental disability.[28]

In addition, despite the high rates of mental health conditions and difficulties in accessing services, people with intellectual disability are often not specifically included in mental health policy [29] and therefore, any policy implementation.

Recommendations:

- Establish an advisory body by Government that includes industry experts, consumers, families and carers so that the needs of people who have difficulty advocating for themselves are taken into account in policy development and implementation. This would include people with intellectual disability and people with mental health conditions
- Address the needs of people with disability, including intellectual disability, within all relevant health, mental health and disability frameworks and policy, including implementation. [16] (while recognising the diversity of need)
- Ensure all government advisory bodies consult with relevant expert, consumer and carer representation so that the needs of people with disability are taken into account which recognises the heterogenous nature of this group.
- Ensure accountability of the quality of care across all mental health services for people with disability, particularly people with intellectual disability.
- Develop specialist mental health services to address service gaps for people with complex and challenging behaviours. These will need to work collaboratively with the NDIS and criminal justice sector.
- Invest in accreditation of medical, nursing, psychology, allied health and support worker training at all tertiary and relevant training institutions. This should mandate specific competencies in the provision of culturally safe mental healthcare to people with disability and people with intellectual disability and include the use of augmentative and alternative communication.
- Improve ability of services to engage with culturally and linguistically diverse (CALD) clients either through increasing the diversity of their own staff or through effective cultural competency training for staff at all levels.[17]

### *Improving connectivity between disability and health supports*

The RANZCP maintains that acknowledging the significant intersection between health and disability is imperative in improving the outcomes for people with disability.[30]

There are significant gaps in data for people with mental health and intellectual disability. For example, for people without intellectual disability a measure such as the Australian Unity Wellbeing Index, [Australian Centre on Quality of Life](#), is a helpful resource in identifying health outcomes. However, any survey or consultation must also be modified for some people with intellectual disability who may need support to complete such a survey. This gap in data access ensures a failure to grasp health outcomes for people with disability, particularly people with intellectual disability.

The RANZCP would like to highlight that ensuring health and wellbeing measures are completely inclusionary is important in providing better understanding of the interventions needed [31] to support the health of people with disability, especially those with intellectual disability.

Recommendations:

- Communicate the responsibilities clearly of federal and state governments in the delivery of health and disability services to enable accountability in service provision.

- Address the needs of people with intellectual disability in specialist inpatient and community mental health services by developing services and projects which aim to address the mental health needs of people with intellectual disability.
- Establish routine data collections of service provision and outcomes in relation to people with disability, to allow for evaluation of effectiveness of service delivery, ensuring outcomes are routinely reported.
- Ensure a cohesive national approach is taken to address the needs of people with intellectual disability including adequate funding to ensure actions can be developed, coordinated and implemented appropriately.[16]
- Create linkages between state and federal datasets to enable examination of mental health outcomes and service use for people with intellectual disability.[16]

### *Cost and financial barriers*

Out-of-pocket costs for people seeking health services are rising across Australia.[32] People with disability are particularly vulnerable in facing financial barriers when accessing health services due to a combination of factors. People with disability may experience poverty as they may have a limited ability to work due to system constraints and bias (and thereby reducing earning potential) and have high levels of need for items such as expensive medications which impacts quality of life and limits choice.[33] People with disability also often have comorbidities which can require specialist health care, oral health care, frequent health appointments and expensive medication, all of which have large out-of-pocket costs, even for those with private health insurance.

Many people with intellectual disability may struggle to finance their healthcare. Notably, most of the health care services for people with intellectual disability are not appropriately covered by the Medicare Benefits Scheme (such as reviewing past assessments and history, liaising with family and carers, travel for home visits). Given that these services are not appropriately covered by Medicare Benefits Scheme, it may be more costly for health practitioners to provide these services to those who need them.

As a result, the RANZCP recognises that people with disability are even more vulnerable to out-of-pocket health costs which must be addressed to help increase healthcare outcomes for this group.

### Recommendations:

- Develop Medicare Benefits Scheme items which are specifically for people with intellectual disability to help improve their access to mental health services.

### *Telehealth*

The RANZCP highlights that the use of telehealth may be helpful in bridging the gap between people with disability and access to health services. While working towards better face-to-face access to services is essential for people with disability, telehealth has the potential to increase access to health services, encouraging independence and self-determination for people with disability [34], for example, using telehealth limits the need for transport. Benefits of telehealth for carers of people with disability, such as increased access, must also be considered.

The expansion of Medicare Benefit Schedule items for telehealth consultations in the current COVID-19 pandemic in Australia has highlighted the ability of the system to further utilise communication technology to enhance access to health services. While telehealth consultations may not suit all people or situations, the RANZCP urges the continued expansion of telehealth in psychiatry as a complement to face-to-face consultations as a means of increasing access to, and offering more choice, for people with disability to attend medical appointments.

### Recommendations:

- Continue the expansion of telehealth services and access to other assistive communication technology for adults and children with disability to better ensure access to appropriate health care.

### *Emergency planning*

The recent COVID-19 pandemic has clearly further highlighted the vulnerability of people with disability within the current structure and systems of Australian society. The RANZCP encourages the Australian Government work together with state and regional governments to ensure a continuity plan is available in preparation for the next emergency response. Such a plan is needed to ensure people with disability will have support and services in the event of another emergency or disaster. This should include natural and man-made emergencies, ensuring access to essential services and protection for workers and carers. Further to this, such a plan should apply to all people with disability, not only NDIS participants. Input from people with disability and carers should be included in any emergency planning.

### Recommendation:

- Prepare a continuity or emergency plan to protect and support people with disability in the event of another emergency or disaster. This should include planning for appropriate schooling arrangements for children with disability and parents with disability and their families.

### *Advocacy and carers*

People with disability may find it difficult to negotiate the physical, social and political environment without assistance from others. This lack of access to the public sphere is a human rights issue and is the direct result of a world which excludes them from fully participating in society.[33]

The RANZCP fully acknowledges that the role of family and carers in advocacy for people with disability cannot be overstated. People with disability, particularly those with intellectual or developmental disability and/or mental health conditions, often require support from family, friends and carers in everyday life. Families, friends and carers play a critical, but often overlooked, role in providing further context of challenges and needs faced by their loved one, liaising with support people to ensure better outcomes.[35] Within the recovery model and with the fluctuating nature of psychosocial conditions, family and friends often provide crucial support in monitoring, identifying and assisting people during challenging times when they may be unable to make decisions or help themselves.[30] Supporting carers can improve continuity and quality of support for people with disability.[30]

The need for advocacy can be particularly challenging for those with disability who do not have someone who can provide them with support and assistance or instances where carers or advocates do not work in the best interests of the person with disability. Advocacy services exist but medical practitioners may be unaware of local advocacy services, so it is important for networking to be undertaken. Mapping of services which includes scope and access location, need to be undertaken to highlight where gaps exist and how they may best be filled. This is particularly relevant for hard to reach populations such as people in remote communities, people who identify as CALD and people who are homeless to access appropriate services such as disability support or the NDIS.

Carers are often left without adequate respite from those they care for placing them at risk of health issues including poor mental health.[33] Please refer to RANZCP's [Position Statement 76 on supporting carers in the mental health system](#) for more information.

### Recommendations:

- Identify and address service gaps for advocacy especially for hard to reach populations like people in remote communities, people who identify as culturally and linguistically diverse and people who are homeless.
- Increase the number of, and funding for, advocacy services for people with disability in urban, regional and rural areas, and both broad and targeted promotion of these services once gaps have been identified by mapping to ensure people with disability have adequate advocacy services (particularly in hard-to-reach populations).[15]
- Ensure better monitoring of health and disability service providers to better safeguard the rights of people with disability against abuse, violence and neglect.
- Provide adequate access to respite for carers of people with disability especially those that care for people with complex and challenging behaviours.

### Informed consent and involuntary treatment

Informed consent and involuntary treatment are complex, remaining an ongoing challenge within the mental health sector. It is important that a person is considered to have decision-making capacity unless proven otherwise and that it is clearly recognised that a person's capacity for decision-making varies for decisions and situations.[36]

The implementation of [Supported Decision Making](#) (SDM) is recognised both in Australia and internationally, as challenging and requiring significant reorganisation, innovation and change to mental health care.[37] A key theme identified by RANZCP members are concerns around supporting a consumer's care decision in cases where psychiatrists have identified potential risks of harm to self or others.

Additionally, the role of carers and family also significantly impacts this area.

Consistent with the United Nations principles for the protection of people with mental health conditions, all states and territories have legislation governing the circumstances in which people with mental health conditions can be provided with treatment without their consent, the use of restrictive practices and the process of review.[38, 39]

However, a number of jurisdictions also have separate legislative approaches to providing treatment to people with intellectual disability who are unable to consent to treatment including treatment for mental health conditions.[40]

The RANZCP also has concerns in regard to consent and involuntary treatment:

1. It creates circumstances in which a person can be administered involuntary treatment or detained purely on the basis of having a disability which would appear to contravene the requirement of the United Nations CRPD which states that the existence of a disability shall in no case justify a deprivation of liberty.[41]
2. People with a disability are often subject to different threshold criteria for a decision about when involuntary treatment can be administered.
3. Different standards and processes are used for people with an intellectual disability in relation to the ongoing monitoring and review of the administration of involuntary treatment and use of restrictive practices.

4. People with intellectual disability are often in receipt of treatment without a diagnosis to justify the treatment.

Increased access to, and understanding of, augmentative and alternative communication is critical to improving the lives of people with disability particularly those who communicate non-verbally in being able to advocate for themselves and support decision making.

### **Use of restrictive practices**

Restrictive practices are generally used with the aim of preventing injury and reducing agitation but it is now well recognised that their use can be traumatic and may infringe on the rights of individuals with mental health conditions.[42] Due to the potential trauma arising from the experience of restraint and seclusion for the individual concerned as well as families and staff, it is important that mental health services in Australia continue to work towards minimising, and where possible eliminating, the use of seclusion and restraint.

Restrictive practices should not be used as a punishment, staff convenience or because of inadequate resources due to a high potential for abuse.[43] The RANZCP strongly supports the development of tools and strategies which work towards eliminating the use of restrictive practices in mental health services.

The RANZCP wishes to acknowledge that the use of medication also plays a significant role in treating mental health conditions and symptoms for people with disability including those with Autism Spectrum Disorder (ASD) and intellectual and developmental disability. Enhancing prescribing skills, especially those related to challenging behaviour and those which are considered restrictive practice under the various legislations, is urgently required to avoid misuse and to ensure appropriate prescribing is recognised.

Some people with intellectual disability, for example, who display challenging behaviours or do not use verbal communication, may be at higher risk of restrictive practice use as health concerns are not identified; [44] challenging behaviours may be the only available response to pain or symptoms which cannot be expressed in other ways. Despite the fact they are often unable to provide informed consent, people with intellectual and developmental disability are frequently subject to mental health interventions, including prescribed psychotropic medications. Although in some cases, consent is provided by a substitute decision maker, one of the consequences is that protection varies significantly by jurisdiction.[45] This presents issues within the context of the United Nations Principles that state that a person's disability should not be the basis for loss of basic rights and freedoms.[1]

Better education and training of the workforce in understanding the needs of people with disability, particularly those with challenging behaviours or who are nonverbal, and how pain and illness may present, would assist in reducing restrictive practices. Developing better understanding across the sectors to identify pain or illness in this population, would also vastly improve their overall health and wellbeing, including treatment for mental health conditions, the symptoms of which, may also be hard to express to support people and health professionals. Trauma informed practice should also be imbedded in all mental health services.

#### **Recommendations:**

- Develop education and training across all sectors in supporting and engaging with people with disability, with extensive modules on listening to and providing support to people with intellectual disability or those who display challenging behaviour or non-verbal means of communication.

### Over exposure of people with disability in the criminal justice system

The RANZCP recognises over-representation of people with disability in the criminal justice system is a human rights issue and a consequence of barriers to services due to stigma and discrimination against people with disability.

Though de-institutionalisation of care of people with disability has occurred over several decades, people with disability still face huge challenges in accessing many systems that people without disability take for granted such as housing and employment.[33] In Australia, when challenging behaviours for people with intellectual disability result in involvement with the criminal justice system, there is a dearth of secure, therapeutic community options.[46] The result is often a default to prison, where challenging behaviours are met with harsh custodial responses.[47] Due to the dearth of appropriate services and support, people with disability remain over-represented in the custodial and forensic systems [33] particularly people with intellectual disability.[48] Additionally, people with disability who are found unfit to stand trial are often detained indefinitely in prison due to a lack of alternatives. More information can be found in RANZCP's [Position Statement 90: Principles for the treatment of persons found unfit to stand trial](#). A Human Rights Watch report identified that between 2010 and 2020 60 per cent of people who had died in Western Australian prisons had a disability.[49] In addition, people with disability are vulnerable to sexual exploitation within the criminal justice system.[46]

In addition, the over-representation of Aboriginal and Torres Strait Islander people in the criminal justice system is a cause for concern for the RANZCP. Institutionalised racism and mis-diagnosis and under-diagnosis of mental health issues and other disabilities due to cultural testing bias perpetuate this human rights issue.[50]

Better screening is needed in early childhood to recognise the potential of delayed childhood development and the potential causes and effects. Early intervention in childhood may help reduce rates of adolescents and adults with disability interacting with the criminal justice system.[50]

Providing better disability awareness and specialist training in medical and nursing schools is essential to assist the education of future professionals on the practical and functional impact of disability in the daily lives of people who live with disability. The RANZCP supports the use of education and training as a useful tool in reducing stigma within these professions and improving healthcare for people with disability.

The effects of interaction with the criminal justice system are long lasting. A study in the US which investigated juvenile youth who had been incarcerated for 7.2 years showed a mortality rate four times the general population for males, female mortality was nearly eight times the general population.[51]

Disability service providers demonstrate good practice when management focuses on driving an appropriate services culture and develop strong working relationships with local hospitals. There may be a need for disability awareness and liaison roles in hospitals to assist people with disability who need more support communicating.

The two sectors, disability and health including mental health, work differently, with separate governance structures, funding streams, organisations and processes. It is difficult for services in these two sectors to work together, and particularly difficult in complex cases. When gaps in governance or service provision occur, services can be slow to respond to crises, and this can lead to criminal justice system involvement. Especially problematic is a lack of certainty around who is responsible for funding disability supports while the person with disability is within a hospital setting as rejection by services can lead to adverse outcomes for the person with disability.

In circumstances where people with disability, particularly people with intellectual disability, are imprisoned they are highly vulnerable.[46] In custody, people with an identified disability and unrecognised mental health conditions receive minimal to no services[46]. The RANZCP supports the introduction of the role of Justice Liaison Officers to provide better assessment and ensure appropriate services are received by prisoners with a disability who are in custody and will be released to the community. It is important these roles are provided with adequate training and resources and made available quickly to support people with disability in prison. The inclusion of this role in the criminal justice sector, needs to implement appropriate testing and screening to ensure people with disability are supported, including those who have yet to be diagnosed.

A national diversion program which provides appropriate, individualised support and assistance for people with disability instead of prison is needed as an alternative to address the over-representation of people with disability in prison.

In addition, the RANZCP would support people with disability who are transitioning out of Corrective Services being linked with planners or case managers in the non-government system, so that individuals can be guided out of correctional services, to assist in finding housing, welfare and employment options to facilitate reintegration into the community.

### Recommendations:

- Invest in a nationwide court diversion program for people with disability to ensure that appropriate alternative pathways are available, addressing over-representation of people with disability in the criminal justice sector.
- Develop appropriate community-based service models to meet the needs of people with disability detained in custody after being found unfit to stand trial.
- Ensure people with disability are identified while in, and transitioning out of, the criminal justice sector so they are able to get the support they need, facilitate reintegration and reduce recidivism.
- Ensure people with intellectual and developmental disability have access to additional models of care, and access to appropriate facilities while in the criminal justice system.
- Develop culturally appropriate models of care of Aboriginal and Torres Strait Islander people in the criminal justice system including appropriate early testing and screening for disability.

### Stigma and discrimination

People with disability often experience significant exposure to stigma and discrimination, directly and indirectly. Internationally, people with disability are more likely to experience poverty than people without disability which can lead to further stigma and discrimination.[52] Stigma may be personal, perceived, self-stigma, or structural and affects people differently, as it intersects with an individual's circumstances.[53]

Stigma and discrimination is particularly important to address as it negatively impacts further on mental health and can, in some instances, be worse than the disability itself.[53] In addition, stigma and discrimination are a barrier to accessing social and economic participation and costs the economy a significant amount in the form of absenteeism and presenteeism, for example.[54]

Exploitation of people with disability remains a problem as scammers target people with disability believing them to be more vulnerable [55] with over 7800 people with disability or chronic illness reporting being scammed \$8.7 million in total in 2018.[56] This can cause embarrassment and further financial stress for people with disability.

While there is the need for further research in this area, children with disability are more likely to be bullied than children without disability [57] which includes exclusion, isolation, abuse and discrimination. Bullying can negatively affect a person's mental health and cause long-lasting harm well into adulthood. [58] A recent survey undertaken by Mission Australia on young people found that 26 percent who identified as having a disability were concerned about bullying and emotional abuse, compared to 14 percent who did not identify as having a disability (of 1,623 young people identifying as having a disability out of 25,126 survey respondents).[59]

People with intellectual disability often find it difficult to access mental health services despite having significant mental health issues.[29] This difficulty is the result of entrenched discrimination against, and assumptions about, people with intellectual disability [33] and, at times they are refused services because of their vulnerability, fears that hospital admission may make things worse, failure to recognise mental health issues, a lack of understanding about the role and capacity of the disability service system and lack of appropriate treatment programmes and facilities. In addition, they may also be refused services as they are perceived as difficult to work with, less deserving of treatment, resource intensive and unlikely to improve. Their disadvantage is furthered by their dependency on others to advocate for them and a lack of clarity about who is responsible when their needs require coordination across service systems (disability, health, mental health, justice, and housing).[29]

The RANZCP supports the Royal Commissions aim as mentioned in the Interim Report to delve further into this topic as a critical part of working to address stigma and discrimination in the wider community.[60]

Recommendations:

- Ensure people with disability are well represented and involved in all levels of decision making and design across all sectors including transport, health, and housing.
- Ensure robust protections exist against stigma and discrimination for people with disability (including those with mental health conditions) including provision of appropriate resources for people with disability to challenge stigma and discrimination.

### **National Disability Insurance Scheme (NDIS)**

The RANZCP commends the National Disability Insurance Agency (NDIA) on its ongoing efforts to improve the NDIS. We continue to actively engage in this effort including contributing [submissions](#) to previous consultations on the NDIS, such as the [Joint Standing Committee on the NDIS](#) and the [NDIS Act Review and Participant Service Guarantee](#) (also known as the Tune Review).

The RANZCP welcomes the release of the [Tune Review Report](#) (and the Government Response to the Tune Review) especially highlighting psychosocial disability as a primary area for continued improvement within the NDIS, recognising the limitations current NDIS legislation places on the psychosocial disability service delivery response.[61]

The NDIS has been a massive reform for people with disability and the disability sector. Given its unique nature, it is expected that it will take continuous improvement measures to ensure its suitability for the wide range of needs and experiences it is required to meet. However, the creation of the NDIS was to promote a person-centred approach for people with disability and all steps must be taken to ensure that people with disability are provided with proper care and support. It is important that people with disability who are ineligible for the NDIS have suitable support as the NDIS does not cover all people with disability in Australia and gaps in services remain. The Productivity Commission's recommendation that the gaps in the provision of disability services be investigated at the jurisdictional level would assist with addressing this issue.[62]

The fluctuating and transitory nature of mental health conditions makes implementation of the psychosocial stream challenging and the RANZCP recognises the NDIA's continual efforts in this space, especially training of NDIA and service provider staff to better support people with psychosocial disability. [63] However, the significant amount of unspent NDIS funds is concerning as an indicator of gaps and inaccessibility that remains for people with disability due to confusion over processes.

The RANZCP has concerns over a recent [announcement](#) by the NDIS Minister to implement independent assessment advisors as part of the eligibility and assessment process to the NDIS. We share concerns with disability advocates that assessments will be conducted by people who are unfamiliar with the individual, taking away participant choice with the potential to create further trauma and distress for people with disability. The creation of Medicare Benefit Schedule-style items for health professionals could be a better way to create equitable access for people with disability seeking to access the NDIS and allow people with disability more choice in decisions which impact their NDIS journey.

The need for advocacy through the entire cycle of the NDIS is crucial for people with disability to ensure their needs are met, such as working with health professionals during the assessment process. Families, friends and carers play a critical, but often overlooked, role in providing further context of challenges and needs faced by their loved one, liaising with support people to ensure better outcomes. Within the recovery model and with the fluctuating nature of psychosocial conditions, family and friends often provide crucial support in monitoring, identifying and assisting people during challenging times when they may be unable to make decisions or help themselves.[30] Better support and involvement of carers in dialogue, where possible, can improve continuity and quality of support for people with disability.[30]

The RANZCP holds serious concern for those who do not have someone to advocate on their behalf. As has been reported in the media, instances of system failures for people with disability remain. Better governance structures are needed to provide accountability and transparency of services to ensure people with disability are protected from abuse and neglect. As mentioned in the Interim Report, it is important that further investigations are undertaken as to how the NDIS Quality and Safeguards Commission can address violence and abuse against people with disability.[60]

### Recommendation:

- Increase the number of, and funding for, advocacy services for people with disability in urban, regional and rural areas, and both broad and targeted promotion of these services [33].
- Create Medicare Benefit Schedule-style items for health professionals to conduct assessments for NDIS purposes, to support more equitable access to the NDIS for people with disability and allow people with disability more choice in decisions which impact their NDIS journey.

### **LIVED EXPERIENCE: Importance of advocacy in accessing the NDIS**

*'It has been back and forth since that time, requiring an enormous amount of my time. Both applications have been declined and reviewed several times. Each time they are reviewed and declined access to the NDIS. The reason? Tourette's Syndrome (TS) and the coexisting conditions are apparently not permanent and can be treated (last NDIS letter this month). K with TS, severe Obsessive-Compulsive Disorder (OCD), Attention Deficit Disorder inattentive and G is in particular affected in their functioning but unfortunately despite medical documents, I cannot get them into the NDIS. There seems not to be a streamlined process which is the same for everyone as some with TS and comorbidity get into the NDIS and others not. Worst of all, TS is not understood by the NDIS as a permanent condition..'*

*'I applied for the NDIS for my then 8-year-old child, B, who has TS, OCD and Attention Deficit Hyperactivity Disorder. I applied because B. needed to see multiple professionals as they are sensitive to medications and the cost was too great for a single parent. We were unsuccessful as we were told that TS isn't lifelong. I did argue the point that it will have life-long issues if B doesn't access supports[early]'*

*Many thanks to the Tourette's Syndrome Association of Australia and to those who provided their stories.*

### *NDIS and the criminal justice system*

Assessment and referral processes leading to a pathway for prisoners with an intellectual disability to access NDIS, while still in custody need to be developed. The RANZCP looks forward to the seeing how the introduction of Justice Liaison Officers [61] may smooth integration between the criminal justice and disability sectors, ensuing individuals in custody are provided with support and planning prior to discharge.

An example of these issues may be a disability service provider which provides services for people with disability in the criminal justice sector. The disability service works with clients who have a recognised disability, often with mental health conditions, and are in contact with the criminal justice sector, bringing a different degree of risk to themselves and the community and can challenge the reputation of the service provider. The service provider provides case management to clients mainly focusing on the reintegration of clients back into the community towards the end, and at the conclusion, of periods in custody. In these circumstances, one of the critical areas of sustaining service delivery has been the volatility of client engagement and employee retention. Clients are often remanded into custody and refuse service at short notice which has an immediate financial impact on the staffing of programs. This needs of this group of clients are very challenging and complex and the funding model needs to account for these challenges. Extension of funding cycles, as mentioned in the Productivity Commission's Report on Mental Health, may assist with this.[62]

A lack of access to services in a timely manner is also faced by remand prisoners with an intellectual disability. They receive little or no services from a reintegration perspective because of the increasing high number and the limited facilities currently in place across the criminal justice system.

The criminal justice sector should provide psychological and professional resources in order to assess eligibility for the NDIS through the established assessment protocols. The RANZCP would urge that if a person in detention is not found eligible, there should be alternative means to assess their functional capacity and provide resources to support them in custody and in the community. This will have the impact of strengthening and supporting the skill base of individuals and provide directions for input, education and training to guide reintegration back into the community.

The impact of disability within the cultural and social context of Aboriginal and Torres Strait Islander people needs to be better recognised and accounted for through appropriate and culturally relevant methods.

### **Conclusion**

Consistent with all people, people with disability have aims and aspirations to live fulfilling and meaningful lives. The RANZCP would like to highlight the importance of acknowledging the capability, diversity and contribution people with disability make to the community every day to help address stigma and discrimination within the wider community against people with disability. In order to do so, people with disability may require varying levels of support from a range of sectors including health, education, employment and disability.[64] When accessing support, people with disability have the right to access appropriate and respectful services across all sectors which are reflective and adaptive to each person's needs. Equity of access needs to be incorporated into all areas of life as a matter of priority.

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