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People with mental and cognitive disabilities: pathways into prison

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From:

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Background Paper: People with Mental Health and Cognitive Disability: pathways into and out of the criminal justice system

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Abstract

Persons with mental health disorders and cognitive disability (MHDCD) are over-represented in the criminal justice system (CJS) as both offenders and victims. Indigenous persons with these disabilities are significantly more over-represented than non-Indigenous persons with MHDCD in the CJS and especially in prisons. How is it that such vulnerable persons are so concentrated in a system primarily for punishment when Australian society has such sophisticated health and support systems? This paper reports on ARC funded research on a cohort of 2,731 prisoners in NSW with MHDCD that examines pathways into the CJS and individuals' interactions with human services and justice agencies. It focuses on the synergistic effects of multiple disadvantage and agency interventions across the lifecourse and reflects on institutional interventions post release in the light of findings such as the very high rate of dual diagnosis and comorbidity (complex needs) amongst this group and the group's early initial and ongoing contact with police. Popular reintegrative/reducing reoffending theories and approaches like desistance and throughcare, do not hold explanatory or predictive power for this group's experiences in the criminal justice system and the community but new ways of conceptualizing disability in the CJS hold promise of leading to approaches that assist in reducing offending and ongoing CJS contact.

Introduction

The presence of people with mental health disorders and cognitive disability (MHDCD) in criminal justice systems (CJS) in Australia, and

internationally is not a new phenomenon but the rate of people with MHDCD and of those with co-occurring disorders in the CJS appears to have increased. International and national evidence points to widespread over-representation of these persons in police work, the courts and juvenile and adult prisoner populations, both as victims and offenders. There is recognition that there is incongruence between human service and CJSs dealing with people with MHDCD. Little headway has been made in keeping these people out of the CJS and new insights into, and understandings of their involvement are required. Disadvantaged persons with MHDCD are also far more vulnerable to homelessness and other socially disabling experiences with homelessness being intimately connected with imprisonment.

It has been clear for some years that descriptive and single system studies are not providing the new information and understandings needed to inform and redirect theory and practice in this field. Pathway studies that show the routes people with MHDCD take into, through, back into the criminal justice system rather than into support and care are one way of providing this new direction. This background paper describes and interprets in-progress findings from a research project using an innovative data merging and pathway building method. The project links and merges data from a large number of human service and criminal justice agencies on 2,731 persons whose MHDCD diagnoses are known and who have been in prison, to create an administrative de-identified life course trajectory for each individual. These individual pathways are then aggregated. This allows aggregated pathway analysis for various sub-groups such as women, Indigenous persons and those with co-occurring (complex) disorders.

Background

Mental health

International studies indicate that the prevalence of MHD amongst prisoners is significantly higher than that found in the rest of the population. For example, Belcher (1988), Aderibigbe (1996), Harrington (1999), Baillargeon et al (2009) and

Steadman et al (2009) all found that persons suffering from a serious mental illness or disorder were significantly over-represented in the USA jail and prison populations. Reed & Lyne (2000) confirmed the same for the UK prison population. NACRO (1992) and James et al (1999) in the UK and Lamb et al (1998, 2002, 2004) in the USA all confirmed that homeless mentally ill persons were much more likely to be incarcerated than non-homeless. People with severe mental illness are more likely to be convicted of misdemeanours than their mentally healthy counterparts, and tend to be incarcerated for longer periods (Lamberti et al 2001:64).

In Australia, Mullen et al (2000) and Mullen (2001) reported that around 25% of Victorian prisoners had had contact with mental health services prior to their imprisonment, and that males with schizophrenia and a coexisting substance abuse were over 12 times more likely to be convicted than males in the general population. A NSW Corrections Health Survey (Butler & Allnutt 2003) using the Composite International Diagnostic Interview (CIDI) which yields both DSM-IV and ICD-10 diagnoses of MHDCD, found a high prevalence of mental illness in the NSW prisoner population. The twelve-month occurrence of any psychiatric disorder (psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder or neurasthenia) was 74% amongst prisoners (86% for females; 72% for males) compared to 22% in the general population. Also almost half the reception inmates and one-third of sentenced inmates had suffered a mental disorder (9% prisoners Vs 0.42% general population suffered psychosis, 22% Vs 6% affective disorder, 43% Vs 10% anxiety disorder) in the 12 months prior to the survey. The most recent Inmate Health Survey (Justice Health 2009:17) indicates an increase in these figures. Inmates who have ever been assessed or treated by doctor or psychiatrist for a MH problem increased from 39% in 1996 to 43% in 2001 to 49% in 2009. This was due to men's increasing MH problems: 35% in 1996, to 41% in 2001, to 47% in 2009. The proportion of women remained steady at around 54%. An increasing

proportion of participants also reported ever having been admitted to a psychiatric unit: from 13% in 1996, to 14% in 2001, to 16% in 2009, and this group contained a higher proportion of women (20%) than men (15%) in 2009. Assessments amongst the juvenile justice detention and community populations suggest even high rates of mental health problems. In the latest juvenile health survey: most (78%) drank alcohol at risky levels (83% Aboriginal, 73% non-Aboriginal); two-thirds (65%) used drugs weekly prior to custody (72% Aboriginal, 58% non-Aboriginal); over half (60%) had a history of child abuse or trauma (81% young women, 57% young men); nearly all (87%) had a diagnosed psychological disorder; ~44% had IQ (<70) or borderline IQ (70-79) (Indig et al 2011: 126, 133, 145, 153)

Cognitive disability

Cognitive disability (CD): that is intellectual disability (ID), borderline intellectual disability (BID) and acquired brain injury (ABI), are different disabilities from mental illness and must be included in any study of disability in the criminal justice system. These forms of disability are poorly understood with many staff members in the CJS being unsure of what ID, BID and ABI are (Snoyman 2010). Many treat people with cognitive disability the same as someone with a MH problem. There is an under recognition of the need for special supports for those with cognitive disability (IDRS 2008) and for those with dual diagnosis or comorbidity (Hayes et al 2007; Kavanagh et al 2010). Internationally it is reported that these persons are over-represented in the criminal justice system (Hayes et al 2007; Herrington 2009).

Australia follows the DSM IV diagnostic requirements for intellectual disability (ID) (learning disability in the UK) of <70 IQ and poor levels on two social adaptive scales. In NSW the high representation of people with an intellectual disability in the CJS has been well recognised (Department of Family & Community Service 1988; New South Wales Law Reform Commission 1993; Simpson et al 2001). In a survey of juvenile offenders in NSW, 17% had cognitive functioning

scores consistent with a possible intellectual disability. Remarkably 74% scored below the average range of intellectual functioning, compared to 25% from the standardised sample (NSW Department of Juvenile Justice 2003). In the most recent juvenile justice survey amongst those in custody, 13.5 % of the young people had IQ < 70 with a further 32% having an IQ between 70 and 79 (BID) compared with less than 9% of the general population. The NSW Sentencing Council (NSW Sentencing Council 2004) recognised the serious consequences of imprisonment for people with cognitive disabilities: entrenchment within a culture of criminality due to the tendency of those with CD to want to be accepted by their peer group; vulnerability to assault and mistreatment in the mainstream prison environment; and readjustment problems post-release as people with CD inherently have impaired adaptive skills. A Victorian study revealed the gross disadvantages suffered by prisoners with ID and the over-representation of Aboriginal (in this case) men amongst ID prisoners (Glaser & Deane 1999).

Those with borderline ID (>70 - <80) face particular difficulties because they are not recognized as having a disability for the purposes of receiving support and assistance from the state disability service. According to NSW and British studies they are significantly over-represented in the juvenile and adult prison populations (Hayes et al 2007).

The NSW Law Reform Commission has recently released an excellent series of background papers on people with mental health and cognitive impairments in the criminal justice system in association with its reference on this matter (http://www.lawlink.nsw.gov.au/lawlink/lrc/ll_lrc.nsf/pages/LRC_cref120)

Trajectories into prison

Internationally there is a recognition that the police carry the major burden of attending to psychiatrically disturbed people behaving in an anti-social or offending manner and that police must make the determination whether to take such persons to a psychiatric unit or to arrest them

(Lamb et al 2004). Added to lack of training in recognising mental health disorders police often find such individuals may not be accepted into the mental health system due to lack of space, the person being deemed not ill enough or that they should be handled by the criminal justice system (Lamb 2002). In NSW, Police report great concern at the demand and stress placed upon police attending mental health crises, that some mental health workers view police as de-facto mental health workers and the criminalizing of mental illness (NSW Legislative Council Select Committee on Mental Health 2002). Internationally, for people with cognitive disabilities, there is a higher incidence of remand or bail than for those without a disability (Lyal 1995). The lack of information and research on police and people with MHDCD in Australia is most notable.

In NSW up to 23% of people appearing before NSW Local Courts on criminal charges may have severe to mild or borderline intellectual disability (New South Wales Law Reform Commission 1993). A much higher percentage is estimated to have a MHD with many having dual diagnosis (both ID or BID and MHD). Despite a variety of court and other diversion and transitional schemes in Australia and elsewhere, there appears to be limited success in the longer term, in keeping people with MHD & CD already arrested by police, out of ongoing CJS entrenchment and re-offending and this is supported by the findings of this current research. This has been due to poor planning; inadequate identification and referral; lack of commitment from and integration with psychiatric services; inadequate resources and lack of suitable accommodation (James 1999; Baldry & Maplestone 2003; Rowlands et al 1996). On their own, such specialist court diversions (the model of therapeutic jurisprudence) do not appear to have reduced the numbers of people with MHDCD in prison.

Within the population of people with MHDCD in the CJS, there is a high proportion with dual diagnosis and other associated disadvantages, such as homelessness and risky behaviours, referred to

in the literature as people with complex needs (Carney 2006; Darine & Salzer 2002). The co-occurrence of a MHD amongst those with ID in the general population is around 50% and while the prevalence in the offending population can be expected to be at least as high there is a lack of knowledge regarding the extent and nature of psychopathology among offenders with ID (O'Brien 2002). Dual diagnosis also refers to those with MHD (excluding substance abuse) and/or CD and a substance abuse problem (Hartwell 2004). These people are doubly disadvantaged (Simpson et al 2001) and at high risk of being caught up in the CJS (NSW Legislative Council Select Committee on Mental Health 2002). There is very little published research on those with dual diagnoses and the CJS in Australia.

Another group needing particular attention is Indigenous Australians. Indigenous people with cognitive disabilities are highly represented in the criminal justice system and face particular challenges in having their disability related needs identified and met (Simpson & Sotiri 2004). The same may well be the case for Aboriginal persons with MHD.

There is though almost no information available on the lifecourse pathways of these people into the criminal justice system.

Why the increase?

There are a number of theories as to why there appears to have been a significant rise in the appearance of people with MHDCD in the CJS (Henderson 2003). Criminalisation of the mentally ill and cognitively disabled as an effect of deinstitutionalisation is commonly cited (Lamberti & Weisman 2001: 65). Although it appears that lack of mental health services in the community following deinstitutionalization is associated with this increase, the lack of community mental health facilities *in itself* may not be the only factor affecting the prevalence of mental illness and intellectual disability in prisons (Fisher et al 2000). The rapid rise in the co-occurrence of substance abuse and mental illness has also been cited as a

very strong contributing factor. Indeed, in an environment in which substance abuse so closely accompanies mental illness, low tolerance to drug crimes (the war on drugs) means an increase in the proportion of these people within the CJS.

In NSW, as in a number of other jurisdictions, legislative changes increasing the use of remand (Baldry et al 2011) and the likelihood of re-incarceration for community correction breaches may be having a disproportionate effect on people with MHDCD as may prevalence of debt and other civil matters. The lack of appropriate accommodation for such released prisoners makes their chances of integration slim (Baldry 2005; Baldry 2010). Importantly the majority of research finds no inherent link between psychiatric disability or ID and *crime* (Simpson & Hogg 2001), but a strong causal link between psychiatric disability and *incarceration* (Henderson 2003) highlighting the impacts that social disadvantages such as homelessness, visibility, prejudice, fear, lack of support and services, and lack of family ability, capacity or will to assist may well be having on these people's life courses. It has been suggested "offending by intellectually disabled persons is directly related to the levels of community care and support and the availability of specialist services" (Byrnes 1999:315).

The social exclusion perspective offers an alternative understanding of the over-representation of people with MHDCD in the CJS and meshes well with critical disability studies and critical criminology perspectives. The concept of social exclusion combines a person's risk and protective factors with system and policy driven problems. Life course studies demonstrate that childhood factors are not reliably or necessarily predictive of CJS involvement, nor are adolescent and adult personal risk factors (Bynner 2000). This does not mean that early intervention is not vital and effective. Rather it suggests that identifying, understanding and removing obstacles to resources are crucial to assisting this group to stay out of the CJS.

MHDCD Study

People with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System in NSW is an Australian Research Council (ARC) Linkage grant project. It is in partnership with Justice Health NSW, Corrective Services NSW, NSW Housing and NSW Council on Intellectual Disability with data agreements with all the CJS and HS agencies noted below. It aimed to create human service and criminal justice life course histories, highlighting points of agency interactions, diversion and support, identify gaps in policy, protocols and service delivery and areas of improvement for CJ and HS agencies and describe individual and group experiences.

It takes a new approach by creating life-course human service & criminal justice histories highlighting points of agency interaction, diversion or support, maps legislation & policy & identifies gaps in protocols and service delivery, noting improvements for CJS & HS agencies. A PhD student on the project has investigated worker beliefs about & attitudes towards offenders with MHD&CD (Snoyman 2010).

The sample is purposive not representative and is taken from the NSW Inmate Health Survey (2001, 2009) & the NSW Department of Corrective Services Statewide Disability Service database and contains 2,731 persons who have been in prison between 2000 and 2008. The project has developed a detailed data set on the life-long human services and criminal justice involvement for this large cohort of offenders using merged but de-identified extant administrative records from criminal justice & human service agencies: Police, Corrections, Justice Health, Courts, Juvenile Justice, Legal Aid, Disability, Housing, Health and Community Services. It is building a pathway and multilevel analysis of these persons' lifecourse pathways through services.

There were significant problems with matching the individuals in the cohort across all agencies as there were many aliases – 30,000 for the 2,731 in the cohort. Because data has been gathered for

different purposes and in different forms (eg definitions vary substantially) it was difficult to clean the data for merging and use in a composite dataset. Eventually, when alias problems had been overcome and the data cleaned, each dataset from each agency was matched then uploaded onto a SQL server that allows relational merging of information.

Study findings to date

Cohort description by primary diagnosis

Full Cohort N=2,731

Intellectual disability N=680

Borderline cognitive disability N=783

Mental health N=965

Substance abuse disorder N= 1276

(note the substance abuse and mental health groups overlap with each other and with the ID and BID groups)

No MHCD diagnosis N=339

Women = 11%

Indigenous Australians = 25%

The cohort has been divided, for the purposes of easy analysis, into the following groups:

Intellectual Disability only - IQ in the ID range less than 70: N= 220

Borderline Intellectual Disability only - IQ in the ID range between 70 & 80: N= 280

Mental Health only - any anxiety disorder, affective disorder or psychosis in the previous 12 months: N= 180

Dual diagnosis (a) -history of mental health problems and an intellectual disability: N= 213

Dual diagnosis (b) -history of mental health problems and a borderline intellectual disability: N= 215

Co - occurring disorder (a) -mental health disorder and a history of substance use: N= 349

Co - occurring disorder (b) - an intellectual disability and a history of substance use: N= 245

Co - occurring disorder (c) - borderline intellectual disability and a history of substance use: N= 288

AOD/PD - any personality disorder or substance use disorder in the previous 12 months and an absence of other category: N= 392

No diagnosis - no Mental Health, Cognitive disability AOD or PD diagnosis: N= 330.

Cognitive disability (CD) ie intellectual disability (ID), borderline intellectual disability (BID) and either of these with other diagnoses (complex) and acquired brain injury (ABI) with either below 70 or between 70 and 80 IQ.

There are 1463 people in the cohort with CD:

- 680 (46%) in the ID (>70 IQ)
 - 465 (68%) have multiple diagnoses (Complex)
 - 215 (32%) have no other diagnosis
- 783 (54%) in the BID range
 - 517 (66%) have multiple diagnoses (Complex)
 - 266 (34%) have no other diagnosis

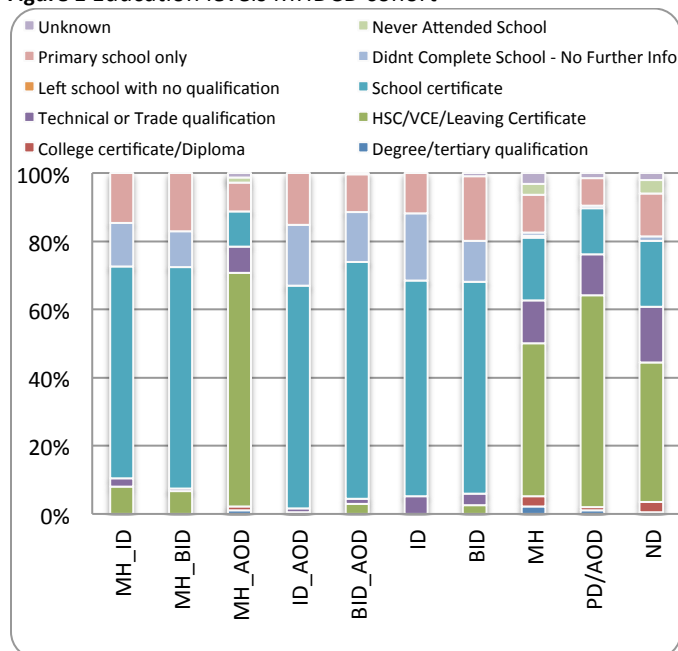
So approx 2/3rd of the CD group has complex needs.

Pathways into, through, around, out of and back into CJS

Education

Although the prison population in general has low levels of education, persons in the diagnosed groups have even lower levels. Those with some form of CD have the worst levels of education as can be seen from Figure 1.

Figure 1 Education levels MHDCD cohort

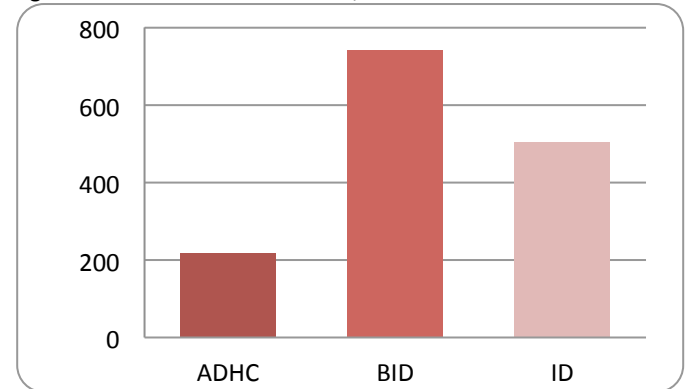


In particular it is clear that those with cognitive disability in combination with any other diagnosis have extremely poor school attainment with by far the majority either having only primary school or leaving school without any qualification.

Disability Service

Of those diagnosed ID only 23% were Ageing Disability and Home Care (ADHC) clients at the time the cohort data was drawn and of the BID group only 4% were ADHC clients (see Figure 2). So there is a very high rate of persons in prison with ID & BID not receiving services from ADHC.

Figure 2 Cohort members who are / are not ADHC clients



There was a high rate of this group who were first diagnosed whilst in prison. 79% of those who are now ADHC clients had been imprisoned prior to becoming a client; in other words they were diagnosed and referred for the first time whilst in prison.

Out of Home Care (OOHC)

The proportion of cohort who had been in OOHC at some time in their childhood is significantly higher than in the general population (at less than 1%). Having been in OOHC is indicative of higher levels of contact with the criminal justice system than those who had not been OOHC.

- 12% of the cohort had been in OHC
- 60% of the OHC group have complex needs
- 80% of this group has cognitive impairment
- Earlier police contact
- Twice as many police contacts
- Twice as many custodial episodes

- Three times as likely to have been incarcerated as a juvenile.

Housing

Not surprisingly, a majority of the cohort sought housing assistance at some stage. Assistance includes both rental assistance and public/community housing provision. Those diagnosed had a high need for assistance (~65-75%) vs the non-diagnosed group of whom less than 50% had ever applied. Of those seeking assistance there was a high rate of provision (~70-80%) for the diagnosed groups. Although complex needs people had higher rates of seeking assistance, MH/BID & ID/AOD had a lower rate of actual assistance.

Housing assistance is being provided at a high rate. But it is known that this group has high levels of homelessness and unsuitable housing (Baldry et al 2006). The problem appears to be in maintaining tenancies that seem to be failing through circumstances such as frequent episodes in prison, escalating mental health and drug problems and behavioural issues with neighbours.

Tenancies failing

Persons with complex needs had higher rates of terminations/evictions than others. 42% of evictions were due to incarceration or re-incarceration.

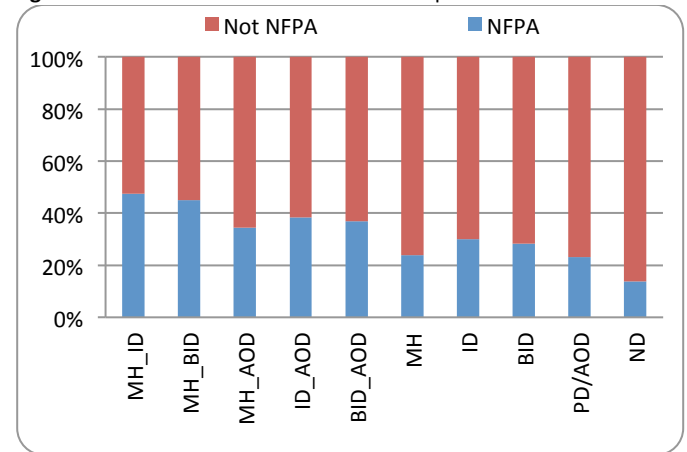
Homelessness

Homelessness markers are not consistently indicated. Nevertheless we have drawn out those with known crisis & homelessness accommodation (no fixed place of abode – NFPA). This does not mean there are not others who have been homeless. HousingNSW housed ~68% of NFPA whereas it housed 44% of those not homeless.

Homelessness and complex needs

The data presents a consistent picture of those in the cohort with complex needs having higher rates of homelessness (Figure 3).

Figure 3 Homelessness and those with complex needs

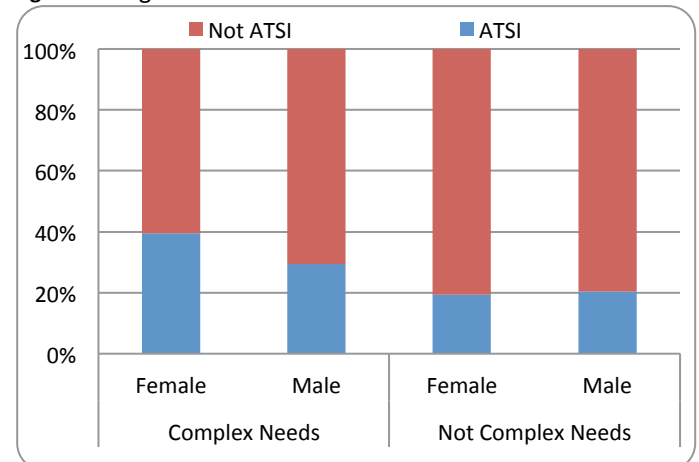


Indigenous members of the cohort and homelessness

Indigenous persons are over-represented amongst those who are homeless in the cohort with 28% of those who experienced homelessness being Indigenous but only 23% of the housed persons being Indigenous.

And Indigenous women form a significantly higher proportion of homeless (Figure 4) than any others in the cohort.

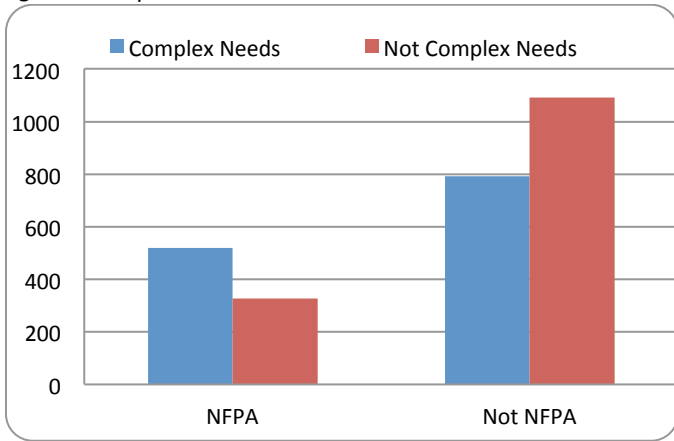
Figure 4 Indigenous Australians & homelessness



Complex needs and homelessness

Those with complex needs form a significantly higher proportion of the homeless than those without complex needs (Figure 5).

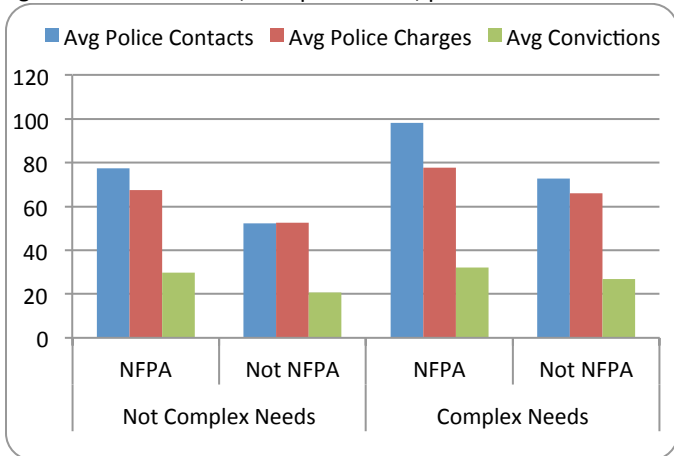
Figure 5 Complex needs and homelessness



And Indigenous women with complex needs form the highest proportion of the homeless. Both male & female with complex needs experience higher homelessness than those without complex needs.

Those who were homeless and with complex needs had significantly more average police contacts & charges & higher average convictions than any other group (Figure 6).

Figure 6 Homelessness, complex needs, police & convictions



Summary housing and homelessness

- Those with complex needs experience greater homelessness and housing disadvantage than those with only 1 or no diagnosis
- High proportion of those with complex needs assisted with housing but almost ½ were evicted due to imprisonment or re-imprisonment.
- Those with complex needs and experiencing homelessness have:

Higher rates of police contact; higher rates of episodes of custody; lower av. days in custody

- Indigenous women with complex needs are significantly more likely to experience homelessness
- Indigenous women with complex needs & homelessness have higher police contacts & higher episodes of custody than anyone else.
- Those with cognitive disability combined with any other disability or disorder & homelessness have higher rates of police and custody episodes than other complex needs and those without complex needs.
- The pathway analysis is suggesting that many in this group with complex needs may never have lived in or had housing in a mainstream community setting and may have, from an early age begun cycling in a liminal, marginal physical and personal space connected with social control agencies.

Police and custody first Contact

The average age at first police contact for the BID/ID/MH/AOD complex groups is significantly lower than those with single or no diagnosis as shown in Figure 7. Note that the averages are biased due to a few much older first contacts. This is highlighted by the fact that ~50% had first contact before age 18 (ie median age). The significantly higher age of first contact with police for those with MH only, may be due to later onset of mental illness. Females tend to be slightly older at first police, custodial and conviction points.

Figure 7 Average age First police contact, conviction and custodial episode

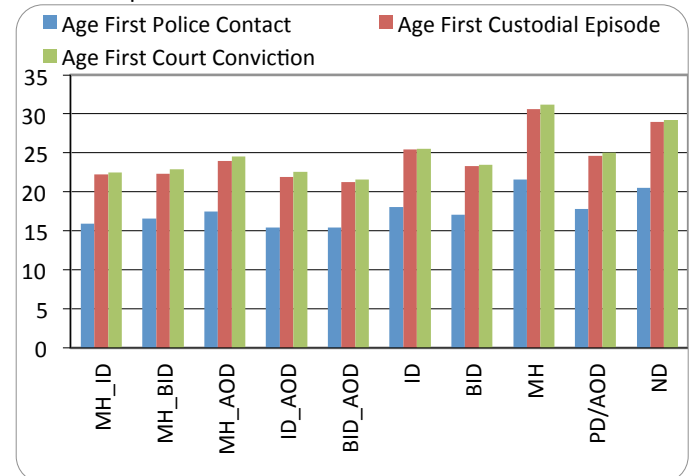


Figure 8 Average Age First Police, conviction and custody for Indigenous persons

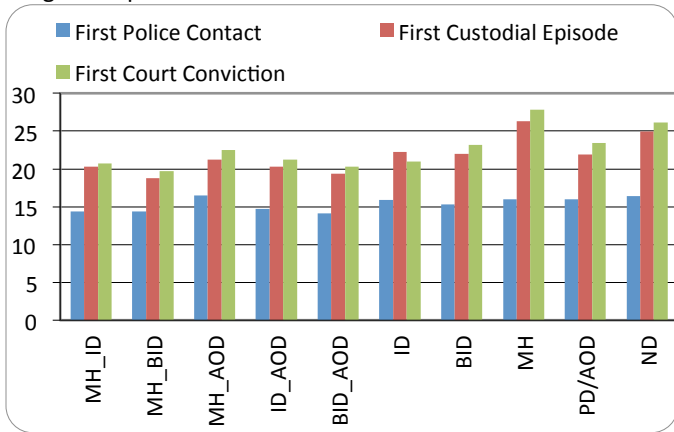
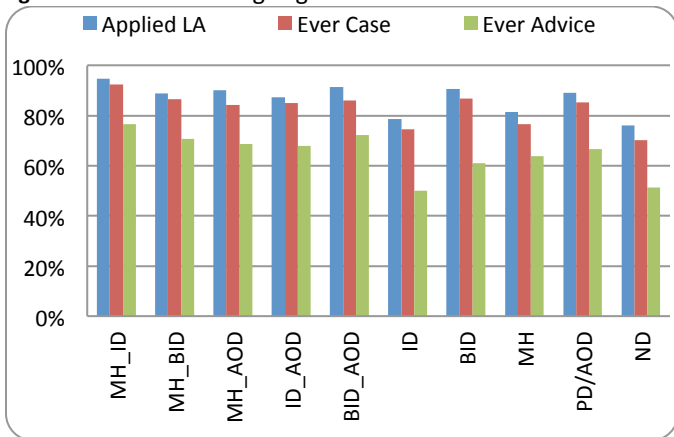


Figure 8 shows significantly lower age of first contact for Indigenous members of the cohort overall and especially first contact with police. Note there is much less difference across the groups for first police contact compared with significant variation across groups in the total cohort. Nevertheless those groups with complex cognitive disability diagnoses again have the lowest ages at first police, custody and conviction points.

Legal Aid

Almost all in the cohort have applied to Legal Aid (LA) for assistance at some point in time as either juveniles or adults or both (av. ~95%) (see Figure 9). A very high proportion of those who applied were represented by LA at least once at some point (av ~89%). A reasonably high proportion has also received legal advice over the phone (68%-80%).

Figure 9 Cohort receiving Legal Aid services



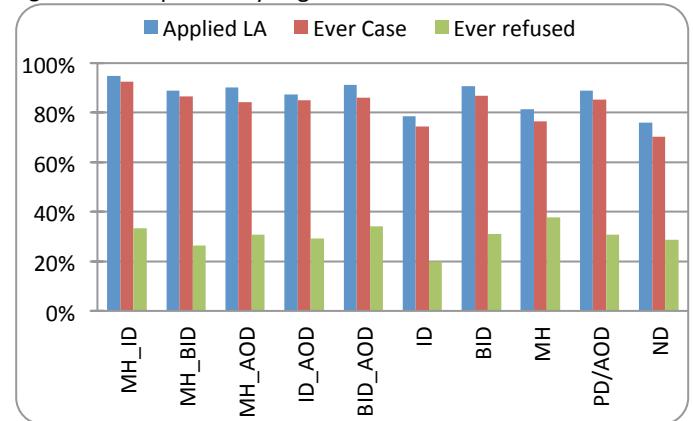
There are though significant differences between the groups in their use of LA. The complex groups

have applied at a significantly higher rate than the ID only, MH only and no diagnosis groups. There is also a significant difference between those receiving legal advice with significantly more in the complex groups receiving advice. Significantly fewer members of the no diagnosis group have ever had a case with LA than the other groups (with the exception of ID only group).

Legal Aid Acceptance rate

Figure 10 shows the rate at which LA cases were accepted for the groups in this cohort. The no diagnosis group had a significantly lower rate of applications and approvals than most of the other groups, and the ID only group had a significantly lower rate of refusal than any other group.

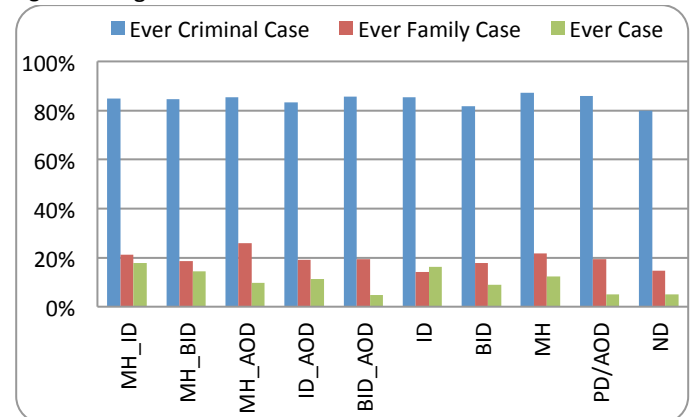
Figure 10 Acceptance by Legal Aid



Types of Legal Matters dealt with by Legal Aid

Although by far the majority of matters dealt with by Legal Aid for the cohort were criminal cases, there were quite a number of civil and family matters as indicated in Figure 11.

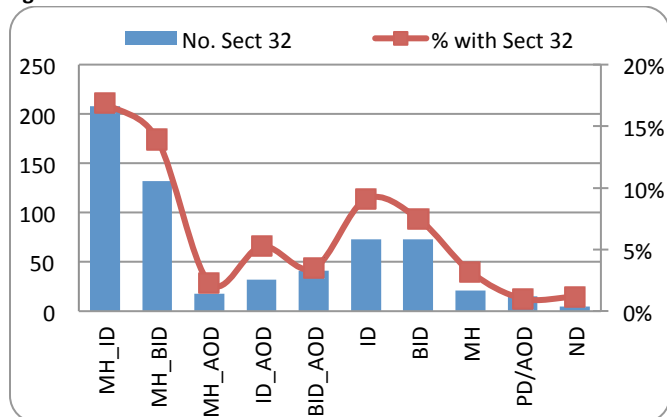
Figure 11 Legal Aid Matters



Use of Section 32

There is a surprising low number of dismissals, including as both juvenile and adult offender, under Sec 32 of the Mental Health (Criminal Procedures) Act for a cohort such as this (see Figure 12). Sec 32 is diversionary allowing the judicial officer to divert a mentally or cognitively disabled person from custody to a community support option. Altogether, for everyone in the cohort and across their whole history as adult offenders there were only 618 dismissals under Sec 32. Of course this may be partly good news in that many offenders with disability who received a Sec 32 may not have returned to prison and therefore are not in this cohort. But the fact that so few in the cohort who would be obviously eligible to apply for Sec 32 have not even applied is concerning.

Figure 12 Dismissals under Sec 32



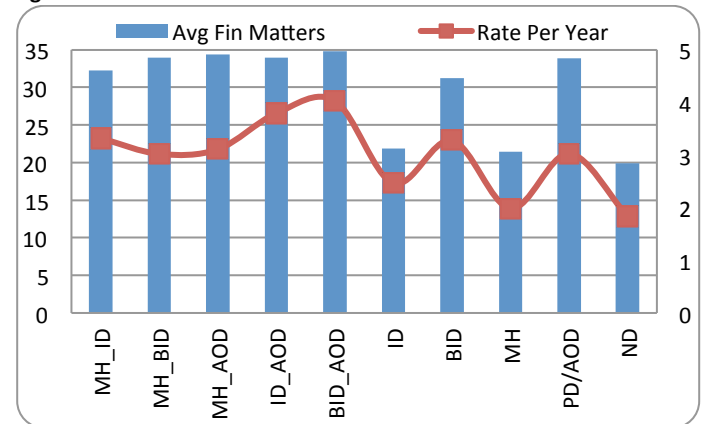
Nevertheless a significantly higher proportion of those in the groups with MH/ID (17%) and MH/BID (14%) had matters dismissed under Sec 32 than any other groups. It is surprising that only 9% of the ID only group have ever had a matter dismissed using Sec 32 given that all members of this group have under 70 IQ. This supports the conclusions reached in the Report *Enabling Justice* (IDRS 2008), which argued that Sec 32 is underused as a means by which to manage offenders with MHD and CD in the community. There may be many reasons for this not least of which may be lack of identification of these persons as having disability especially when they are juveniles, lack of familiarity with Sec 32 by LA and duty lawyers, recommendations by

lawyers to plead guilty and the lack of appropriate community case management options.

Court Finalised Matters

Figure 13 shows the same pattern for court finalized matters as for police contact: those with cognitive complex needs have the highest rates of finalized matters overall and higher rates each year.

Figure 13 Court finalized matters

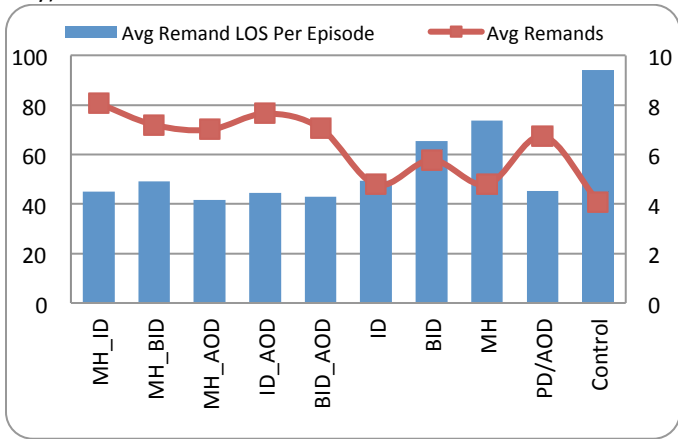


Bail and Remand(adult only)

Across the whole cohort for all court finalized matters, there was a higher proportion who had received bail than were held on remand or had bail dispensed with, nevertheless 30 % had had bail refused and had been remanded in custody. There are though significant differences across the groups for bail/remand status. Those with ID only had a significantly lower proportion of their group have bail refused than the other groups.

There are also significant differences between the groups regarding averages of episodes of remand and length of time spent on remand (Figure 14). The Cognitive complex groups have significantly higher numbers of episodes of remand than the single and no diagnosis groups but significantly shorter periods spent in remand for each of those episodes.

Figure 14 Episodes of and time spent in Remand (adult system only)

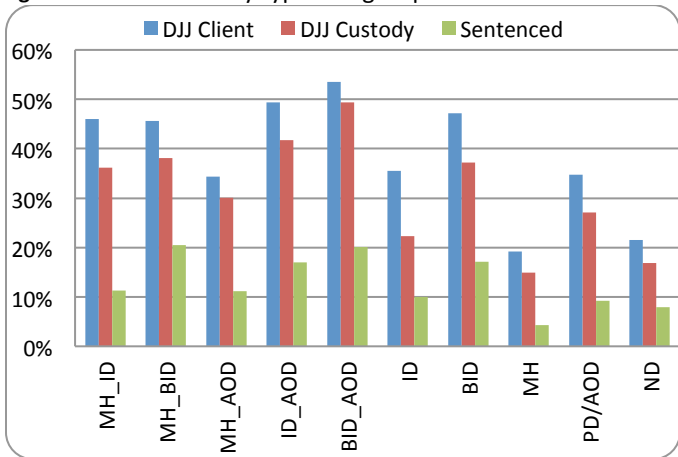


Juvenile Justice

Contact with Juvenile Justice

Figure 15 shows there is a significantly higher contact rate for those with CD complex diagnoses with Juvenile Justice than for those without a diagnosis, with a single diagnosis or without a CD diagnosis of some sort. Those with cognitive and complex needs had a significantly higher likelihood of being clients of Juvenile Justice than those with a MH or no diagnosis. Between 40 and 60% of those with complex cognitive disability had been clients of Juvenile Justice while ~20% of the MH only and no diagnosis group had been clients.

Figure 15 Clients of JJ by type and group

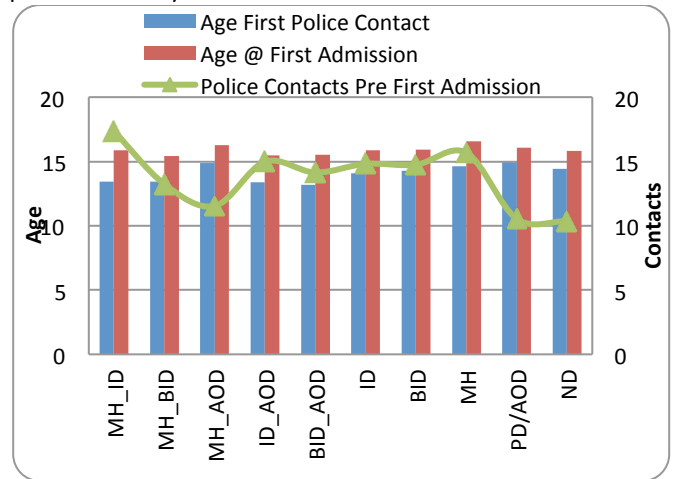


First Police and JJ contact

The pattern of earlier average first police and earlier first JJ contact for the CD complex diagnosis groups is repeated in Figure 16. It can also be seen that there were significantly more police contacts prior to first custody for these complex groups

suggesting police and perhaps community advocacy attempted to keep them out of custody for longer than those without a disability.

Figure 16 Average first Police & JJ contact & police contacts prior to custody

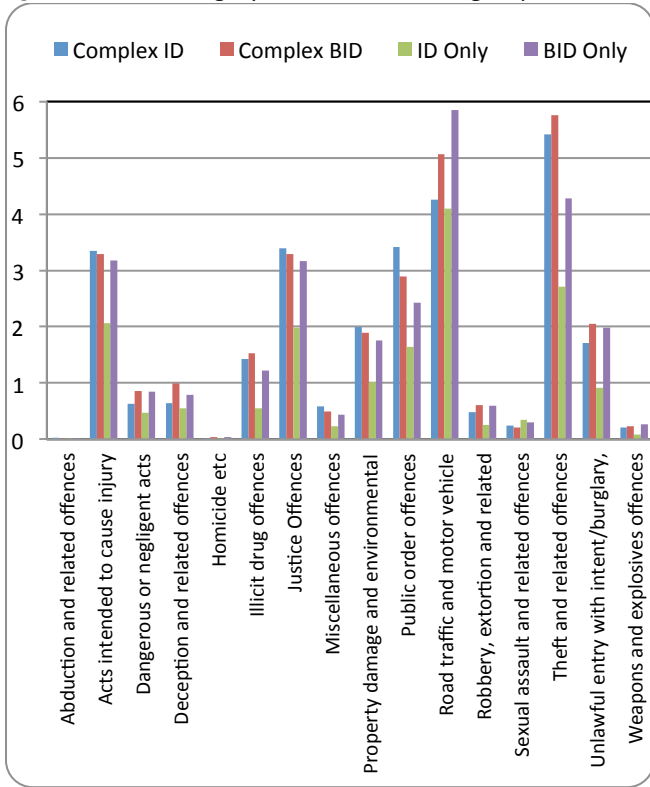


Offence types

Theft and road traffic/motor vehicle regulatory offences were the most common offences at around 20% of all groups. Justice Offences were the next most common at around 10% across all groups. ‘Acts intended to cause injury’ was also a common offence across the cohort (approx. 10%), except for those with co-occurring disorders – intellectual disability/mental health disorder and history of substance abuse groups who were more likely to commit public order offences (approx. 10%).

For the CD groups, rates of convictions are even more concentrated around theft, road traffic, public order and justice offences and acts intended to cause injury. As can be seen in Figure 17 traffic offences are the most consistent convictions across the groups.

Figure 17 ASOC Category convictions for CD groups



Trajectories into the CJS

For the Complex ID group, first police contact for ~80% was before age 21 and there was high and ongoing contact over time and age (see Figure 18). Prison rates continue through life. So prison episodes do not appear to have a rehabilitative effect on offenders or reduce police contact.

Figure 18 Police contact for Complex ID group

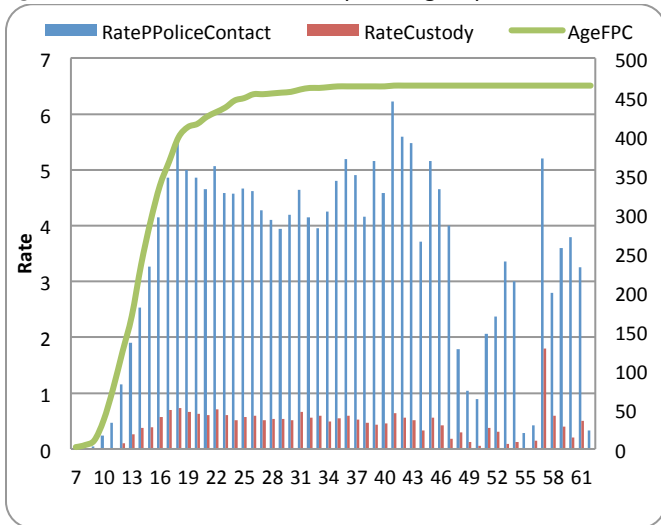
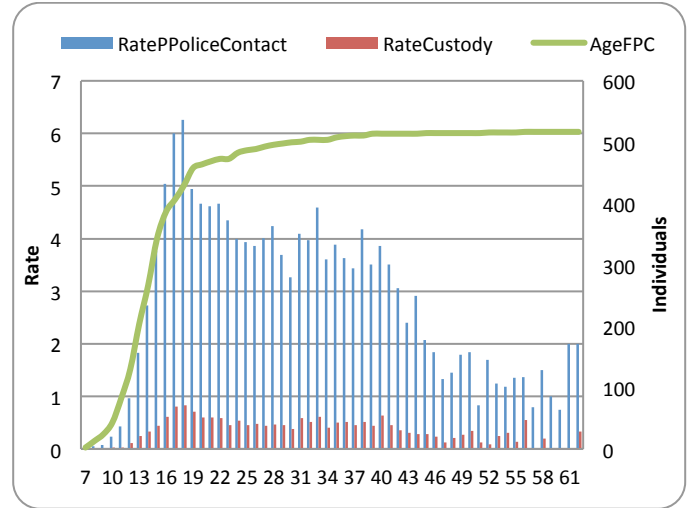


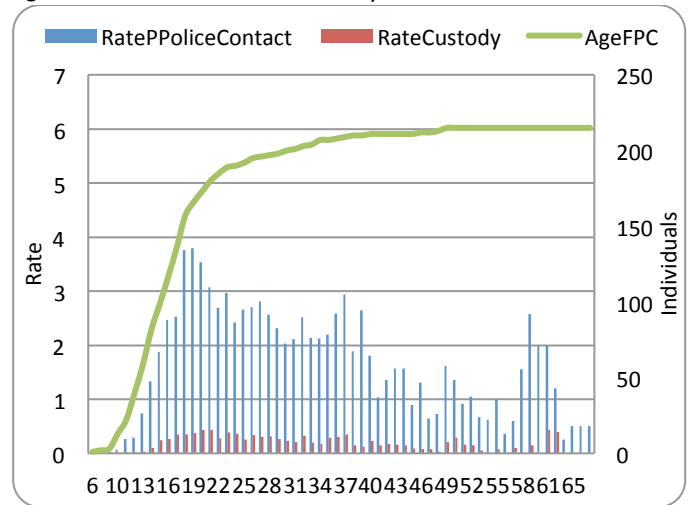
Figure 19 shows that, for the complex BID group, first police contact for ~ 80% was even earlier than for the ID complex group at before age 19 and with relatively high and ongoing contact but less than that for the ID complex group. The rehabilitative impact of continued incarceration on re-offending and police contact, as with the complex ID group, appears minimal.

Figure 19 Police contact for Complex BID group



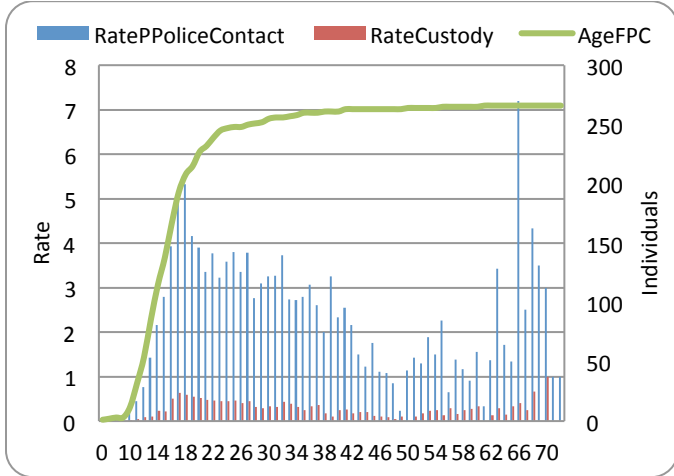
The ID only group (Figure 20) had first police contact spread over a longer period and significantly lower numbers of contacts, but still ongoing lifetime contact.

Figure 20 Police Contact for ID only



The BID only group (Figure 21) had a similar trajectory to the ID only group but a lower number of contacts and lower continuing contact.

Figure 21 Police contact for BID only



Time in custody

Those with complex needs have higher rates of episodes in custody but significantly shorter duration each time in custody than those with single or no diagnosis (see Figure 22 & Figure 23).

Figure 22 Custodial episodes

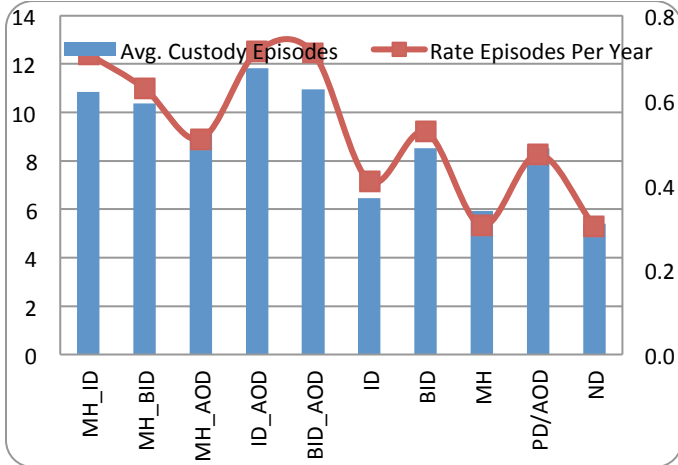
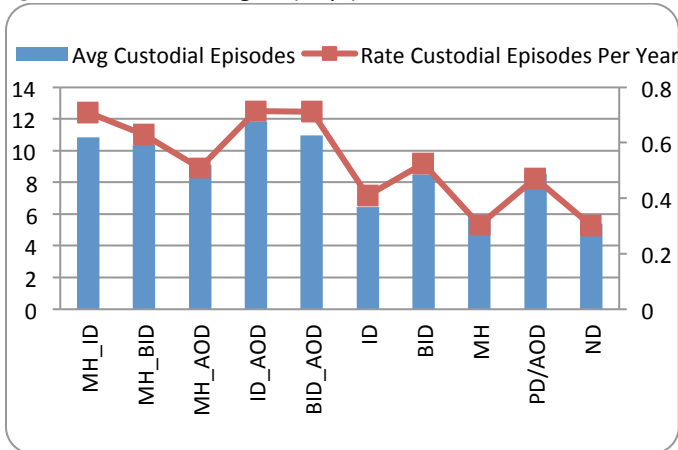


Figure 23 Custodial lengths (Days)



Gender differences

- Women have higher rate of custodial episodes per year than men
- Women with complex needs have significantly higher number and rate of custodial episodes than their male counterparts
- But men have significantly greater number of days in custody than females
- So women have more custodial episodes but they are shorter in duration than men's resulting in a greater rate of cycling in and out of prison for women with complex needs
- Women with complex needs spend less time in remand but have a higher number of remand episodes than the average and than those with single or no diagnosis
- 75% of women in the cohort were reliant on social housing
- 1/3rd of the women were clients of juvenile justice
- Only 7% of women with a cognitive disability were supported by Disability Services

Aboriginal persons in the cohort

- 86% of the Indigenous people in the cohort is male, 14% female.
- 91% of the Indigenous cohort identified with MHD/CD; most have complex needs, eg of those with MHD, 77% have AOD and 36% also have a CD.
- Indigenous persons in the cohort had significantly higher number and rate of convictions than non-Indigenous persons.

Conclusions

These findings indicate that those with complex cognitive disability (ie comorbidity / dual diagnosis) are significantly more likely to have earlier contact with police, more police episodes, be more likely to have been clients of juvenile justice, have more police episodes through life and more prison episodes than those with single, or no diagnosis and for this high and ongoing contact with the

criminal justice system (CJS) to lock them into the CJS very early rather than assist in rehabilitation. Their offences are almost all in the lowest 10% of seriousness.

Those with complex needs have significantly higher offences, convictions and imprisonments than single and non-diagnosis persons both as juveniles and adults. Those with cognitive impairment in combination with any other disability had the highest rates of CJS involvement both early and ongoing into later years. They had had very poor school education and low disability service recognition and support and although there were strong housing responses people in these groups do not appear to be able to maintain their tenancies. They were significantly more likely to experience homelessness, and Indigenous girls and women with complex needs were more likely than any other group to experience these problems. As an indication that appropriate supportive intervention can assist these persons to a significant degree, those becoming clients of ADHC after going to prison fared much better than those who did not become clients. This appears to be the case because they were afforded holistic case managed supported accommodation with appropriate disability service support.

It can be theorized that many in these groups with complex needs become locked, early in their lives, into cycling around in a liminal, marginalised community/criminal justice space (Baldry et al 2008; Baldry 2009; Dowse et al 2009; Baldry 2010), a space that is neither fully in the community or fully in the prison. They do not fall through cracks, they are directed into the criminal justice conveyor belt. This suggests it is important to recognise the different space & need for different disability and rehabilitative interventions and supports at many points along these persons' pathways.

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