Mental Health and Clients of the Public Advocate

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1. Purpose

This report highlights the challenges faced by adults with a cognitive disability and complex behaviours in accessing appropriate mental health support. The intersection between mainstream mental health services, forensic mental health services and the National Disability Insurance Scheme (NDIS) is difficult to navigate, particularly for those who are under the guardianship of the Public Advocate (PA) who have complex diagnoses.

The profile of PA clients significantly affected by these challenges includes people who have Intellectual disability (ID), psychosocial[1] disability, Autism Spectrum Disorder (ASD), Borderline Personality Disorder (BPD), Complex-Post Traumatic Stress Disorder (C-PTSD), or other trauma (i.e. childhood trauma), and chronic behaviours of concern. A key identifier of these clients is a lack of diagnostic clarity surrounding their mental health diagnoses. They often have interactions with the forensic mental health system and criminal justice system and face exclusionary criteria when attempting to access mental health support in both tertiary hospital and community settings, due to lack of clearly defined mental health diagnoses (despite having other complex diagnoses).

Australia's Disability Strategy 2021-2031 (ADS), identifies key areas of policy priority under *Outcome Area: Safety, Rights and Justice*, in particular:

- Policy Priority 2: Policies, processes, and programs provide better responses to people with disability who have experienced trauma,
- Policy Priority 6: The criminal justice system responds effectively to the complex needs and vulnerabilities of people with disability[2]

This report outlines issues with access to mental health services, and gaps in NDIS funding. Individuals (and their representatives) within this group have trouble in navigating service systems. Complex conditions like C-PTSD or BPD require specialised and trauma-informed care responses, yet these services are often inadequate or unavailable for those with intellectual disabilities or complex psychosocial presentations. The fragmentation of mental health, disability, and justice systems pose significant barriers, preventing individuals from receiving the integrated care they require.

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[1] Psychosocial disability is a term used to describe a disability that may arise from a mental health issue (NDIS)

[2] Australia's Disability Strategy 2021-2031 Australia's Disability Strategy 2021–2031 - 2024 Update: Building a more inclusive Australia

2. Access Issues and Lack of Diagnostic Clarity

There are significant barriers to gaining access to mental health services for people with cognitive disabilities, especially individuals who present with a diagnosis of Intellectual Disability (ID), Borderline Personality Disorder (BPD), Autism Spectrum Disorder (ASD), or "complex trauma", all of whom often exhibit challenging behaviours, self-harm and suicidal ideation. These clients are frequently caught in a repetitive cycle of escalation, service breakdown, and hospital admission or detention in prison or a forensic mental health facility. This is due to the lack of mental health support that is tailored to their complex needs.

For many individuals, episodes of emotional or behavioural escalation are misinterpreted as being intrinsic to their diagnosis, such as being a direct consequence of BPD or ASD, without deeper exploration of the underlying causes. This complexity in presentation often leads to situations in which clients of the PA have their mental illness misattributed to their primary disability (such as ID) or overlooked altogether. In these situations, opportunities for mental health assessment and treatment are missed with no clear discharge support plans in place, resulting in poor outcomes for the client who is consistently excluded from appropriate clinical care.

Community Mental Health Services (CMHS) within the Local Health Networks have prescribed eligibility criteria which have the effect of excluding access to services[3]. Under the established criteria, referrals are not accepted for consumers who have complex mental illness complicated by alcohol or drugs, or with primary presentations of:

- Intellectual disability (ID)
- Autism Spectrum Disorders (ASD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Acquired Brain Injury (ABI).

In the current system, the criteria for accessing supports are contingent on a clinical mental health diagnosis. This excludes many people who require either emergency support in crisis or ongoing support to manage the fluctuating nature of mental health conditions. A frequent experience of PA clients is being locked into ongoing crisis scenarios as the current mental health and forensic systems are not structured to meet the complexity of their dual diagnoses, resulting in fragmented and ineffective care. These clients often present to hospital, are discharged, and then re-present within hours or days, experiencing a repetitive cycle and utilising hospital and health resources inefficiently.

Clients of the PA who have met access requirements for the NDIS for psychosocial disability, intellectual disability, or ASD are unable to access mental health supports through their NDIS funding. The NDIS is responsible for supports that are not clinical in nature and focus on improving functional ability, independence, and social and economic participation. The NDIA refers participants to mainstream mental health systems for support, leading to increased pressure on an already fragile mental health support ecosystem.

Mental health services endorse the "recovery" model of mental health treatment whereby there is a goal to return an individual to their pre-morbid state after a bout of mental illness. This implies that mental health supports are short-term and episodic. The NDIS approach is that disability is ongoing and requires continuing provision of support. These competing philosophies lead to circular debates about which needs of a particular individual relate to a mental illness and which relate to an underlying psychosocial disability. It is this debate, compounded by the desire for the NDIS to be responsible for as much as possible, that led many State-funded community mental health services to be delineated as "psychosocial disability" and therefore the funding responsibility of the NDIS.

While the NDIS accepted psychosocial disability as a "disability," which the previous State disability system did not,

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[3] CMHS MoC v1.3 FINAL FOR PUBLISHING

the NDIS will not fund clinical mental health recovery services. When an Occupational Therapist (OT) is assisting a client to improve their daily living skills is this considered “a rehabilitation service aiding recovery from a mental illness” (and therefore a State funding responsibility) or “a disability service assisting the independent living skills of the individual” (and therefore a NDIS funding responsibility). It depends on the words used to describe the activity that decides which. This is why the previous State disability systems left psychosocial disability to Mental Health services – avoiding this never-ending debate which creates gaps and leaves clients poorly supported.

Diagnostic overshading remains a significant barrier in the effective treatment of individuals with cognitive disabilities, whereby mental health conditions and trauma-related disorders are frequently misattributed to the cognitive disability itself. Specialised diagnostic tools and routine interdisciplinary case reviews should be embedded within clinical pathways to enable improved diagnostic clarity, and to develop new models of care that are inclusive of individuals with cognitive disabilities and complex behavioural or forensic needs. These models should be flexible, person-centred, and designed to reduce reliance on crisis services, hospital emergency departments, and custodial environments. This requires clarity of roles and collaboration between the NDIS and the state mental health system.

Case Study 1

J is a 31-year-old person who is diagnosed with C-PTSD, BPD, ADHD, and a mild intellectual disability.

J has a full guardianship order appointing the Public Advocate since April 2017.
J exhibits high-frequency, high-risk behaviours including significant self-injury, significant property damage, and persistent verbal and physical aggression, particularly towards J’s support staff. J has had a forensic matter - a very serious assault to a support worker who was in intensive care for weeks due to strangulation.

J currently resides under a heavy seclusion model (3 workers:1 client) due to the intensity of their behaviours, which often result in SA Police (SAPOL) and SA Ambulance Service (SAAS) attendance. J has accrued multiple assault charges. A recent critical situation led to J being sedated and shackled resulting in physical injury.

J was discharged within hours without a mental health assessment. The Public Advocate escalated J’s case within the SA Intellectual Disability Health Service (SAIDHS), requesting an emergency review of her current medications and presentation. This did not occur for three months.

Over time, there have been multiple behavioural incidents with continued episodes of aggression towards her staff and herself, resulting in continued SAAS and SAPOL attendance and repeat hospital admissions.

The reactive and fragmented nature of J’s care, often driven by crisis rather than sustained therapeutic engagement, has not only failed to meet J’s clinical and psychosocial needs but has also led to significant financial and resource strain on emergency services and the acute healthcare system. Despite the evident risk to both the individual and J’s care providers, there remains a lack of an appropriate, trauma-informed, integrated care model that can address J’s needs holistically and proactively.

Recommendation 1

Develop new models of mental health care that are inclusive of individuals with cognitive disabilities and complex behaviours.

3. SA Intellectual Disability Health Service (SAIDHS)

The South Australian Intellectual Disability Health Service (SAIDHS) is a state-wide specialised health service funded by SA Health. SAIDHS currently provides mental health care for adults who have a diagnosed intellectual disability and complex needs, which may include ASD, mental illness, behavioural issues, and other complexities that are difficult to manage within mainstream community services. SAIDHS are mostly unable to provide emergency or crisis support, ongoing medical or psychiatric management, or any Intelligence Quotient (IQ) assessments[4].

Patients require a referral by a GP or disability care provider to access SAIDHS, although alternate referral pathways are available if a person with an intellectual disability is unable to access a GP service. At the time of this report, there is a significant waitlist (6 months) for clients to access services at SAIDHS, with no suitable pathways for alternative support available. Currently, there are not clearly defined or effective pathways in place to escalate cases when a PA client urgently requires an assessment or medication review by SAIDHS. This has resulted in significant delays in access to critical support for PA clients with complex needs, which exacerbates the existing crisis and increases the risk of further deterioration. A formalised escalation protocol needs to be developed to ensure that clients with urgent and high-priority needs are not overlooked, to sit alongside the MOU between OPA and SAIDHS to ensure prompt referrals and assessments for PA clients who have a suspected intellectual disability.

Without access to timely and tailored crisis intervention, these individuals rely on hospital emergency departments or SAAS and SAPOL intervention, both of which are not well equipped to manage their complex and specific needs. SAIDHS plays a critical role in supporting individuals with intellectual disabilities and mental health risks. However, demand for specialised assessment, treatment and behavioural management is increasing, particularly for those involved in the forensic mental health and criminal justice systems. Expanding SAIDHS to include a dedicated crisis response team or establishing partnerships with existing crisis services could provide more appropriate and timely interventions, reduce the risk of escalation, and improve health outcomes for this very vulnerable population.

Recommendation 2
Expand the South Australian Intellectual Disability Health Service (SAIDHS) to meet the growing demand for mental health services for individuals with cognitive disabilities, complex comorbidities including crisis situations.

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[4] Clinician information for SA Intellectual Disability Health Service | SA Health

4. Specialised Forensic Disability Service

In South Australia forensic patients are often directed to reside in prisons instead of James Nash House or an appropriate mental health facility by order of a Ministerial Direction under s 269V(2) of the Criminal Law Consolidation Act 1935. This contributes to challenges for the prison system because they are not well equipped to meet their forensic, clinical and disability support needs.

The current structure of the forensic mental health system in SA is primarily designed to suit the needs of those with psychiatric disorders, rather than those who have co-morbid or complex diagnoses. Existing facilities such as James Nash House and the Tarnanthi and Subacute unit at Glenside have become increasingly unsuitable for delivering forensic mental health care due to their outdated infrastructure and inherently custodial design. James Nash House is designed as a prison like environment where security features are embedded into the physical structure, resulting in the absence of therapeutic space. Tarnanthi and SubAcute Unit is a ward light environment with limited shared and common spaces. These settings undermine recovery-focused care and fail to adequately support the psychological needs of clients, as the buildings are not able to meet contemporary standards for forensic mental health facilities.

Critically, the ongoing shortage of forensic mental health beds means that clients are redirected to correctional facilities rather than being able to maintain placement in appropriate clinical settings. This creates a damaging cycle in which individuals move between James Nash House, prison, hospitals, and community without sustained supports, often falling through system gaps.

There is an urgent need to upgrade, refurbish or replace James Nash House with a facility that can support safe, therapeutic, and recovery-oriented care. There is also a strong need for the establishment of a dedicated forensic disability service, separate to forensic mental health services that is residential in nature rather than a ward environment to address the complex needs of individuals with cognitive disabilities who have entered the criminal justice system.

The Queensland Government has successfully implemented a person-centred Model of Care within their dedicated forensic disability service which incorporates key evidence-based practice frameworks including person centred care, trauma informed practices, positive behaviour support and integration of the “Good Lives” and the “Risk Needs Responsibility” models. The multidisciplinary care team focuses on rehabilitation and skill development, and planning for a client’s transition to return to living in the community. These goals are considered upon admission to the Forensic Disability Service and are pursued through individual development planning and transition planning meetings. The Queensland Forensic Disability Service collaborates with external support services to ensure long term support and social inclusion upon discharge and provides oversight to clients who are discharged from inpatient treatment.

There is an urgent need for a dedicated Forensic Disability Service in South Australia which offers secure inpatient treatment, forensic risk assessment, behavioural support planning (including the role of NDIS supports) and programs designed to address offending behaviours. A specialised service would divert individuals from the prison system, offer a framework for long-term management and rehabilitation and reduce the cycle of offending and associated costs.

Recommendation 3
3.1 Upgrade or replace James Nash House with increased capacity. **3.2 Develop a specialised Forensic Disability Service which is residential in nature to effectively manage offending behaviours by individuals with cognitive impairment.**

5. NDIS Issues and Gaps in Funding

Public Advocate clients who are participants of the NDIS and who are also involved in the forensic mental health or criminal justice systems face significant inconsistencies in funding and support. Individuals with diagnoses such as BPD, PTSD, ASD, or forensic-related behaviours frequently receive low levels of funding and inappropriate support ratios within their NDIS plans, despite being on the Complex Support Needs (CSN) pathway. Such participants often require highly intensive supports, specialised therapeutic engagement and increased staffing ratio, as per clinical recommendations. Forensic NDIS participants often experience disruptions in service continuity, as their funding is paused when entering correctional or forensic mental health facilities. During these periods, responsibility for care shifts to the Department for Correctional Services or the Department of Health, creating tensions over who is best positioned to provide necessary support. Furthermore, the NDIS typically does not fund in-reach supports for individuals in custody, leading to a reliance on the Exceptional Needs Unit (ENU) in the Department for Human Services (DHS) to fund assessments.

The NDIS also does not fund *safety, risk management*, *forensic risk,* or *community security,* leading to long standing blockages for release and debates about who is responsible for funding these aspects of a person's release and support. There are often lengthy delays in collating evidence to submit to the NDIA for increased funding (which may not be approved). This is compounded by commencing discharge planning from prison or JNH only when the forensic order is nearing expiration, and discharge is imminent. Opportunities are diminished for suitable people to be approved by the Court to move to a community setting earlier. The Court must be satisfied that appropriate support and accommodation are in place and, without a NDIS plan and supports, this cannot be considered by the Court. Further delays and inefficiencies are created by the NDIS requiring repeated costly assessments, rather than relying on existing clinical information.

Upon discharge from prison or forensic mental health services, clients are often placed into underfunded accommodation placements where there is an overreliance on disability support workers to manage complex challenging behaviours. These workers frequently lack the required specialised training, leading to behavioural escalations which exceed the capacity of the funded support. This can result in plan overspend and places both the participant and service providers at risk, often culminating in service breakdowns. In such cases, the individual may be taken to hospital as a last resort, re-entering the health system in a crisis—a scenario commonly described as "*dump and run*," at significant financial and resource cost to the State. Disability support agencies require access to specialised mental health services to assist them in supporting a participant.

Courts commonly order high levels of supervision and support for release into the community to meet the legislative standard for the (paramount) safety to the community, and NDIS funding outcomes remain at odds with court ordered licence conditions and community supervision regimes. The NDIS does not fund forensic risks or community safety leading to long-standing blockages for release into the community. Without appropriate intervention, these individuals' situations reach crisis point repeatedly, deepening their entrenchment in the criminal justice or forensic mental health system.

Case Study 2

S is a 22-year-old Aboriginal person with a diagnosis of C-PTSD and BPD, who came under the full Guardianship of the Public Advocate in January 2021.

S is a high lethality risk with chronical suicidal behaviours and complex behaviours of concern, who has cycled between community settings, emergency admissions to hospital, prison placement and admissions to James Nash House. S is a NDIS participant who is allocated to the CSN pathway but has a modest (given their complex presentation) NDIS plan - $520,000 over 12 months.

There has been significant data collection and incident reporting from James Nash House provided to the NDIS, and clear evidence from multiple treating clinicians recommending increased supports – such as higher staffing rations, increased therapeutic input and a secure placement tailored to their complex presentation – however, S's NDIS plan has remained stagnant.

No appropriate placement can be secured for S, as providers are unwilling to accept S without the adequate funding and support ratios to effectively support S's reintegration into community.

NDIS funded care teams, and Technical and Further Education (TAFE) trained support providers involved with S are left managing high lethality incidents, extreme events, and complex behaviours resulting in high risks to staff safety and welfare.

After multiple reviews with the NDIA and appeals to ENU for additional supports, S has been granted higher intensity supports for three months to assist in reintegration to community.

These situations create confusion and frustration around who is responsible for funding necessary supports – particularly in cases like S's, where NDIS eligibility is clear, but the current funding framework does not respond to complexity and risk appropriately.

There is a lack of clarity regarding responsibilities between the State and the NDIS, leading to fragmentation and inefficiencies in service provision. This highlights the need for the development of a Working Arrangement or Memorandum of Understanding (MOU) between state funding bodies and the NDIS, which would provide a cohesive partnership between the two parties. Documentation would provide clarity on:

- Roles and responsibilities for funding and service provision across custodial, forensic, hospital and community settings,
- Funding escalation pathways for high-risk individuals whose needs are not met under standard NDIS mechanisms,
- Service continuity obligations, ensuring that transitions between NDIS and state-funded systems do not result in support gaps or risk escalation, and
- Defined mechanisms for collaboration between the NDIS, state health and mental health systems, correctional services, and disability providers to plan safe and sustainable placements.

By formalising responsibilities and funding agreements, this would help reduce service delays, support recovery and risk reduction, and ensure that individuals like S are not left unsupported due to systemic ambiguity.

Clients with cognitive disabilities and complex forensic or behavioural profiles frequently fall through the gaps in the system due to unclear delineation of funding responsibilities between the NDIS and State services. This results in inconsistent service access, delayed placements, and increased reliance on crisis-driven, reactive responses particularly in hospitals and over-utilising emergency services. A formal agreement is needed to better define roles, ensure continuity of care across custodial and community settings, and create mechanisms for joint funding or service escalation where NDIS plans are insufficient. This would better support long-term outcomes, reduce systemic gaps, and ensure vulnerable individuals receive timely and appropriate support.

Recommendation 4

Establish a formalised agreement such as a Memorandum of Understanding (MOU) or Working Arrangement between the State and the NDIA to clarify responsibilities and address funding gaps for individuals with complex diagnoses and forensic needs.

6. Voluntary Modes of Engagement

Mental Health services, both community based and inpatient, typically operate under a voluntary model of engagement which assumes that individuals are willing and able to actively consent to and participate in their mental health treatment. Voluntary participation respects autonomy and the decision-making capabilities of the individual. However, it will add a significant systemic barrier for PA clients who are unable to meet the expectation of voluntary engagement due to the very nature of their mental health issues and impaired decision-making capacity.

A key issue is that Community Mental Health matters are often closed prematurely for clients who fail to attend appointments regularly or who demonstrate behaviours that are interpretated as non-engagement. Individuals who are most unwell, marginalised, or struggling to maintain stability are the most likely to be excluded from mental health care. PA clients with complex needs, multiple diagnoses, and psychosocial barriers such as homelessness, self-harm and suicidal ideation are often filtered out of mental health services because of refusal to engage or (more often) failure to engage. Such exclusions are contributing to the cycle of crisis presentations experienced by PA clients, with individuals unable to achieve long term stability. These clients may only be granted access to supports once their risk escalates to a level that would necessitate involuntary intervention, which undermines the early intervention, person-centred approach to mental health care.

Despite the SACAT authority granted to the PA to make healthcare decisions, many mental health services operate on the premise that direct consent from the individual is essential for service engagement to proceed.
To address these challenges, there is a need for mental health services to develop more inclusive models of engagement that recognise ambivalence, fear, and avoidance as meaningful clinical data rather than strict indicators of non-compliance and non-engagement. This would include assertive outreach, trauma-informed persistence, and greater flexibility in how and where services are offered. The implementation of an assertive engagement model should also recognise the complex needs of individuals under guardianship orders. Under this model, the guardian's decision-making powers would be considered sufficient to meet the criteria for voluntary engagement in mental health services. This approach would allow the guardian, acting in the best interests of the individual, to provide consent for mental health treatment, thus ensuring that individuals under guardianship are not denied care due to their inability to personally consent. The model would also include regular assessments of fluctuating capacity to ensure that the individual is always involved in decisions about their care when they are able to do so.

Mental health services could develop clear protocols, guidelines, and models of care for how to manage consent from guardians to facilitate voluntary treatment, ensuring that staff members are trained to appropriately navigate cases where guardianship is involved. Without a shift in how voluntary engagement is conceptualised and responded to, mental health systems risk continuing to serve only those who already have the capacity to navigate them, leaving behind those who cannot.

Recommendation 5

Establish an inclusive and assertive model of engagement that qualifies PA clients as voluntary patients of mental health services when consent is provided by the Public Advocate.

7. Need for a Trauma Informed Step-Down Service

There is a need for the establishment of a trauma-informed step-down service specifically designed to support individuals with complex trauma and co-occurring conditions such as ASD, BPD and C-PTSD, many of whom self-harm and/or experience suicidal ideation. There is a group of 15-20 individuals who are clients of the Public Advocate at any one time who have extremely complex presentations due to trauma and who are highly vulnerable and at serious risk of misadventure, exploitation, and abuse. A small cohort but very intensive and high use of emergency and hospital services. These clients often experience repeated cycles of crisis, hospitalisation, and disengagement from services due to the lack of sustained and integrated support. Traditional acute mental health services are not equipped to provide the long-term, stabilising support required by individuals with these complex presentations. Hospital settings, while necessary in acute phases, are inherently restrictive and often exacerbate trauma-related symptoms and behavioural dysregulation. Furthermore, premature discharge without adequate follow-up contributes to poor outcomes, including but not limited to re-traumatisation, service disengagement and placement breakdown, and recurrent presentations to emergency or crisis services, which places a significant burden on the currently strained health system.

The establishment of this service would address the needs of a vulnerable group of clients who are at an increased risk of self-harm, suicidal ideation, homelessness, domestic and family violence due to their impaired decision making and fragmented support systems. A trauma informed step-down service would support the development of a person-centred model of care, provide outreach clinical support in community to assist in maintaining accommodation placements and allow for a wrap-around model of care that ultimately leads to a sustainable, long term therapeutic outcome that respects the complexities and fluidity of the support needs of this vulnerable cohort.

A trauma-informed step-down service would function as an intermediary between acute hospital care and full community reintegration. PA clients are often referred to “Transition to Home” services. However, these services do not provide trauma informed or mental health service. A specialised trauma informed service would provide a safe, structured, and therapeutically supportive environment where individuals can stabilise following a crisis episode. The model would be grounded in trauma-informed principles—emphasising safety, choice, collaboration, empowerment, and responsiveness—and tailored to the unique cognitive, emotional, and behavioural needs of individuals with cognitive and psychosocial disabilities. This approach not only supports recovery but also reduces dependence on emergency departments, inpatient units, and custodial environments. By providing a pathway to long-term stability and community integration, a trauma-informed step-down service fills a significant gap in the current continuum of care and offers a more person-centred, effective, and sustainable response for these vulnerable clients.

Case Study 3

M is a 50-year-old person with an Intellectual disability, BPD, and a significant and complex trauma history. L came under Limited Guardianship of the Public Advocate in August 2022.

M has been in a sustained state of crisis for months and is currently averaging 17 high risk incidents per week that include serious self-harm, escalating suicidal ideation, property damage, threats, and attempted assaults on support staff. In a recent 48-hour period, M made three serious suicide attempts.

M receives low level NDIS funding, which is not reflective of the intensity or complexity of M’s presentation nor suitable for their support needs. M lacks consistent access to specialised therapeutic care, and M’s behaviours frequently exceed the capacity of their support services, resulting in repeated service breakdowns and increased instability.

Without a 24/7 active Supported Independent Living (SIL) model, M is left for extended periods of time without support, resulting in a further deterioration of M’s mental state. Currently, support workers are unable to enter their home because of the forensic risk presented by the 'inhumane' state of their home due to significant property damage.

M's current crisis presentation includes daily SAAS and SAPOL interventions, and almost daily hospital admissions due to risk of harm to self and others. The crisis responder services report excessive use of their resources.

Despite this level of acuity, there is no coordinated, long term therapeutic plan in place, and M is unable to access sustainable models of support. M has had repeated social admissions to hospital, but there have been poor outcomes due to the lack of support available that matches M's complex presentation.

M's diagnosis does not qualify for a long-term psychiatric admission, and M cannot access higher amounts of funding through the NDIS due to the current funding model being constrained by a binary understanding of mental health and psychosocial disabilities.

M remains at a significant risk of death by misadventure due to the lack of coordination between current mainstream and NDIS supports, leading to a total absence of suitably trauma-informed options to assist in ongoing crisis.

M's situation illustrates the urgent need for a trauma-informed, step-down service that operates a wrap-around model of care, incorporating multidisciplinary teams—including mental health clinicians, disability support workers, allied health professionals, peer workers, and NDIS providers—to deliver coordinated and continuous support. The service would provide holistic health, safety, and functional needs assessments, support the development of plans that address the person's presenting issues (which often involve significant trauma and complex behaviours), and upskill existing support services for the client, thus reducing the likelihood of multiple presentations to hospital.

Recommendation 6

Establish a trauma-informed step-down service for individuals with complex trauma and complex diagnoses who repeatedly present at hospital emergency services and repeatedly demand emergency service responses from SAPOL and SAAS.

8. Recommendations

1	Develop new models of mental health care that are inclusive of individuals with cognitive disabilities and complex behaviours.
2	Expand the South Australian Intellectual Disability Health Service (SAIDHS) to meet the growing demand for mental health services for individuals with cognitive disabilities, complex comorbidities and for crisis situations.
3	**3.1** Upgrade or replace James Nash House with increased capacity. **3.2** Develop a specialised Forensic Disability Service which is residential in nature to effectively manage offending behaviours by individuals with cognitive impairment.
4	Establish a formalised agreement such as a Memorandum of Understanding (MOU) or Working Arrangement between the State and the NDIA to clarify responsibilities and address funding gaps for individuals with complex diagnoses and forensic needs.
5	Establish an inclusive and assertive model of engagement that qualifies PA clients as voluntary patients of mental health services when consent is provided by the Public Advocate.
6	Establish a trauma-informed step-down service for individuals with complex trauma and complex diagnoses who repeatedly present at hospital emergency services and repeatedly demand emergency service responses from SAPOL and SAAS.

9. Glossary and Acronym List

ABI	Acquired Brain Injury
ADHD	Attention Deficit Hyperactivity Disorder
ADS	Australia’s Disability Strategy
ASD	Autism Spectrum Disorder
BPD	Borderline Personality Disorder
CMHS	Community Mental Health Services
C-PTSD	Complex Post Traumatic Stress Disorder
CSN	Complex Support Needs
DHS	Department of Human Services
ENU	Exceptional Needs Unit
FDS	Forensic Disability Service
GP	General Practitioner
ID	Intellectual Disability
IQ	Intelligence Quotient
JNH	James Nash House
MOC	Models of Care
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
OT	Occupational Therapy
PA	Public Advocate
SAAS	South Australian Ambulance Service
SACAT	South Australian Civil and Administrative Tribunal
SAIDHS	South Australian Intellectual Disability Health Service
SAPOL	South Australian Police
SIL	Supported Independent Living
TAFE	Technical and Further Education