People with intellectual and other cognitive disability in the criminal justice system

Final 1.0

Operational Performance Directorate

Ageing, Disability and Home Care

Department of Families and Community Services NSW

December 2012

NSW GOVERNMENT Family & Community Services Ageing, Disability & Home Care

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People with intellectual and other cognitive disability in the criminal justice system

Report for

NSW Family and Community Services

Ageing, Disability and Home Care

Professor Eileen Baldry, Dr Leanne Dowse and Ms Melissa Clarence

December 2012

Citation

Baldry, E. Dowse, L. and Clarence, M. (2012) *People with intellectual and other cognitive disability in the criminal justice system*. Sydney, University of New South Wales.

ISBN: 978-0-9873593-1-5

Acknowledgements

The data presented in this report is derived from:

Australian Research Council (ARC) Linkage Grant (Project LP0669246) at UNSW 'People with mental health disorders and cognitive disability in the criminal justice system in NSW'. Chief Investigators: Eileen Baldry, Leanne Dowse, Ian Webster; Partner Investigators: Tony Butler, Simon Eyland and Jim Simpson. Partner Organisations: Corrective Services NSW, Housing NSW, Justice Health NSW, Juvenile Justice NSW, and the NSW Council on Intellectual Disability.

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Content of this report was accurate at the time of delivery in June 2012

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ACRONYMS

ABI	Acquired Brain Injury
ADHC	Ageing, Disability and Home Care
AOD	Alcohol and other Drugs
ARC	Australian Research Council
ASOC	Australian Standard Offence Categories
BID	Borderline Intellectual Disability
BOCSAR	Bureau of Crime Statistics
BPD	Borderline Personality Disorder
CD	Cognitive Disability
CJS	Criminal Justice System
CN	Complex Needs
HS	Health Services
ID	Intellectual Disability
IHS	Inmate Health Survey
IQ	Intelligence Quotient
MH	Mental Health
MHA	Mental Health Act
MHD	Mental Health Diagnosis
MHDDC	Mental Health Disorder and Cognitive Disability
NFPA	No Fixed Place of Abode (Homeless)
NGO	Non-Government Agency
OOHC	Out of Home Care
PD	Personality Disorder
POI	Person of Interest
SDD	Statewide Disability Dataset
WAIS-R	Wechsler Adult Intelligence Scale Revised

Executive Summary

This report outlines the key findings of a research project conducted by investigators at UNSW on a cohort of 2,731 individuals whose mental health disorders and cognitive disability (MHDCD) diagnoses are known, who have been in prison and whose criminal justice and human service contacts have been compiled into a linked and de-identified dataset (The MHDCD dataset). It is the third deliverable in a project funded by NSW Family and Community Services, Ageing, Disability and Home Care (ADHC) under the Research Grants Program 08/09. The two other deliverables, a Data Dictionary of ADHC data in the MHDCD dataset and a Policy and Legislative Map relevant to this group were completed in 2010.

Description of the Project

The MHDCD dataset is the outcome of an ARC Linkage project completed in 2009 which used identifiers from the 2001 NSW Inmate Health Survey (IHS) and from the NSW Department of Corrective Services State-wide Disability Service Database (SDD) to draw data on a cohort of individuals whose mental health disorders and cognitive disability diagnoses are known (including Intellectual Disability and Borderline Intellectual Disability), from Criminal Justice and Human Service agencies in New South Wales including Corrective Services NSW; Juvenile Justice NSW; The NSW Police Force; Justice Health; NSW Bureau of Crime Statistics and Research (BOCSAR), Legal Aid NSW, Community Services; ADHC; Housing NSW, and Health NSW. Data has been drawn from each agency on the 2,731 individuals in the cohort, linked in a relational database and de-identified prior to analysis. The dataset allows description and analysis of the pathways, aggregated by diagnostic group, taken by persons in the cohort through criminal justice and human service agencies. It also enables detailed analysis of the trajectories of particular individuals in the cohort. This report contains findings from these two levels of analysis, that is, aggregate pathway data and individual case studies.

Specifically this report is in three parts as follows:

1. A general description of the whole MHDCD cohort by diagnostic and demographic characteristics, including gender and Indigenous status, criminal justice history including patterns of police contact, juvenile justice contact, patterns of offending and custody.
2. Analysis of individuals in the cohort who have an Intellectual Disability (IQ<70) (ID) and a Borderline Intellectual Disability (IQ 70-80) (BID) and those from these groups who are clients of ADHC. Those who have been clients of the Community Justice Program (CJP) are reported separately. Comparative analysis of the pathways of these four groups is undertaken in relation to their Police contact, Court records, Corrections history, Juvenile Justice contact and Legal Aid provision. In addition their Health, Housing and Community Services use is reported. Those with Borderline Personality Disorder (BPD) are reported in some detail.

3. Case studies of five individuals in the cohort chosen from the MHDCD Dataset to bring into focus the compounding effects having more than one disability and disadvantage have on individual interactions with criminal justice and human service agencies including ADHC and CJP.

Findings from the Project

Key findings are:

- There are 1463 individuals with a cognitive disability (CD), 680 of who have an ID and 783 have a borderline intellectual disability. Of these approximately 66% has complex needs, that is, have dual diagnosis[1], co-morbidity[2] and multiple mental, physical and cognitive disabilities.
- Indigenous Australians have higher rates of intellectual disability at 65% when compared to 54% of the whole cohort.
- The average age of first police contact[3], is 17.7 years, with approximately 50% of the cohort having had first police contact by their sixteenth birthday. By the age of 21, almost 50% of the cohort had been convicted of at least one offence and had spent time in prison. For those with cognitive disability the average age of first police contact is younger at 16.5 years. This group went into custody on average over one year sooner than those without a CD.
- The average age at first police contact for the BID/ID, Mental Health (MH) and Alcohol and Other Drugs (AOD) complex groups is significantly lower than those with single or no diagnosis (ND).
- Seventy per cent of the cohort had an average of 19 police contacts as a juvenile.
- Those with CD had almost twenty-two more police contacts over their lifecourse with over two additional contacts per year (at 5.5) than those without cognitive disability.
- Having a CD is associated with a much higher rate of custodial episodes, those with a CD having almost twice as many episodes per year as those without, though those with an ID only have fewer episodes than the rest of the CD group.
- Females with a CD experience earlier police contact, and have substantially more police contact, and earlier first custody and conviction than their male counterparts.
- For Indigenous Australians, having a CD is associated with earlier police contact and higher levels of contact than those without this disability. When compared with those with a CD who are not Indigenous, this group had police contact over two years earlier, with earlier custody and earlier first conviction. Indigenous Australians with a CD also progress more quickly to custody from police contact than non-Indigenous people with a CD, on average approximately one year faster with more episodes in custody than the comparable non-Indigenous group.

Analysis of the pathways of ADHC and the CJP clients indicate the following key issues:

[1] Mental health disorder and alcohol or other drug problematic use

[2] Mental health and cognitive disability

[3] Defined as where the person is of interest in an investigation

- Only a small proportion of individuals in the MHDCD cohort with a CD had received services from ADHC including both the CJP (n=86) and other ADHC services (n=131), with 504 individuals with an ID and 743 individuals with a BID never having received a disability service.
- Contact with ADHC services is highest for the ID groups as would be expected, however, even in these groups the contact is only around a quarter of those who would appear to be eligible.
- Of the 217 individuals who have received ADHC services, 89% are male and 11% are female, 25% are Indigenous, 71% are non-Indigenous and 4% have an unknown Indigenous status.
- 79% of the 217 who are clients of ADHC only became clients after being identified as having a cognitive disability whilst in prison.
- A high number of individuals in the CJP have complex needs, with almost three quarters of these individuals having multiple diagnoses.
- Homelessness has been experienced by 55% of CJP clients and by 49% of the ADHC group. For those who are not clients of ADHC, 38% of the BID group and 37% of the ID group are reported as experiencing homelessness at some point.
- Indigenous persons with a CD are slightly less likely to receive a disability service than non-Indigenous persons however they comprise a higher proportion than would be expected of CJP clients.
- Almost all individuals with a CD, whether or not a recipient of a disability service, had high levels of police contact both as victims and offenders.
- Individuals who were clients of ADHC have substantially higher contact with police under the Mental Health Act, with those in the CJP having the highest average of almost fourteen contacts per person, resulting in a higher proportion of time spent in custody than other groups. This suggests that the CJP is indeed working with those who are the most complex of the CD cohort.
- The ADHC group has the lowest proportion of days in custody.
- In relation to Juvenile Justice contact, those who had received an ADHC service (non CJP) had the lowest rates of being a client and being in custody as a juvenile, while 50% the CJP group had been in custody as a juvenile.
- The CJP group had the highest proportion of individuals who had been in Out Of Home Care (OOHC) as a child (31%), with 20% of the ADHC group, 16% of the ID and 16% of the BID group who were not ADHC clients experiencing OOHC. This pattern is repeated for the number of episodes in OOHC.
- CJP clients had the highest incidence of admissions to hospital at 80%, although all other groups had a relatively high proportion of individuals with hospital admissions. This pattern is repeated for the groups specifically in relation to psychiatric admission with 40% of CJP clients, 36% of ADHC clients, and 28% of each of the BID and ID groups having had at least one psychiatric admission.
- In relation to housing, ADHC clients received the highest numbers of housing tenancies with an application rate of 66% as compared with 56% for the ID group and 54% for the BID and CJP groups. This same pattern is evident in relation to rental assistance. The proportion of individuals, who have had a failed tenancy, is around 15% for all groups.

- All groups are serviced by Legal Aid with high frequency with the BID and the CJP groups having the highest proportion of applicants at 90%, followed by the ADHC group with 85%. CJP clients have the highest number of applications at twelve per individual. By far the greatest proportion of legal aid was granted for criminal matters.
- Sixteen per cent of the CJP group had been diagnosed with a Borderline Personality Disorder (B) with an over-representation of females to males. Those with a BPD in the CJP had a greater volume of police contact both as victims and offenders. This group also had a significantly higher rate of contact with Police under the Mental Health Act and much earlier contact with all sections of the CJS, with an average age at first police contact at fourteen years of age. This translated to a higher average number of custody episodes.

The case studies included in this report offer an in-depth and detailed narrative on the lives of five individuals, two females and three males, from the study cohort whose diagnostic and service profiles are as either service users or within the purview of ADHC services. They include Natalie[4] who is an ADHC (but not CJP) client who has complex needs, Ned who is not a client of ADHC although has an ID and a MH diagnoses, and three CJP clients: Casey (case study 5) who has a MH diagnosis and an ID, Matthew (Case study 2) who has a MH diagnosis, BID and experience of homelessness; and Eddie who has a primary diagnosis of a BPD and an ID. The case studies detail the chronology of each individual's early, intensive and ongoing enmeshment within the criminal justice system (CJS), their multiple human service interventions and the myriad layers of individual and social disadvantage that infuse their lives and increase their experience of disability and the range of support needs that emerged as a result. Taken together they give a dynamic sense of the very high human, social and economic costs that accrue to this group of highly marginalised and disadvantaged individuals.

Conclusions and Further Exploration

Having a cognitive impairment predisposes persons who also experience other disadvantageous social circumstances to a greater enmeshment with the CJS early in life and persons with cognitive impairment and other disability such as mental health and AOD disorders (complex needs) are significantly more likely to have earlier, ongoing and more intense police, juvenile justice, court and corrections episodes and events. The cognitive and complex needs groups in the study have experienced low rates of disability support as children, young people and adults with Indigenous members of the cohort having the lowest levels of service and support. It is evident that those who are afforded ADHC support do better, with less involvement in the CJS after they become clients compared with those with cognitive disability who do not receive ADHC services.

[4] All names used here are fictitious

It is evident that CJP clients are at the more complex and 'deeply enmeshed in the CJS' end of the MHDCD cohort, that the CJP is engaging the most complex cognitive impairment individuals, and it may be the case that their significantly greater police, court and imprisonment events may have been before their entry into the CJP. It is recommended that further analysis be undertaken to explore and clarify the impact of this intervention.

It is also evident that particular aspects of persons with cognitive impairments' lives and contexts are 'markers' of their deeper CJS histories: contexts such as their family's capabilities and resources, their lack of access to disability services, their school education, their being in out of home care, their events in juvenile justice and their housing circumstances are all important in determining their pathways. Those with a BPD are also evidently more likely to have deeper CJS histories, a matter warranting further analysis.

Project Description

The Mental Health Disorders and Cognitive Disability (MHDCD) in the Criminal Justice System (CJS) study involves a cohort of 2,731 people drawn from the 2001 NSW Inmate Health Survey (IHS) and from the NSW Department of Corrective Services State-wide Disability Service Database (SDD). This project represents an innovative approach to researching populations who experience multiple and compounding disabilities, health and social disadvantages (complex needs) by creating a detailed dataset on the life-long Criminal Justice (CJ) and Human Services (HS) involvement for a cohort of offenders using linked but de-identified extant administrative records from CJ agencies (Corrective Services NSW; Juvenile Justice NSW; NSW Police Force; Justice Health; Bureau of Crime Statistics and Research (BOCSAR), and Legal Aid NSW) and HS (Community Services; ADHC; Housing NSW, and Health). Linking data across CJS sub-systems with Health and Human Services data reveals a coherent picture of the multiple factors contributing to the complex pathways of people with MHDCD into and through the CJS and is assisting in the development of new interventions to address offending, preventative health, duty of care and human rights needs.

Cohort Description

The cohort was divided into ten study groups to enable analysis and identify trends across diagnostic groups. These are detailed below in Table 1. Diagnostic information on mental health was obtained from the 2001 Justice Health Inmate Health Survey, with mental health from this subset of data defined as any anxiety, affective or psychotic episode in the previous twelve months as determined by the International Classification of Disease 10. Diagnostic information regarding CD, either an ID or BID, was obtained from the SDD at Corrective Services NSW. In this report, CD is used for any individual with an IQ assessment with a result below 80, without differentiation between an Acquired Brain Injury (ABI) and a developmental disorder. Intellectual disability was predominantly assessed using the WAIS-R measure of intelligence, however when assessed in a prison the adaptive functioning component of this measure was not utilised, as it is impossible to measure usual social adaptive functioning in the abnormal context of prison. Additionally, staff at Corrective Services NSW obtained confirmation when available of any assessments conducted when an individual was a juvenile. For individuals with a CD, co-existing diagnoses (MHDs) were identified from the SDD, however this was not collected in the same systematic manner as in the Inmate Health Survey. Rather this data relied on a range of assessments, including those conducted by staff or undertaken for court reports, and these diagnoses reflect a historical presence of the conditions and are not necessarily indicative of the condition existing in the preceding twelve months.

The cohort consists of 2,731 individuals who have been incarcerated as an adult in NSW. This is a purposive not a representative sample, intentionally focusing on those whose MH and CD diagnoses are

known, but with a no-diagnosis group for comparative purposes. It is important to remember whilst reading this report, that the cohort is not representative but is intended to provide in depth information on life course pathways for people with a MH disorder & a CD in the CJS. Thirty five percent (965) has a history of anxiety, affective disorders or psychosis (MH), 54% (1463) a cognitive disability, 56% (1518) a substance use disorder (AOD) and 22% (609) a personality disorder (PD). There is a great deal of cross over between these categories, and the complexity of these interactions is illustrated in the detailed analysis undertaken of the five individuals in the Case Studies. To capture this complexity, the cohort was divided into smaller sub-groups to identify different pathways for people with different diagnoses or combinations of diagnoses. The breakdown of the cohort into these groups is displayed below in Table 1.

These groups are not mutually exclusive. The allocation to a study group was made in descending order as depicted in the hierarchy present in Table 1, and so the presence of an individual in a study group does not indicate an absence of another disability or diagnosis further down the hierarchy. For example, individuals in study group one, the MH_ID group may also have an AOD history and/or a PD.

Table 1: Definitions Of Study Groups And Compilation Of Cohort

Study Group Name	Definition	Number
1. MH_ID – Dual diagnosis (a)	History of mental health problems and an intellectual disability	213
2. MH_BID – Dual diagnosis (b)	History of mental health problems and a borderline intellectual disability	215
3. MH_AOD – Co-occurring disorder (a)	Mental health disorder and a history of substance use	349
4. ID_AOD – Co-occurring disorder (b)	Defined as an intellectual disability and a history of substance use	247
5. BID_AOD – Co-occurring disorder (c)	Defined as borderline intellectual disability and a history of substance use	288
6. ID – Intellectual Disability	IQ scores less than 70 - no confirmation of adaptive functioning or age of onset	220
7. BID – Borderline Intellectual Disability	IQ scores between 70 and 80 - no confirmation of adaptive functioning or age of onset	280
8. MH – Mental Health	Any anxiety disorder, affective disorder or psychosis in the previous 12 months	188
9. AOD/PD	Any personality disorder or substance use disorder in the previous 12 months and an absence of other category	392
10. ND – No diagnosis	No mental health or cognitive disability diagnosis	339
Total		**2731**

The first five groups detailed above (N=1312) have either dual or multiple diagnoses. Individuals in these groups will be referred to throughout the report as having complex needs. Complex needs encompasses dual diagnosis[5], co-morbidity[6] and multiple mental, physical and cognitive disabilities[7]. Individuals with complex needs have a different pattern of contact with the CJS, associated with cycling in and out of the CJS more rapidly and more often, compared to those without complex needs. Individuals in the case studies provide salient and real-life examples of this constellation of complex needs, since all have multiple diagnostic labels, for example Natalie in Case Study 1 who has a BID, MH diagnoses and an AOD history. Many also have compounding social disadvantage such as homelessness or having experienced out of home care as a child.

In total, there are 1463 individuals with a CD, of which 680 have an ID and 783 have a BID. Nine hundred and sixty five individuals have a MH disorder (any anxiety, affective or psychotic disorder). One thousand five hundred and eighteen individuals across all categories have problematic substance use, whilst 609 individuals have a BPD.

A range of analyses were conducted comparing individuals by diagnosis regardless of study group that they were in. For example, individuals in the MH_ID, MH_BID groups may also have a PD, and so analysis was conducted for all individuals with the diagnosis of a PD. This analysis was conducted across all diagnosis types to examine the influence of any specific diagnosis, which might be obscured by the creation of the study groups.

Data was drawn from participating agencies between 2008 and 2011. At this time information was captured from the earliest point of contact with an agency up to the day the data was drawn.

1. Demographics

1.1. Age

The average age[8] for people in the cohort is 35.8 years, however there is large variation in age across the study groups as a result of the different timeframes associated with the cohort establishment process. Figure 1 shows the variation in average age across the groups. To address this variation in average age across the study groups, rates of contact per year will be used where possible to demonstrate variations in contact across the study groups.

[5] Mental health disorder and alcohol or other drug problematic use

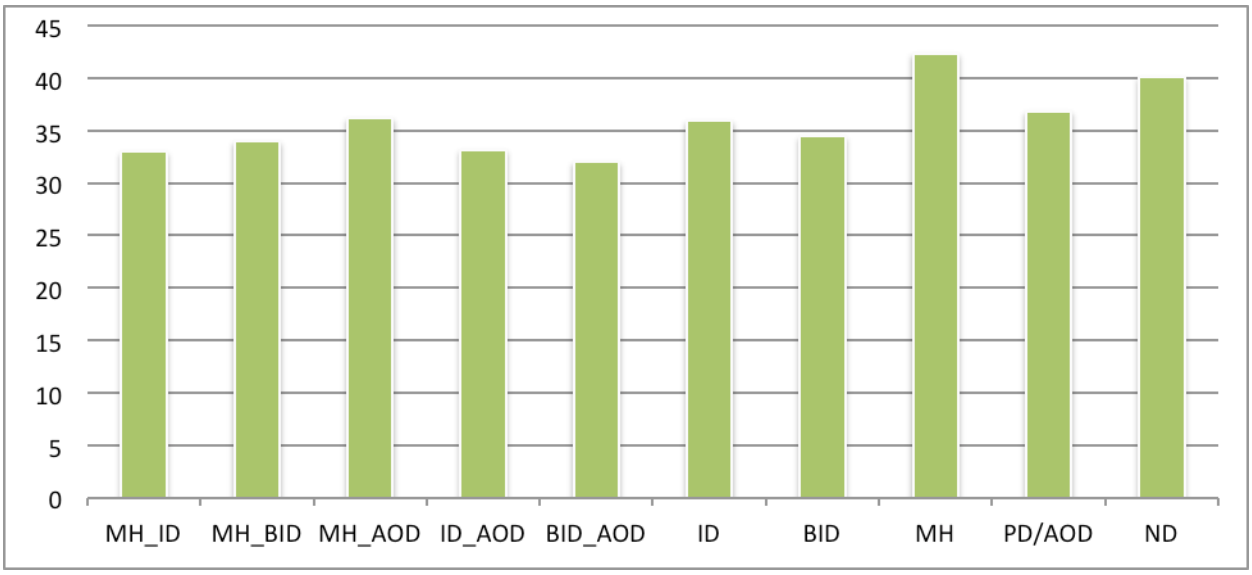
[6] Mental health and cognitive disability

[7] Cognitive disability includes intellectual disability i.e. under 70 IQ; borderline intellectual disability i.e. between 70 and 80 IQ; and people with significant acquired brain injury (ABI) that puts them into the intellectual or borderline intellectual disability range.

[8] Taken at the establishment of the cohort 30 April 2008.

People in the study with a CD are younger than the rest of the cohort by an average of 4.6 years and a median difference of 3.7 years (U = 668232, p < .001). Likewise, people with a history of substance abuse are on average 3.5 years younger with a median difference of 2.2 years (U = 773484, p < .001) than the rest of the cohort. People with a PD are on average older than the rest of the cohort by an average of 1.6 years and a median difference of 1.7 years (U = 564112, p <.001) and those with no diagnosis are on average, 4.8 years older than the rest of the cohort, with a median difference of 3.5 years (U =308305, p < .001). This variation in average age across the cohort is probably due to the fact that those with no diagnosis and MH only diagnosis have on average significantly longer episodes in custody than the other groups and are significantly older at first contact with the CJS. It should be noted that there is a significant biasing effect due to a small number of persons in the cohort first coming into contact with the criminal justice system in their 50s or 60s.

Figure 1: Average Age At Cohort Establishment Date By Study Group



The age information provided here is somewhat detailed, some study groups are on average much older than others and older individuals will have had more opportunity to offend and receive services. This highlights both systemic factors around the datasets and issues associated with age of onset of disorders. Specifically, the cohort was established using datasets with different time frames, and also reflects that those with no diagnosis and a MH only diagnosis are significantly older at first contact with the CJS.

1.2. Gender

Three hundred and thirteen people (11%) in the cohort are female and 2417 (89%) are male with one person having an unknown sex. The proportion of females across different study groups varies as a result of both the composition of the groups and of the datasets used to create the cohort. The

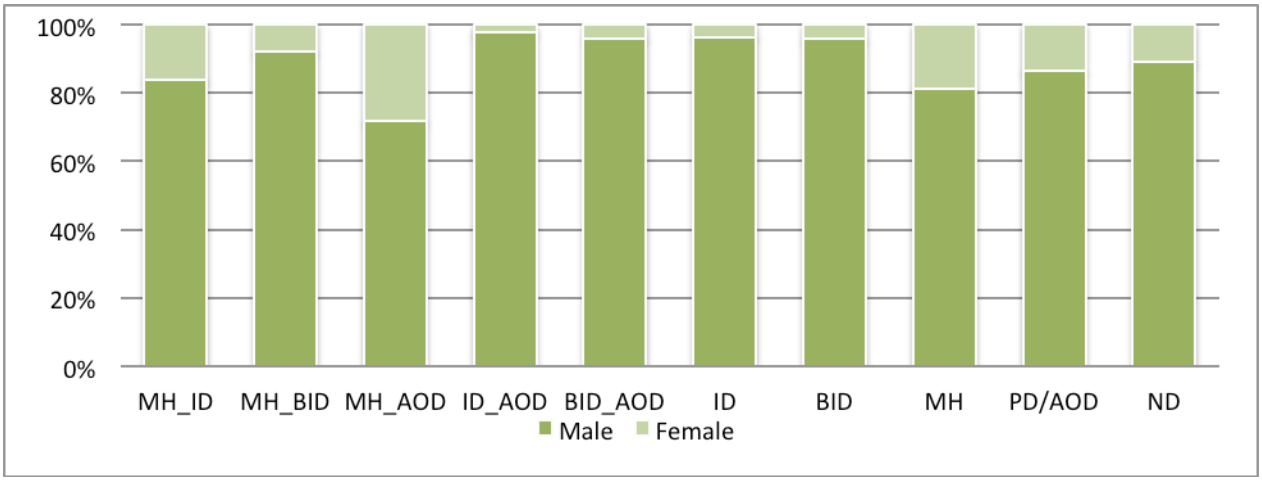
Corrective Services NSW State-wide Disability Database is known to under-represent women, probably due to lower recognition and referral processes inside the Department for women with an ID/BID, not necessarily because women have lower rates of cognitive impairment. As such, 28% of females in the study have a cognitive disability compared to 57% of males. It must be remembered that the cohort is not a representative sample of the NSW prison population.

However, females are over represented in the cohort in a range of non-CD based diagnostic categories, including:

- 59% of females having a history of a MH disorder, compared to 32% of males,
- 65% of females having a history of AOD use compared to 54% of males in the study,
- 42% of females having a PD compared to 20% of males,
- 54% of females having complex needs compared to 47% of males.

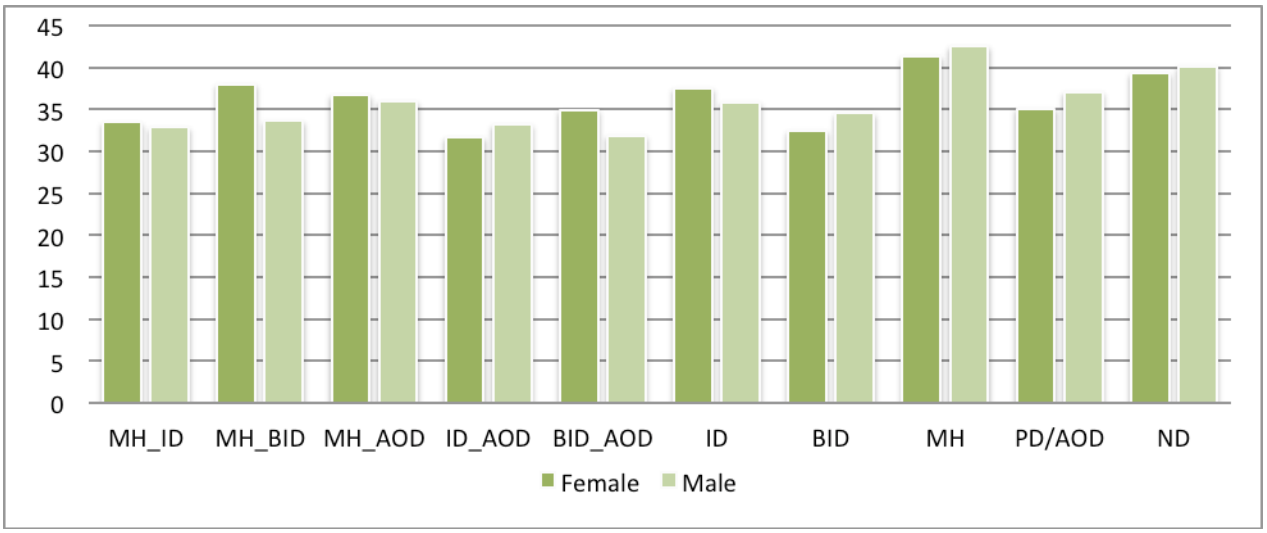
Gender across the study groups is shown in Figure 1 and reflects the general patterns described above.

Figure 1: Proportion Of Males And Females In The Study Groups



Females in the study are on average almost one year older than males, however this is not consistent across all diagnostic categories. There is no difference in the age between males and females for those with a PD, whilst those with a CD, AOD or MH disorder reflect the trend of females being approximately one year older than males. However, those females with a history of substance use are almost two years older than males, and females with complex needs are two years older than males with complex needs. Figure 2 shows the average ages of males and females across the study groups.

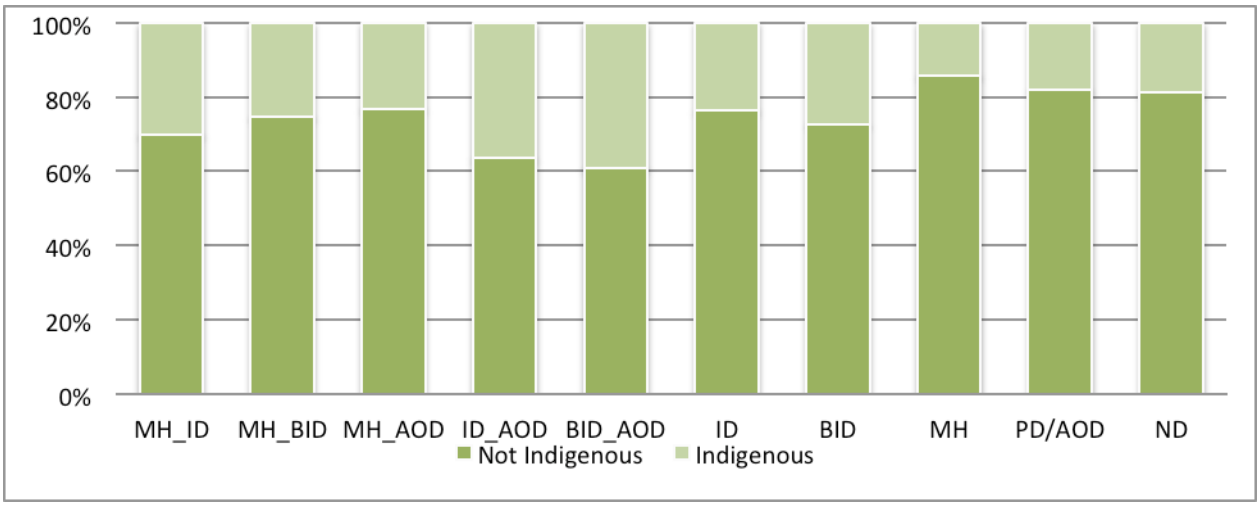
Figure 2: Average Age At Cohort Establishment By Gender And Study Group



1.3. Indigenous Australians

Twenty five per cent of the cohort (676) is identified as being of Aboriginal or Torres Strait Islander descent. This Indigenous identification is taken from the source from which the individual was selected for inclusion into this study (the IHS or the SDD), as Indigenous status of individuals varies from data source to data source in the MHDCD dataset. The proportion of Indigenous Australians with a history of a MH disorder at 33% is equivalent to that in the entire cohort (35%), as is the rate of BPD at 18% compared to 22% of the entire cohort. However, Indigenous Australians in the cohort have higher rates of ID at 65% compared to 54%, and substance abuse disorders at 63% compared to 56%. The distribution across the cohort study groups, as shown in Figure 3, represents these trends, with higher rates of Indigenous Australians represented in the ID_AOD, BID _AOD and MH and ID groups.

Figure 3: The Proportion Of Indigenous Australians In The Study Groups

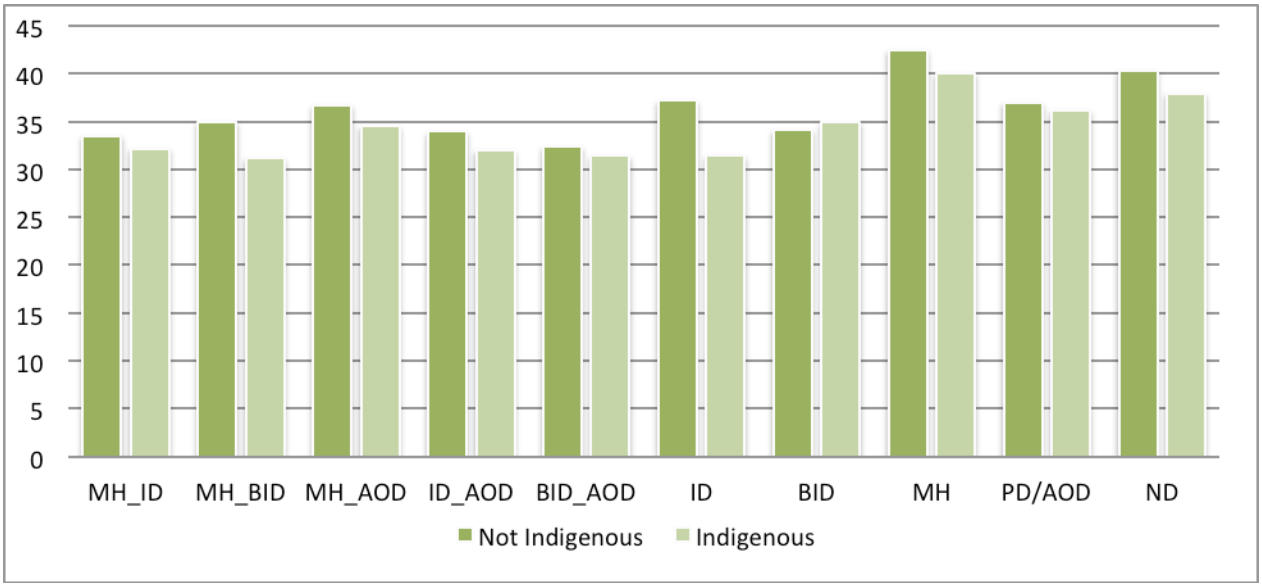


Indigenous Australians in the study are significantly younger by an average of 2.8 years compared to non-Indigenous Australians with a median difference of 1.8 years (U = 574299, p <.001). There is little difference in the age of individuals between Indigenous Australians and non- Indigenous Australians across the diagnostic groups.

Across all study groups Indigenous Australians are younger, as displayed in Figure 4. Some of these differences are statistically significant, including for the:

- MH_BID group where the difference is an average of 3.8 years and median difference of 1.7 years (U = 3126, p = .006),
- ID Group where the difference is 5.7 years and a median difference of 6.7 years (U = 2798, p < .001)

Figure 4: Average Age By Indigenous Status And Study Group



2. Criminal Justice System (CJS) History

2.1 Initial Criminal Justice System (CJS) Contact

Across the whole cohort there is a high incidence of contact with the CJS, which in general commences at an early age. CJS contact is identified from the data at three different points: age at first police contact, age at first conviction and age at first custody episode – with an assumption that contact proceeds in this order. The average age of first police contact[9] for the cohort is 17.7 years, with approximately 50% of the cohort having had first police contact by their sixteenth birthday. This early police contact is exemplified in detail in the five case studies at the end of this report, with each

[9] Defined as where the person is of interest in the investigation

individual having had their first contact with police before the age of fourteen. Case Study 2 introduces Matthew who has the earliest police contact of all individuals in the cohort at age seven.

By the age of 21, almost 50% of the cohort have been convicted of at least one offence and have spent time in prison. Despite this often early contact with the CJS, there is a group in the cohort whose first contact with the CJS is at a much later stage in life, with a small group of people in the cohort not experiencing their first contact with the CJS until their sixties. This group may represent a small number with dementia who have offended or come to the attention of police late in life due to changed care and support circumstances.

People with any diagnosis have a much earlier age of first police contact than those without a diagnosis, on average over three years earlier at 17.3 years of age, with a median age of 15.7 years of age ($U = 308305$, $p < .001$). Individuals with a diagnosis also went into custody earlier by four years and received a conviction earlier than the group without a diagnosis ($U = 294435$, $p < .001$).

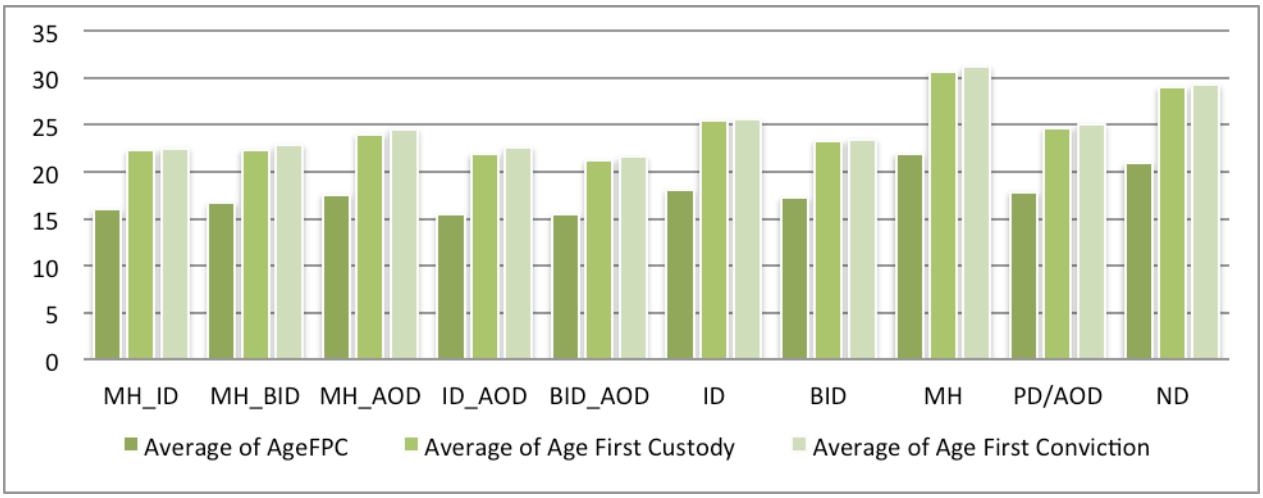
Having a CD is associated with earlier contact with the police, an average of almost three years earlier than those without a CD and a median difference of 1.7 years ($U = 682630$, $p < .001$). This group has an average age of first contact at 16.5 years of age and a median age of 15.2 years of age. This group also went into custody approximately 3.5 years after first police contact, with an average age of first incarceration of 22.7 and a median age of 20.

Having an AOD history is also associated with younger police contact, at an average age of 16.4 and a median age of 15.4 years of age, significantly younger than those without an AOD history ($U = 723732$, $p < .001$). This is an average of almost three years younger than the group without a substance use history with a median difference of 1.4 years. This group also went into custody four years after first police contact.

Having a PD is associated with older first police contact, occurring at an average age of 17.9 and a median age of 16.2 years of age, significantly older than those without a PD ($U = 610625$, $p < .001$). There was no difference in the age of first incarceration or the time between first police custody and first incarceration. For individuals with a MH disorder there is very little difference in first contact at all points with the CJS. Age at the various points of contact with the CJS is detailed in Figure 5.

There is a significant difference in the average age of first police contact between individuals in different study groups ($H = 212.2$, $p < .001$), with MH and ND groups being older than all other groups. It must be noted that these averages are biased, (i.e. there is a very long tail at the older end), by a few people who were much older at first entrance into the CJS. By the age of twenty, 80% of the MHDCD cohort had contact with the police as a person of interest.

Figure 5: Average Age Of First Police Contact, First Custodial Episode And First Conviction By Study Group



2.3.1. Juvenile Contact

Individuals in the cohort had substantial amounts of contact with the police as juveniles. Seventy per cent of the cohort had police contact as a juvenile, on average twenty occasions prior to turning eighteen years of age. Those who went on to have contact with Juvenile Justice (JJ) had substantially more contact with the police. The Case Studies offer insights into the ongoing and usually increasing cycles of police contact experienced by individuals in this cohort through detailing the police contact pathways of Natalie in Case Study 1, Matthew in Case Study 2, Eddie in Case Study 4, and Casey in Case Study 5, all of who were clients of JJ. Those in the cohort who were incarcerated as a juvenile had an average of 35 contacts with police when less than eighteen years of age, and those who became clients of JJ but were not incarcerated had twelve contacts with police prior to turning eighteen. For clients of JJ, this contact with police as a juvenile accounts for approximately one third of all lifetime contacts. As identified in the section on demographics, some in the cohort are still young and so have not had the opportunity to build up longer histories with the police or conversely, to reduce their offending.

Over one third (1047) of all individuals in the MHDCD cohort were clients of Juvenile Justice NSW, and of these individuals 80% were incarcerated as a juvenile. Those who were incarcerated had an average of six admissions per person as a juvenile and went on to have greater numbers of custody episodes as an adult and greater numbers of days incarcerated. This culminated in those incarcerated as juveniles spending an additional 5% of their lives incarcerated compared to individuals who were not incarcerated as juveniles. These persons returned to custody on average every 335 days with these custody days spent over much shorter average periods of incarceration. Additionally, contact with police persisted at a much higher rate over their life to date, with individuals incarcerated as juveniles having over seven contacts per year since initial police contact, an average of two additional police contacts per year greater than individuals who were clients of JJ but never incarcerated, and over four additional contacts compared to individuals in the MHDCD study who were not in contact with Juvenile Justice.

JJ clients had higher rates of complex needs, with over 50% of all individuals who were clients having complex needs compared to 43% for individuals who were not clients of JJ. For those clients who were incarcerated (as compared with those who had JJ contact but were not incarcerated) as a juvenile, 60% had complex needs. Natalie in Case Study 1 and Casey in Case Study 5 exemplify individuals with complex needs who had JJ contact.

These complex needs clients of JJ also have significant levels of contact with other human service agencies as juveniles. Over three quarters of individuals recorded as being a child receiving a service from NSW Housing were clients of Juvenile Justice and 86% of those with JJ contact had been in custody as a juvenile. JJ and Community Services NSW shared many clients, with 83% of the cohort who as children were in Out Of Home Care (OOHC), also being clients of JJ. Of those who had been in OOHC and who were also clients of NSW Housing as children, 90% were also clients of JJ. This overlap in agency contact is depicted in the case studies of Natalie (Case Study 1), Eddie (Case Study 2) and Casey (Case Study 5) who all spent periods of time in OOHC and were also clients of JJ.

2.2 Ongoing Criminal Justice System (CJS) Contact

2.2.1 Police Contact

The cohort has a high incidence of contact with the police over their lives. On average the cohort has 70 contacts per person, with a median of 60 contacts per person. All the case studies at the end of this report exemplify the kinds of low level events and offences which characterise this frequent contact, particularly in the early years of an individual's pattern of contact, with several case studies, notably Casey (case study 5) and Matthew (case study 2) exemplifying a typical pattern where frequent low level offences in the early years of contact escalate to more frequent and more serious events as time progresses. The rate of police contacts was calculated to account for variation in both age and the number of years that individuals have been offending. The rate of police contact was calculated by:

1. Identifying the first police contact as a POI that each individual had;
2. Identifying the number of years elapsed since first police contact; and
3. Dividing the number of police contacts by the number of years of police contact.

The presence of any diagnosis is associated with a higher number of police contacts, with people with a diagnosis having on average 33 more contacts with police per person, and a median difference of 35 additional police contacts ($U = 232023$, $p < .001$) over their life than those with no diagnosis. A closer examination shows that this is the case for all diagnosis groups, with only the size of the effect changing across groups. Compared to all others, individuals with:

- MH disorder have an average of 72 police contacts and a median difference of over four more police contacts over their lives ($U = 802621$, $p = .012$); however, this occurs at the same rate of contacts at an average of 4.5 and median of 3.7 police contacts per year;

- CD have an average of 80 and a median of 70 police contacts, with a median difference of 21 more police contacts (U = 703855, p < .001). The CD group has a median rate of 4.5 contacts per year which is a difference of 1.7 additional contacts per year (U = 635616, p <.001);
- AOD history have a median difference of 28 more police contacts (U = 626854, p < .001) and 1.6 additional contacts per year with a median of 4.2 contacts per year (U= 637139, p <.001);
- PD have a median difference of six more police contacts (U = 603894, p = .014) than those without this diagnosis and a similar rate of police contact with a median of 3.6 contacts per year; and lastly
- Complex needs had 25 additional police contacts (U = 657677, p <.001) and a higher rate of contact with a median difference of almost 2 additional contacts per year at 4.5 contacts per year (U = 639951, p <.001). The case study on Natalie in particular offers insight into this relationship between complex needs and high levels of police contact.

Figure 6 shows the average number of contacts per person and the rate of this contact by study groups. There is significant variation in the amount of contact across the study groups, with the complex needs groups having significantly more police contacts than the single or no diagnosis groups. The rate of contact follows a similar pattern. This is shown in Figure 6 which demonstrates that despite the longer timeframe of offending for some groups, the rate of contact with the police remains consistently higher over time than for those in groups such as the MH only group, who commenced offending later, and have less contact with the police. The rate of police contact for those in the MH_ID and ID_AOD is almost three times that of the ND group.

Figure 6: Average Police Contacts And Rate Of Police Contact Per Year By Study Group

2.2.2 Custodial Episodes

The experience of custody is comprised of two key elements, the number of custodial admissions and the duration of stay. A custodial episode is defined as incarceration in a correctional facility (either adult or juvenile) and includes periods in prison on remand awaiting the outcome of legal proceedings as well

as a sentenced prisoner after having been found guilty of an offence. There is significant variation across the cohort as to how the time in custody is experienced.

The cohort has a large number of custodial episodes arising from the high incidence of contact with the police, with an average 6.9 custodial episodes per person. On average, an individual in the cohort has spent 1111.6 days or three years in custody over their life, having on average 272 days, or approximately eight months incarcerated for each episode in custody. Differences in the experience of custodial episodes, including differences in number of custodial episodes and duration of stay in custody, can be identified within the case studies, for example Natalie (Case Study 1) and Casey (Case Study 5) illustrate individuals who experience a high number of custodial episodes, while Ned (Case Study 3) illustrates an individual who spends a substantial number of days in custody.

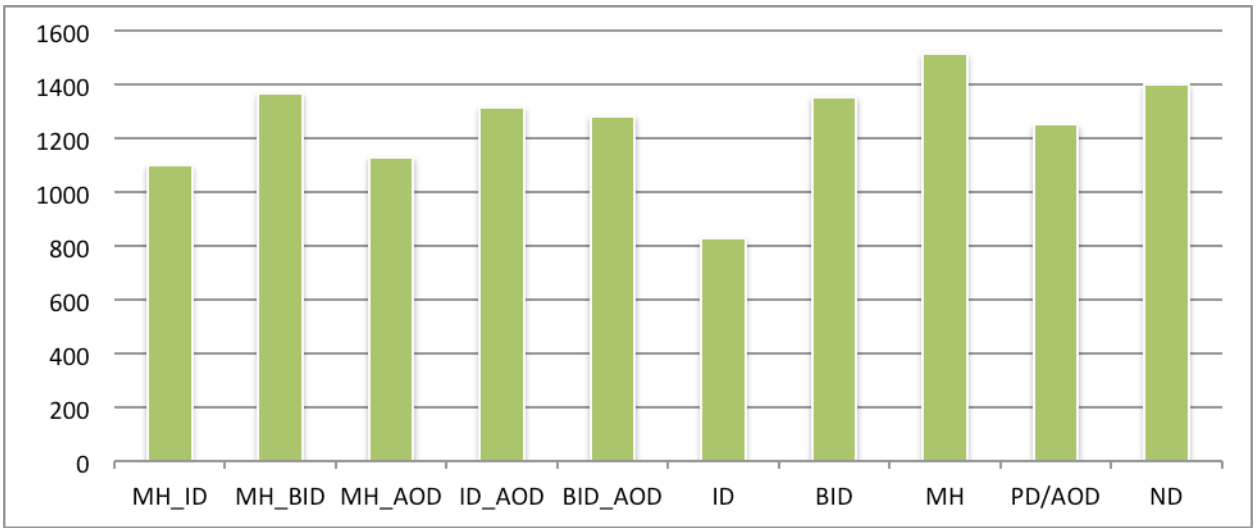
Table 2: Custodial Trends By Diagnosis

Diagnosis	Custodial Episodes	Avg. Days in Custody	Avg. LOS	Avg. Days Between Episodes
Cognitive Disability				
CD	9.85	1218.79	212.60	563.09
No CD	7.47	1296.23	334.87	800.11
Mental Health				
MH	9.16	1250.98	274.07	654.88
No MH	8.52	1256.80	266.80	683.42
Substance Use				
AOD	10.30	1240.09	181.18	534.80
No AOD	6.80	1273.09	379.73	849.47
Personality Disorder				
PD	9.86	1452.97	288.56	634.55
No PD	8.43	1197.86	263.86	684.57
Complex Needs				
CN	10.51	1232.19	187.47	525.68
No CN	7.11	1275.61	345.09	810.75
Overall				
Diagnosed	9.22	1234.37	237.18	628.00
Non Diagnosed	5.40	1398.51	496.47	997.57
Overall	**8.75**	**1254.75**	**269.37**	**673.36**

There is significant variation in the number of episodes ($H = 229.9$, $p < .001$) and length of stay per episode ($H = 155.3$, $p < .001$) across the study groups. And there is a significant difference in the number of days spent in custody across the study group ($H = 65.2$, $p < .001$). The ID group has spent significantly

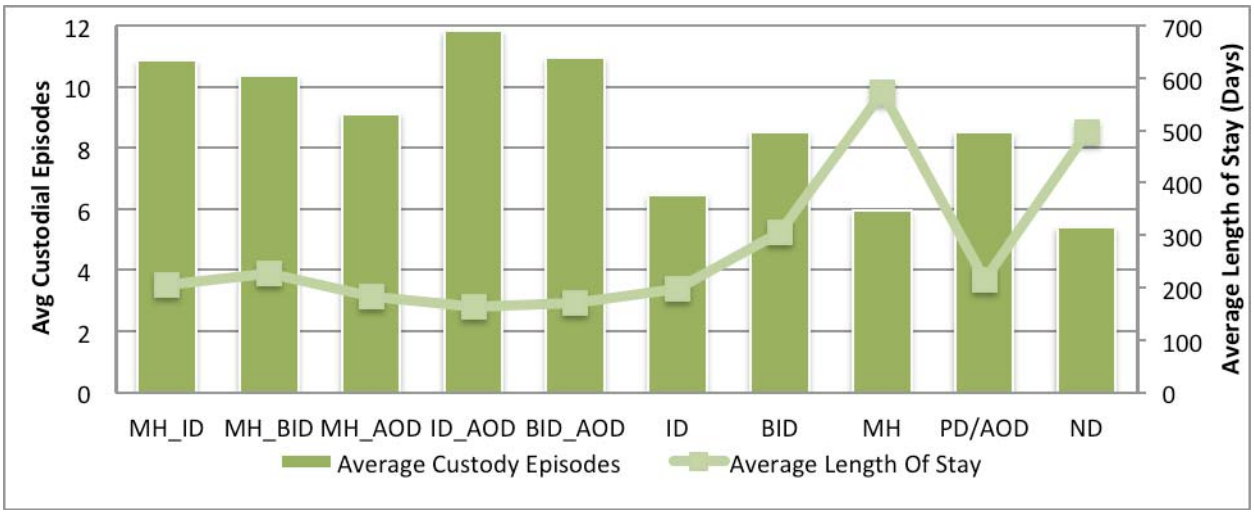
less days in custody than all other groups. Figure 7 shows that the MH group has the greatest total number of days in custody.

Figure 7: Average Total Days In Custody By Study Group



Whilst Figure 8 shows the total days in custody, the way these days are experienced is also important, and is very different across the various study groups. The number of admissions and length of stay per admission varies substantially across the groups, with both the rate of custodial episodes ($H = 264.0$, $p < .001$) and days in custody per year ($H = 88.6$, $p < .001$) significantly different across the study groups, as seen in Figure 9. Whilst those in the MH only group have the greatest number of total days in custody (Fig 7), they also have many less admissions than all groups except the ND group with similar admission to the ID only group (Fig 8), but with the length of each custodial episode being much longer than all other except the ND group. The groups with more than one diagnosis have many more episodes, which are much shorter in duration, indicating that this group is cycling in and out of prison at a higher rate than the other groups and probably have more remand stays in prison.

Figure 8: Average Custodial Episodes And Length Of Stay By Study Group



As the cohort was established using data with two different time frames (one a snapshot in 2001 and one compiled across time), the most meaningful measure of incarceration frequency is the rate of custodial episodes on average since first incarceration, which is what has been presented. It is important however, to also consider the proportion of time individuals spend incarcerated. This emphasizes the rapid cycling between community and custody that is experienced by some groups.

The proportion of life spent incarcerated was calculated by:

1. Identifying the first police contact as a person of interest (POI) that each individual had,
2. Identifying the number of days elapsed since first police contact,
3. Aggregating the total number of days incarcerated, and
4. Dividing the days elapsed by the days incarcerated.

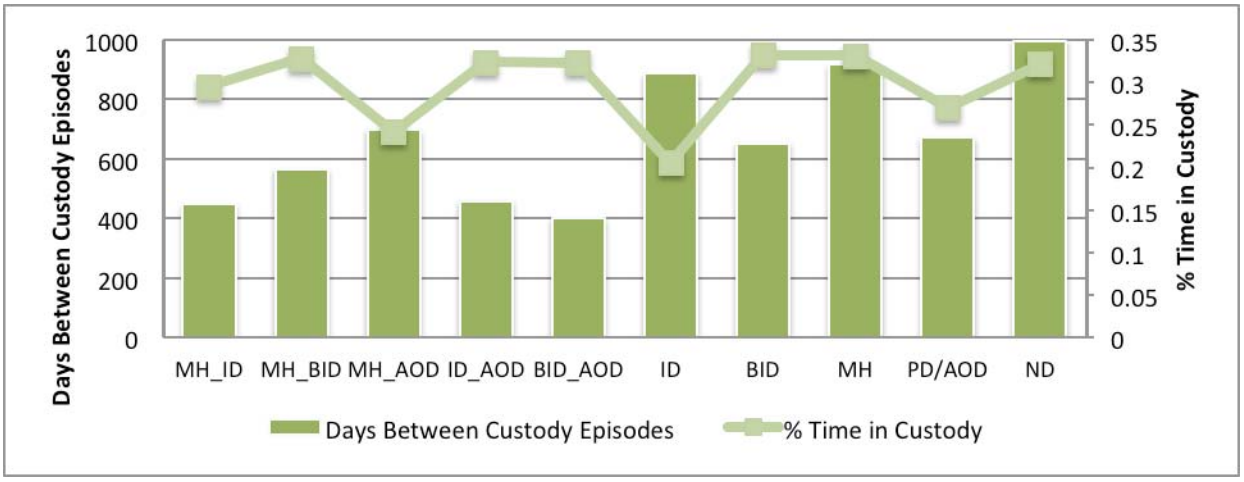
Having any diagnosis is associated with twice the rate of custodial episodes per year, with an average of 1.65 episodes per year compared to .81 per year for those without a diagnosis. The proportion of time spent incarcerated however was higher for those without a diagnosis, with an average of 32% compared to 29% for those with a diagnosis. Individuals with a MH disorder had the highest rate of incarceration with 2.3 custodial episodes per year, however spent a similar proportion of time in custody to those without a MH disorder. Individuals with complex needs had a similarly high rate of incarceration, with just over two admissions per year, and again there was no difference in the proportion of time spent in custody. The CD group had the highest proportion of time spent in custody of any of the diagnosed groups, with just over 30% of time spent incarcerated, which compares to 28% for those without a CD.

Having a CD is associated with a much higher rate of episodes in custody, with the CD groups having more frequent custodial episodes per year compared to those without a CD ($U = 720570$, $p < .001$), though those with an ID only have fewer episodes than the rest of the CD group. This is starkly exemplified in the case studies, where those with complex needs have very high numbers of

incarceration episodes. Having a history of substance use is also associated with higher rates of custodial episodes (U = 65954, p < .001), with these groups having one third more custodial episodes per year than those without a substance use history. There is no difference in the rate of custody per year when comparing individuals with and without a PD.

Variability in patterns of incarceration for the different study groups is shown in Figure 9. Those in the MH_ID group are incarcerated on average three times more often in a year than those in the MH group. As a specific example, the MH group spends on average ten days more in custody per year than the MH_ID group, however the MH_ID group is much younger than the MH group at first incarceration. This finding - that those with complex needs are more likely to spend fewer days in custody but go into custody more often than those with a single diagnosis - further emphasizes their continual cycling between community and custody, suggesting as discussed later, the elision between community and custody for these groups. This cycling between community and custody for people with CD and MH diagnoses is clearly illustrated in all five Case Studies at the end of the report.

Figure 9: Rate Of Custodial Episodes And Days In Custody Per Year By Study Group



In Figure 10, the two groups that deviate from the trend of around 30% of their life since initial police custody spent incarcerated are the MH_AOD group and the ID group. The MH group and the non-diagnosed group show a difference in the rate of police contact that led to the incarceration, with a similar proportion of life incarcerated resulting from a much lower rate of police contact. This indicates more serious offending resulting in longer periods incarcerated although on the whole the cohort's offending was in the lowest decile of the Australian Standard Offence Classification for offences. The offences according to that table that individuals were found guilty of, is shown in Table 3.

Figure 10: Proportion Life Incarcerated And Rate Of Police Contact Per Year By Study Group

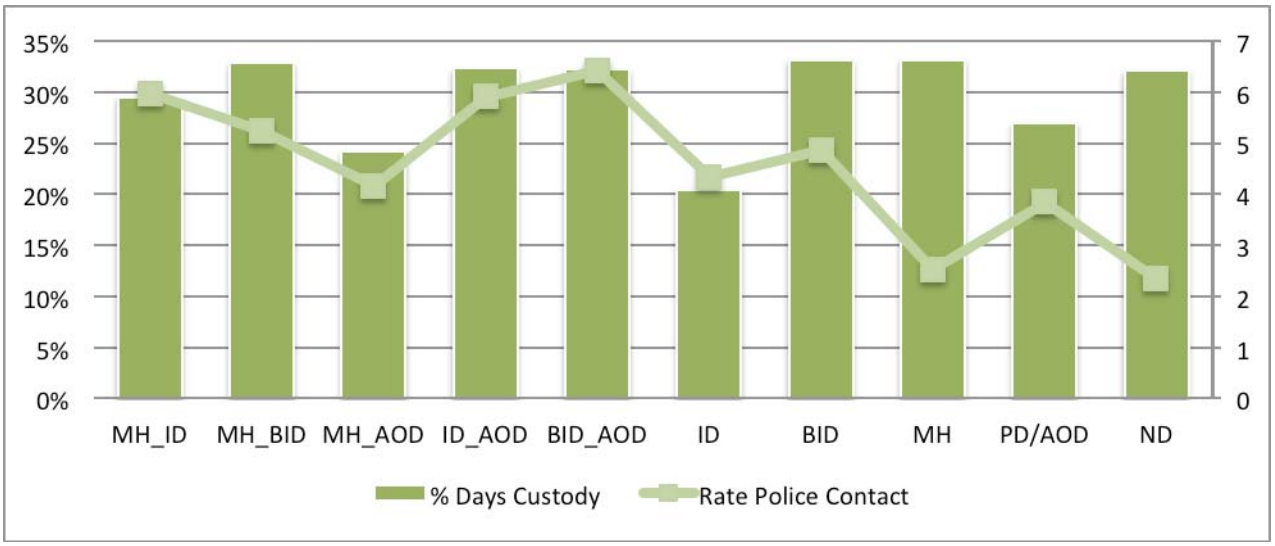


Table 3: Percentage Of Offences With Guilty Finding By Australian Standard Offence Category (ASOC) And Study Group

ASOC Category	MH_ID	MH_BID	MH_AOD	ID_AOD	BID_AOD	ID	BID	MH	PD/AOD	ND	Total
Theft and related offences	19.51%	18.68%	25.52%	19.40%	20.71%	16.39%	15.63%	19.79%	23.58%	16.97%	20.35%
Road traffic and motor vehicle regulatory offences	14.60%	15.73%	19.75%	16.05%	18.61%	23.13%	21.21%	23.85%	22.23%	27.67%	20.09%
Justice Offences	12.11%	10.91%	8.26%	12.32%	11.67%	11.63%	11.42%	9.48%	9.21%	8.22%	10.37%
Acts intended to cause injury	12.79%	11.34%	7.51%	11.56%	11.10%	11.98%	11.77%	8.81%	7.59%	8.27%	9.96%
Public order offences	11.48%	10.52%	8.99%	12.40%	9.33%	10.74%	9.15%	6.29%	7.31%	7.26%	9.27%
Unlawful entry with intent/burglary, break and enter	6.52%	6.89%	6.80%	6.07%	7.05%	5.09%	7.36%	4.52%	6.21%	5.86%	6.42%
Illicit drug offences	4.85%	5.66%	6.84%	5.48%	4.97%	3.17%	4.45%	6.09%	7.05%	6.57%	5.72%
Property damage and environmental pollution	7.53%	7.33%	3.95%	6.75%	5.87%	6.28%	6.44%	4.35%	3.98%	3.44%	5.43%
Deception and related offences	3.04%	4.13%	5.72%	1.67%	2.69%	3.32%	3.16%	6.06%	5.79%	4.61%	4.11%
Dangerous or negligent acts endangering persons	1.94%	3.04%	2.79%	2.58%	2.84%	2.63%	3.17%	3.36%	3.29%	3.66%	2.94%
Robbery, extortion and related offences	1.46%	2.01%	1.55%	2.01%	2.06%	1.39%	2.27%	1.74%	1.44%	2.79%	1.85%
Miscellaneous offences	2.14%	1.83%	0.97%	2.15%	1.63%	1.37%	1.54%	1.45%	1.09%	1.18%	1.48%
Weapons and explosives offences	0.83%	0.89%	1.00%	0.68%	0.75%	0.48%	0.99%	1.01%	0.79%	1.32%	0.88%
Sexual assault and related offences	0.90%	0.76%	0.20%	0.76%	0.55%	2.15%	1.21%	2.20%	0.21%	1.61%	0.84%
Homicide etc	0.09%	0.10%	0.09%	0.04%	0.12%	0.08%	0.16%	0.72%	0.09%	0.38%	0.15%
Abduction and related offences	0.16%	0.13%	0.03%	0.06%	0.02%	0.15%	0.03%	0.23%	0.08%	0.17%	0.09%
Unknown	0.07%	0.05%	0.05%	0.03%	0.02%	0.00%	0.04%	0.06%	0.05%	0.03%	0.04%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

2.3 Gender

Females come into contact with police later than males in the cohort, at twenty years of age on average over three years later with a median difference of 1.5 years ($U = 281627$, $p < .001$). Females experience their first conviction and custodial episode also on average much later than males, on average at 26 years and a median age of 23 years of age ($U = 326016$, $p < .001$). But the time between first police contact and first custodial episode for females is over one year shorter than for males, at an average of 5.5 years and a median of 4.5 years ($U = 335979$, $p < .001$). It is noted that later contact with police for females may be because they have higher rates of MHD than males and this may suggest more of the females have later emergence of a disability. It may also be because there are lower rates of females with CD (an indicator of earlier police contact) in the cohort than might be expected.

For females, having any diagnosis is associated with earlier contact with the police, occurring at an average of twenty years and a median age of 17.2 years ($U = 3737$, $p = .008$), a difference of almost six years. This early contact results in an earlier first custodial episode by four years. However, there is little difference in the time difference between first police contact and first custodial episode with an average of five years (median of four years) from initial police contact to time of first custody.

The pattern of later contact for females than males is maintained in this group, with women having contact on average three years later than males, with a median difference of 1.7 years ($U = 215498$, $p < .001$). This later contact is also maintained in the age of first custodial episode ($U = 246752$, $p < .001$). Women with a diagnosis have a shorter time between first police contact and first custodial episode than males by an average of one year and a median of half a year ($U = 266301$, $p = .018$).

Females with a CD have contact with the police approximately two years earlier than those without a CD, at an average age of 19 years of age and a median age of 16 years ($U = 8021$, $p = .007$). Females in this group continue to have on average earlier first custody, an average of two years and a median of three years earlier ($U = 8435$, $p = .034$). Females with a CD also have contact with the CJS later than males in the same group, by an average of approximately three years at first police contact, and a median of one year ($U = 47997$, $p = .001$). However there is no significant difference in the age of contact at other points in the CJS, as females with a CD take a slightly shorter timeframe to transition from first police contact to first custody.

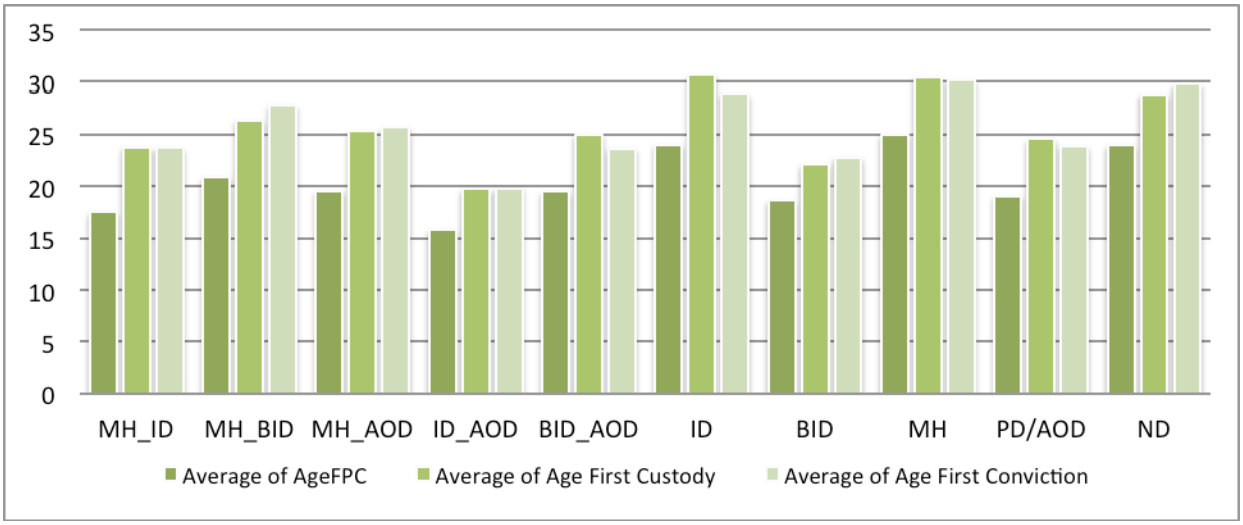
Females with a history of substance use have significantly earlier contact with police at an average age of 18.9 years and a median age of 16.9 years, which is on average 4.5 years earlier with a median difference of 2.6 years, than females without a substance use history ($U = 8272$, $p <.001$). This continues on to earlier incarceration ($U = 8840$, $p = .003$). The pattern of later contact with the CJS than males continues for females in this group, with police contact later by an average of almost three years and a median difference of 1.7 years ($U = 96173$, $p < .001$), and later first custodial episode ($U = 109963$, $p <$

.001). There is no difference in the gap between first police contact and first custodial episode between males and females, with an approximate interval of six years from first contact.

For those females with a MH diagnosis, the pattern of later onset than males is continued, with first contact for females also at an average of approximately three years later than males and a median of 1.6 years in this category ($U = 53682$, $p < .001$). This is carried through to all points of contact with the CJS.

There is no difference in contact with the CJS for females with a PD at any point compared to females without a PD. However, when comparing males and females in the study with a PD, similar patterns of later police contact for females is found, on average almost three years later with a median difference of 1.5 years ($U = 24002$, $p < .001$). Females with a PD also progress more quickly than males into custody by 1.5 years ($U = 26752$, $p = .011$). Figure 11 shows the age of first contact with the CJS at different points across the study groups.

Figure 11: Age Of First Police Contact, First Custodial Episode And First Conviction For Females By Study Group



Females in the cohort have fewer total police contacts with two fewer contacts than males. The rate of police contact is similar with approximately 3.6 contacts per year since first police contact. This police contact translates into a similar number of custodial episodes, with an average of almost nine admissions over life, and a median of six admissions compared to seven admissions for males in the cohort. Females however, have substantially fewer days in custody, by ten months, and on average each admission is shorter by over 50 days. This results in a substantially smaller proportion of females' lives spent incarcerated (23%), compared to males (30%).

There is variation across diagnoses in the CJS contact when comparing genders and when looking at the presence of a diagnosis for females compared to females without a diagnosis. Females with a diagnosis

have a similar rate of police contact compared to males, at 4.0 compared to 3.8 contacts per year. Females also have a similar number of custodial episodes with a median of over seven episodes over their life. Again, the total number of days incarcerated is much lower for females with a diagnosis compared to males, of just under one year less time in custody. This is reflected in the difference in average length of stay, where males with a diagnosis stay over one month longer compared to females. When looking at females and comparing those with a diagnosis to those without any diagnosis, there is a 250% increase in the rate of police custody, with females with a diagnosis having almost four police contacts per year compared to 1.5 for non diagnosed females. This trend continues across most CJS indicators, with the median figure for diagnosed females more than three times the number of custodial episodes (7), compared to non-diagnosed females in the study (2). In total, the diagnosed group has a higher number of total days incarcerated by 41 days, than females without a diagnosis, however the diagnosed groups' stays in custody are much shorter in duration at 77 days compared with the median for the average length of stay of 156 days for females without a diagnosis.

For females with a CD, there is no difference in the average number of police contacts compared to males, with on average approximately 70 contacts over their lives. However females with a CD have a higher rate of police contact than males with an average of one additional police contact per year compared to males and a median of 5.2 contacts per female. Additionally, females with a CD have an additional custodial episode compared to males, with a median of eight admissions, occurring at a slightly higher rate than males. In total, females have had approximately 55 fewer total days incarcerated, with the average length of stay shorter by 14 days for females compared males with a CD. When comparing females with and without a CD, females with a CD have substantially more police contact, with an additional 21 police contacts occurring at almost twice the rate compared to those without a CD. This contact results in two more custodial episodes on average, with women with a CD having a median number of eight admissions to custody, and 231 additional days in custody. The average length of stay for females with a CD is similar, with a difference of only five fewer days.

Females with a MH disorder have a similar pattern with police compared to males with a MH disorder, with approximately 60 police contacts accrued at a rate of 3.7 police contacts per year. There was no difference in the number of custodial admissions, with seven for both males and females, however the experience of custody was different. The median for females was 360 fewer days in total incarcerated than males and an average length of stay of 46 days shorter duration. This is similar to the overall comparison between males and females provided earlier. When comparing females with and without a mental health disorder, females with an MH disorder have more police contacts, an additional nine and a median of 61 police contacts. The rate of police contact reflects this small difference, with approximately the same rate of contact at 3.7 contacts per year. Females with an MHD have almost 1.5 additional episodes in custody, and a slightly higher total number of days in custody. The average length of stay was also shorter by approximately 20 days per episode for females with an MH disorder compared to all other females.

Females with a PD had a similar number (56) and rate of police contacts (3.5) and number of custodial episodes (6) compared to males with a PD. These rates and differences are similar to the overall differences between males and females reported previously. However, the difference in days spent incarcerated between males and females with a PD was substantial with females spending six months less time incarcerated than males, and the median period incarcerated being shorter by half (69 days). When comparing females with and without a PD, females with a PD had 5 additional police contacts, which were accrued at approximately the same rate (3.9 per year) as those without a PD. Females with a PD had an additional 2 periods in custody, however spent 155 fewer days incarcerated. This equated to 22 fewer days per episode in custody.

Females with a history of substance use (AOD) in the cohort had slightly less (eight less, out of a total of 65) police contacts than males with the same diagnosis, but at a similar rate of police contacts per year. The number of custodial episodes was the same (a median of eight episodes), with the same trend of substantially fewer days in custody (405 fewer) at 568, and shorter average length of stay by 37 days (median of 68 days) than males. Females with an AOD history have 28 additional police contacts occurring at a rate of an additional 1.7 contacts per year more than those without a history of substance use and have four additional custodial episodes, with an average stay of fewer days both in total (163 days) and per admission (58 days).

2.4 Indigenous Australians

Indigenous Australians in the study come into contact with the CJS much earlier when compared to the rest of the cohort, on average over three years earlier, at an average age of 15.3 years of age and a median age of 14.3 ($U = 445488$, $p < .001$). Over fifty percent of the Indigenous persons in the cohort had their first police contact by fourteen years of age, and one quarter had their first police contact by age twelve. They continue to have much earlier contact, with first custody also occurring four years earlier than the non-Indigenous cohort ($U = 479367$, $p < .001$). The time between first police contact and first custodial episode between Indigenous and non-Indigenous Australians is also much shorter, with an average difference of one year and a median difference of half a year ($U = 633530$, $p = .015$). Figure 12 shows the average contacts points for Indigenous Australians across the study groups. There is a significant difference at all points of contact with the CJS across the study groups for Indigenous people. In addition there is a difference in the rate of progression from police contact into custody across the study.

Indigenous Australians with any diagnosis have first police contact just over one year earlier than those without a diagnosis, at an average age of fifteen years and a median age of fourteen years ($U = 15594$, $p = .03$). This difference in time at first custody becomes greater for Indigenous people with a diagnosis, with an average of four years difference and a median difference of three years at first custodial episode between diagnosed and no diagnosis persons ($U = 14349$, $p = .002$) occurring at an average age of 21

and a median of 18.6 years of age. The rate of progression between police contact and custody is much greater for diagnosed people, occurring on average 2.8 years sooner than for the non-diagnosed group.

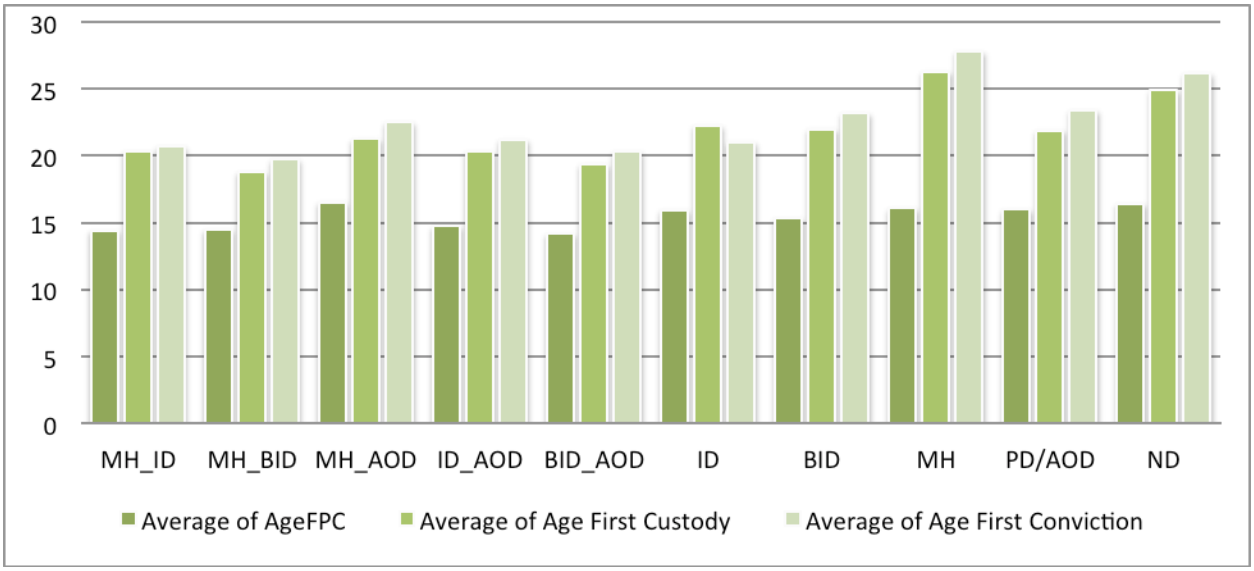
Indigenous Australians with any diagnosis have contact with the criminal justice system earlier than non-Indigenous Australians with a diagnosis, on average over two and a half years earlier, with a median difference of 2.2 years ($U = 358044$, $p < .001$). This contact occurs at an average age of 15.2 and a median of 14.1 years of age. This continues at all points of contact, with Indigenous Australians with a diagnosis also progressing to custody faster after first police contact than the non Indigenous group on average by over one year, with a median difference of half a year ($U = 489427$, $p < .001$).

Indigenous Australians with a MH disorder also have first police contact much earlier than non-Indigenous Australians with a diagnosis, on average three years earlier, with a median difference of 2.2 years ($U = 358044$, $p < .001$). This contact happens at an average age of 15.2 years and a median of 14.1 years of age. This earlier contact continues with earlier first custodial episode ($U = 381270$, $p < .001$), however there is no difference in the age of first conviction. The gap between first police contact and first custodial episode is much smaller, with Indigenous Australians with a MH disorder going to custody over one year earlier than their non-Indigenous counterparts, with a median difference of half a year ($U = 489427$, $p = .003$).

For Indigenous Australians, like the rest of the cohort, having a CD is associated with earlier contact with the CJS than those without this disability. Police contact for the CD group occurs approximately one and a half years earlier than for those without CD with a median age of first contact of 13.8 years of age ($U = 38111$, $p < .001$). This is consistent at all levels of first contact with the CJS. However there is no difference in the time between first police contact, and first custodial episode for Indigenous people with a CD.

Unlike the rest of the cohort, having a history of substance use is not associated with earlier first police contact for the Indigenous cohort. However, this group does experience custody earlier ($U = 44658$, $p = .001$) and sooner after first police contact ($U = 45326$, $p = .001$). Indigenous Australians with a substance abuse history have contact with police earlier than the non-Indigenous group by approximately two years ($U = 160495$, $p < .001$), have earlier custody, and move sooner to custody from first police contact ($U = 165817$, $p < .001$) than non- Indigenous Australians by approximately one year.

Figure 12: Age Of First Police Contact, First Custodial Episode And First Conviction For Indigenous Australians By Study Group



Indigenous Australians have significantly higher police contact both in total (median of 32 additional contacts) and rate per year, with 1.8 additional contacts per year. In addition, Indigenous Australians have four more custodial admissions than non Indigenous Australians, and on average spend more than an additional year of their lives incarcerated. This time in custody is spent in much shorter admissions, with the average stay being 77 days shorter (median difference of 12 days) in duration than non-Indigenous people in the cohort. Indigenous Australians spend a larger proportion of their lives incarcerated than non-Indigenous Australians with 4% greater proportion of their time spent in prison.

When comparing Indigenous persons with and without a diagnosis, those with a diagnosis have twice as many police contacts with an average of 96 (median of 88) contacts, and this occurs at more than twice the rate, with more than five contacts per year. This contact results in 10 admissions to custody, five more than for Indigenous people who do not have a diagnosis, however this does not translate into more days in custody. The median total duration in custody for Indigenous persons with a diagnosis is 1185 days, a total of almost two years less in prison, and this is spent in much shorter stays with an average stay of six months (median of three months) in prison. There is variation in the pattern of contact with the CJS when comparing across diagnosis types.

Indigenous persons in the cohort with a CD have on average 17 more police contacts than non-Indigenous people in the cohort with a CD, with 91 contacts compared to 74. This difference is not as substantial as the difference between Indigenous and non-Indigenous Australians across the cohort as a whole, and the difference in the rate of contacts is also not as marked, with Indigenous people with a CD having 1.4 times the rate of contacts per year compared to non Indigenous Australians with a CD. Indigenous Australians with a CD have 1.5 extra episodes in custody, however this does not result in

additional time spent incarcerated, with Indigenous Australians with a CD spending two months less time incarcerated than non Indigenous Australians with a CD and, these episodes are typically shorter in duration.

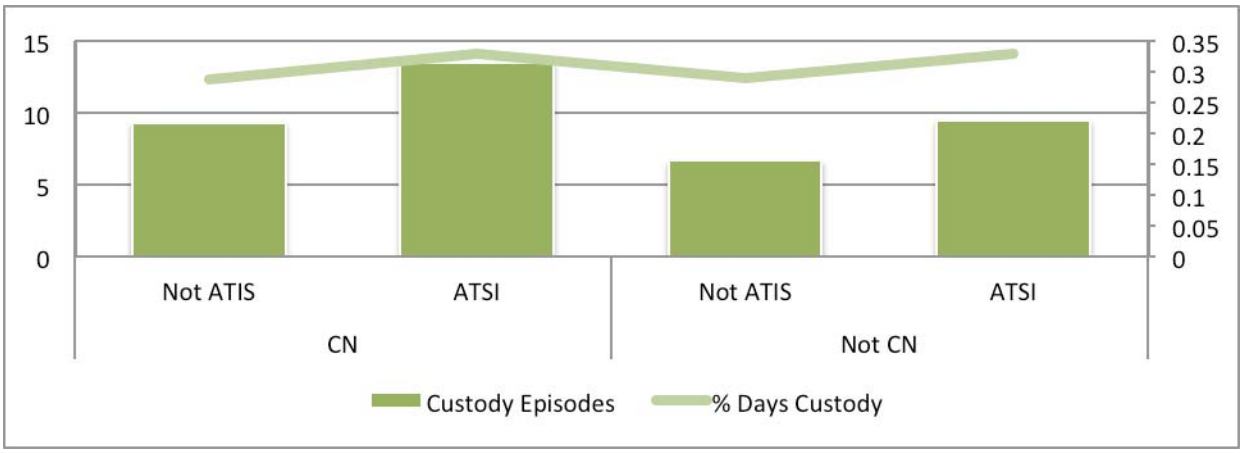
When comparing Indigenous and non Indigenous Australians with a MH disorder, Indigenous Australians have substantially more police contact, with an additional 29 contacts per person at an increased rate of 1.7 contacts per year. This group of Indigenous people has a greater number of custodial episodes (five) than non-Indigenous Australians with a MH disorder, resulting in twelve additional months incarcerated, but comprised of much shorter stays in custody, on average 135 days (median of 22 days) shorter in duration.

Indigenous Australians with a PD have a similarly increased amount of police contact compared to non-Indigenous Australians with a PD, with an additional 27 police contacts which occurred at a slightly faster rate of over one additional contact per year, comparable with the difference between the Indigenous and non-Indigenous cohort as a whole. Indigenous Australians with a PD have an additional five admissions into custody compared to non-Indigenous Australians, and this results in an additional ten months incarcerated. Once again, Indigenous Australians have shorter stays in custody by approximately six months (median of 12 days) per admission.

When examining the CJS contacts for people in the cohort with complex needs, the increased amount of contact for Indigenous Australians persists, with Indigenous Australians having an additional 29 police contacts which occur at a rate of an additional 1.9 contacts per year than non-Indigenous persons with complex needs. Likewise, this police contact results in an additional five admissions into custody, and a total of an additional twelve months in custody for Indigenous Australians. This was comprised of shorter stays, with Indigenous Australians having on average two months less per stay (median of eight day) compared to non-Indigenous Australians

Indigenous Australians in the cohort spend a larger proportion of their lives incarcerated than non-Indigenous Australians with approximately 5% greater proportion of their time spent in prison. When comparing this information for individuals with and without complex needs, there is little difference in these two figures for either Indigenous Australians or non-Indigenous Australians. This contact is shown in Figure 13.

Figure 13: Proportion Of Time Spent In Custody By Indigenous Status For Individuals With Complex Needs



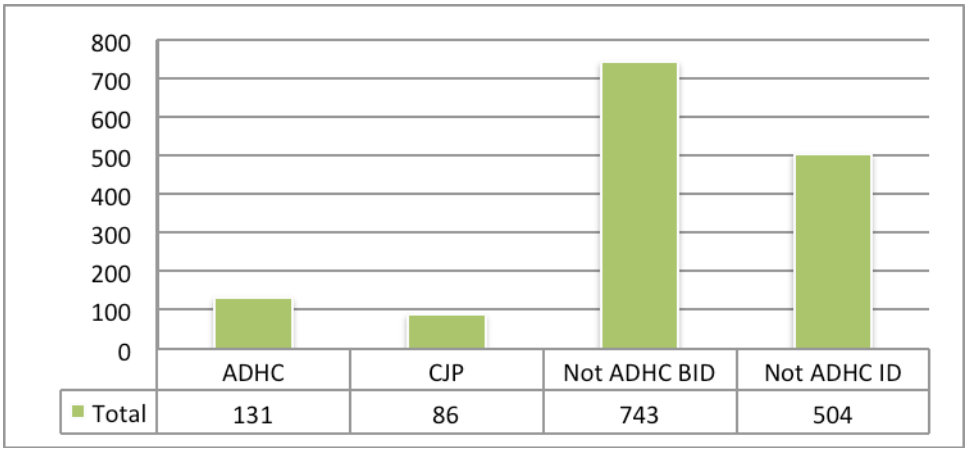
3. Ageing, Disability and Home Care (ADHC)

3.1 Overall Description

A small proportion of individuals in the MHDCD cohort had received services from ADHC including both the CJP and other ADHC services. The following section includes individuals who have a CD and separates them into four groups. The first section comprises clients of ADHC who have not been in the CJP, the next group comprises ADHC clients who are in the CJP program, then the remaining group comprises those with a CD who are not clients of ADHC: this group is split into those with an IQ score in the ID range and those in the BID range. The analysis of CJP is limited and biased as a result of information gaps. Currently, dates of program entry and exit into the CJP are unknown, and as a consequence the impact of participation in the CJP on contact with the CJS and other health and human service agencies is unknown.

Figure 14 shows the breakdown of the cohort into these four groups. While 131 individuals have received services from ADHC, and a further 86 are clients of the CJP, a high proportion of those with CD are not in receipt of a service. Case Study 3 offers an example of a person in this situation, where Ned has an ID but has no ADHD contact. Those with an CD who have not been an ADHC client account for 85% of the MHDCD cohort with a cognitive disability, with 40% of these individuals having an IQ score in the ID range, with the remaining 60% who have not received an ADHC service having an IQ score in the BID range.

Figure 14: Members Of The Cohort Receiving ADHC Services And Those With Intellectual Disability (ID) And Borderline Intellectual Disability (BID) Who Are Not Receiving Services And Those In The Community Justice Program (CJP)



Across the study groups, contact with ADHC services is highest for the ID groups as would be expected, however, even in these groups the contact is only around a quarter of those who would appear to be eligible. In the ID group 27.8% (61) and in the MH_ID group 24.9% (53) received ADHC services. In the borderline groups contact with ADHC was very low: in the BID group only 4.7% (10) had contact with ADHC and in the MH_BID group 5.7% (16) had contact with ADHC. The lowest level of service use is seen in the PD/AOD groups, with only one individual having had contact with ADHC.

Table 4 shows key statistics across the CD study groups. This table shows that a higher number of individuals in the CJP have complex needs, with almost three quarters of these individuals having multiple diagnoses. The ADHC group has the lowest proportions of individuals with complex needs. These complex needs are evident in the high proportions of individuals to have a diagnosis of a problematic substance use disorder or a MH disorder. Comparatively fewer persons with complex needs received ordinary ADHC services and this may be a reflection of the difficulty ADHC and NGO services have in providing services for persons with multiple diagnoses and disadvantages.

Table 4: Cognitive Disability Group With Proportions Of Complex Needs, Problematic Substance Use, Mental Health Disorder And Homelessness

Cognitive Disability Group	% Complex Needs	% Problematic Substance Use	% Mental Health Disorder	% Homeless
ADHC	58.78%	48.85%	26.72%	48.85%
CJP	72.09%	65.12%	32.56%	54.65%
Not ADHC ID	68.45%	59.72%	31.75%	36.90%
Not ADHC BID	64.47%	56.12%	27.59%	37.55%

Significant numbers of persons in each of the study groups have experienced homelessness as indicated in Table 4. These figures have been derived from data recorded by at least one agency identifying the individual as having 'no fixed place of abode' (NFPA) or recording the person's address as at a homelessness service provider. In the CJP group NFPA has been experienced in the past by the majority, with 54.65% (47) having been homeless on at least one occasion. In the ADHC group 48.85% (64), in the BID group 37.55% (279) and in the ID group 36.90% (186) are reported as experiencing homelessness at some point. It must be recognised that this method of ascertaining homelessness is very limited, unreliable and does not capture the extent of homelessness amongst the cohort as it is derived from a proxy indicator of homelessness and is probably a significant under count. This was the only method available of identifying homelessness. All five Case Studies document the known housing pathways of each individual. They offer insights into experiences of 'official' homelessness, as in the case of Natalie (Case Study 1) and Matthew (Case Study 2), but also other complex experiences including difficulty in finding appropriate and stable housing, for example Casey in Case Study 5.

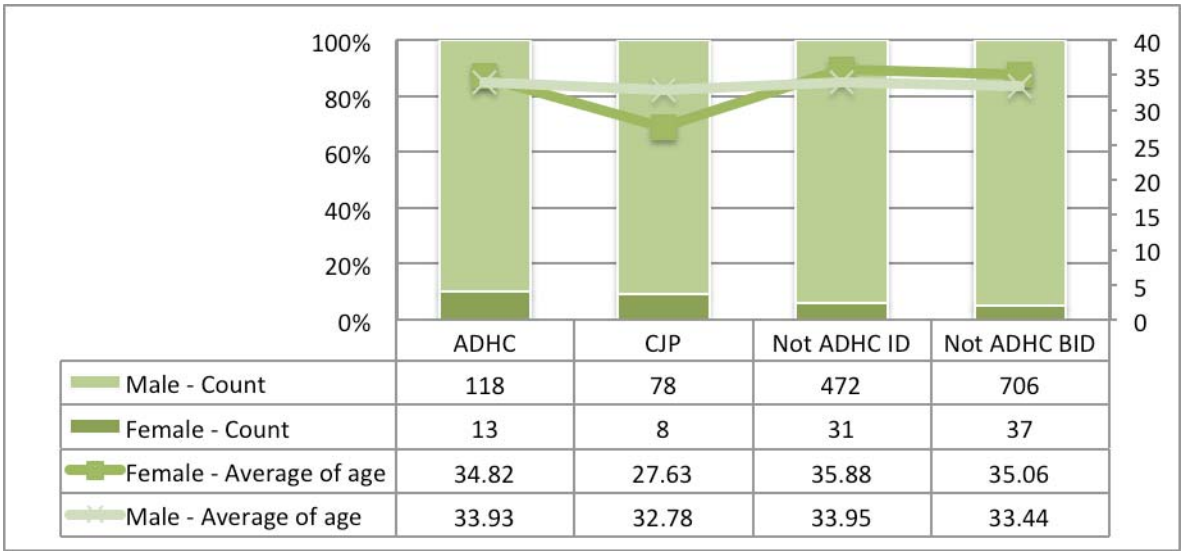
3.2 Demographics

A comparative analysis of individuals in the MHDCD cohort who are ADHC clients and those who appear eligible but do not receive ADHC services is undertaken below. For the purposes of fine grained analysis two key categories of ADHC service are utilised, those receiving services from the CJP and those who receive other (non CJP) ADHC service. These two groups are mutually exclusive. This breakdown enables comparative analysis between ADHC clients (CJP and non CJP) and those individuals who have been diagnosed with an ID or a BID and who do not receive ADHC services. This allows scrutiny of the pathways, contexts and impacts of agency interactions for these differently supported individuals.

Of the 217 cohort members who have received ADHC services, 90.3% (196) are male and 9.68% (21) are female, with one respondent having 'null' recorded as their gender. Of those who received ADHC services 24.9% (54) are Indigenous, 71% (154) are non-Indigenous and 4.15% (9) have an unknown Indigenous status.

The comparative breakdown in Figure 15 between the ADHC group, those in the CJP and those with an ID or a BID who are not in contact with ADHC reveals a higher proportion of males in both receiving ADHC services and not receiving ADHC services groups than females. The average age in the CJP group is lower for both males (32.78) and females (27.63) compared to the other groups. In the other groups the average age is slightly higher for females across all the study groups. In the group receiving ADHC services, females have an average age of 34.82 and males 33.92. In the ID group not receiving ADHC services, the average age is females 35.88 and males 33.95 and in the BID group the average age for females is 35.06 and males 33.44. One individual having 'null' recorded as their gender in the 'Not ADHC ID' group has been omitted from Figure 15.

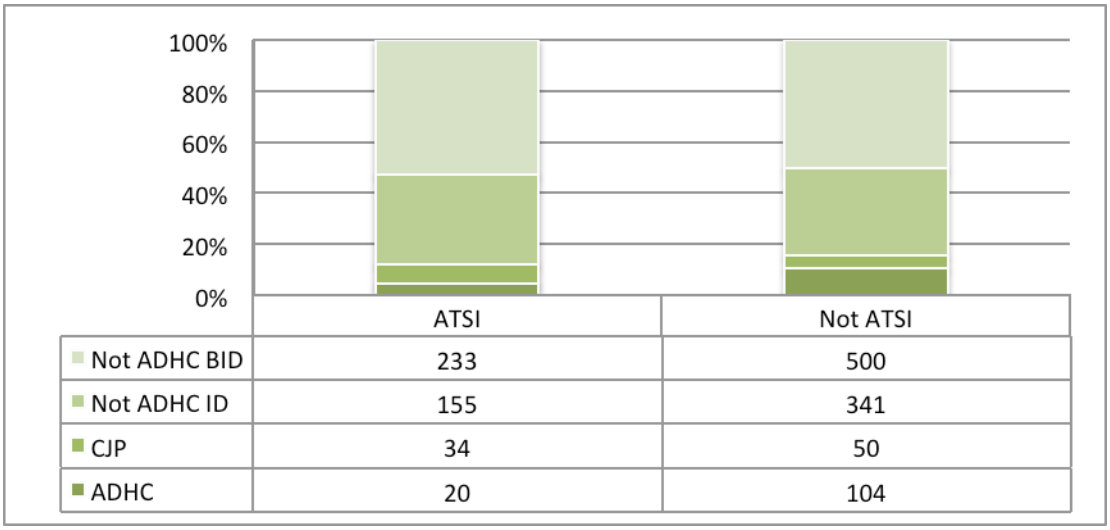
Figure 15: Gender And Average Age Across Groups



	ADHC	CJP	Not ADHC ID	Not ADHC BID
Male - Count	118	78	472	706
Female - Count	13	8	31	37
Female - Average of age	34.82	27.63	35.88	35.06
Male - Average of age	33.93	32.78	33.95	33.44

Figure 16 shows the proportion of people by CD study group. Indigenous people are slightly less likely to be a client of ADHC with 12% of the Indigenous group with a CD receiving services from ADHC. However, Indigenous people comprise a higher proportion of individuals on the CJP, with almost 40% of individuals on the CJP being Indigenous Australians. The experiences of Matthew (Case Study 2), Eddie (Case Study 4) and Casey (Case Study 5), who are all Indigenous Australians and received CJP contact, are described in more detail below.

Figure 16: ATSI Status Across The Study Groups



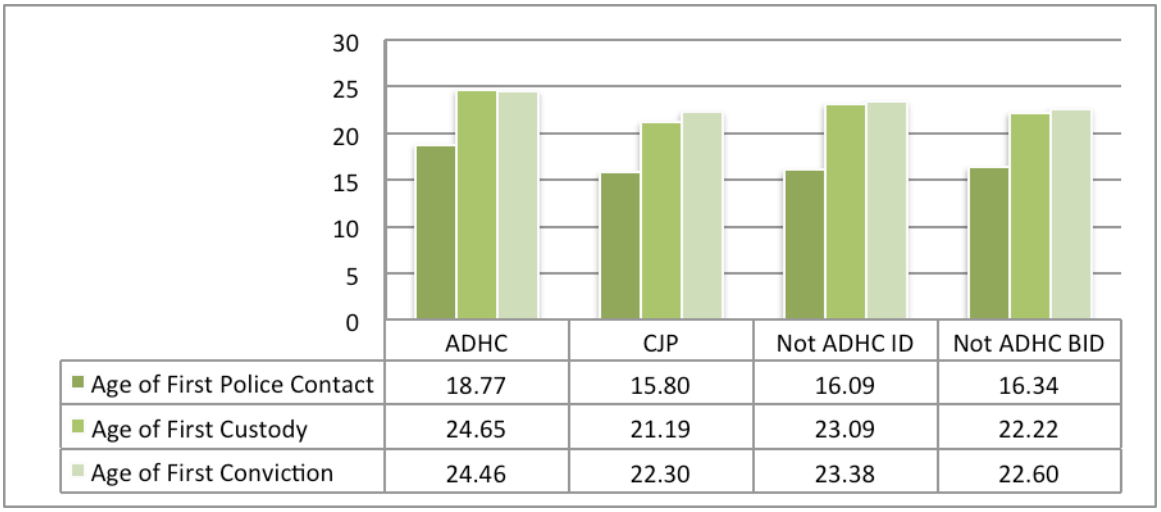
	ATSI	Not ATSI
Not ADHC BID	233	500
Not ADHC ID	155	341
CJP	34	50
ADHC	20	104

3.3 Intellectual Disability And Borderline Intellectual Disability And Ageing, Disability and Home Care (ADHC)

3.3.1 Criminal Justice Contacts

Individuals in the MHDCD study come into contact with the CJS at an early age, and progress through the CJS quickly. Examples of this progression for five individuals from the cohort can be seen in closer detail in the case studies. Figure 17 shows a comparison between the groups on age at first police contact, first custody episodes and first convictions. Immediately noticeable is that the ADHC group (excluding the CJP clients) has the highest average age for all four categories compared to the other groups; with first police contact at 18.77 years old, first conviction at 24.46 years old and first custody occurring at 24.65 years old. Contrastingly, the CJP clients were the youngest at all points of first contact with the CJS. Although 54 of the 84 CJP clients in the cohort are listed in the dataset as being ADHC clients, information regarding the date of admission to ADHC was not available for this analysis and it is quite likely, given all the other information available, that by far the majority of the CJP clients had not been ADHC clients as young people. It is likely they became ADHC clients after being assessed as having a disability in prison. Those who were ADHC clients as younger persons (but have not become CJP clients) appear to have some small measure of protection in that they come into contact with the CJS later than all others with a cognitive disability. Those who have not had an ADHC service in their youth appear to have become tightly enmeshed in the CJS as recidivists early in their lives. The CJP is a back end service, so to speak, picking up this group of the most complex needs persons who have a CD.

Figure 17: Average Age Of First Police Contact, First Conviction And First Custody Across The Study Groups



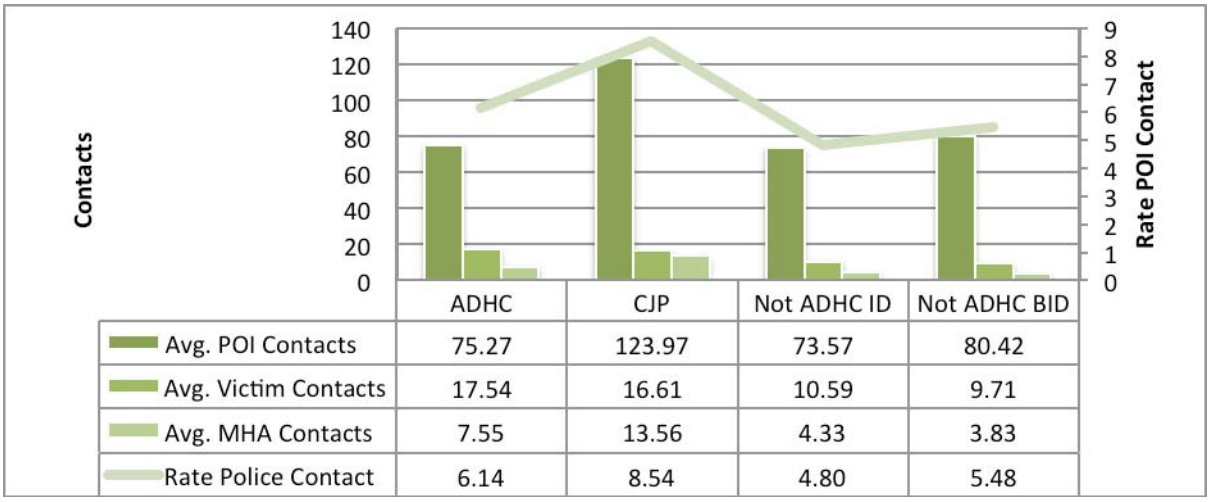
	ADHC	CJP	Not ADHC ID	Not ADHC BID
Age of First Police Contact	18.77	15.80	16.09	16.34
Age of First Custody	24.65	21.19	23.09	22.22
Age of First Conviction	24.46	22.30	23.38	22.60

Across the study groups there are substantial numbers of contacts with police as a person of interest to police in a crime (POI), as a victim and under the Mental Health Act (MHA). All individuals have had POI contacts and in all the groups there has been considerable victim contacts. Only a small number of individuals have not experienced being a victim of crime; the ADHC group at 96.95% (127), the BID group at 96.90% (720), the CJP group at 98% (84) and the ID group at 96.07% (489) have all had high

frequency contact as a victim. In the ADHC group there is a higher number of average contacts over life (17.54) as a victim comparative to both the ID (10.59) and BID (9.71) groups. Examples of ADHC clients who experience victim contacts can be seen in Case Study 1 where Natalie experiences significant conflict with her family including assault, and Case Study 5 where Casey (a CJP client) has a long history of self-harm and physical abuse. The average number of POI contacts highlight that individuals in the CJP have a much higher total number of police contacts as a POI and also that this contact occurs at higher frequency compared to the other three groups.

Approximately 30% of individuals had a contact with police that was dealt with under the MHA, with those individuals who did have contact with police under the MHA had a substantial number of contacts, with an average of five and a half police contacts per person over their life to date dealt with by police in this manner. Individuals who were clients of ADHC have substantially higher contact with police under the MHA, most starkly those in the CJP, with those who had been dealt with under the MHA having an average of almost fourteen contacts per person. This is in addition to their overall higher volume of contacts both as a person of interest and as a victim of crime.

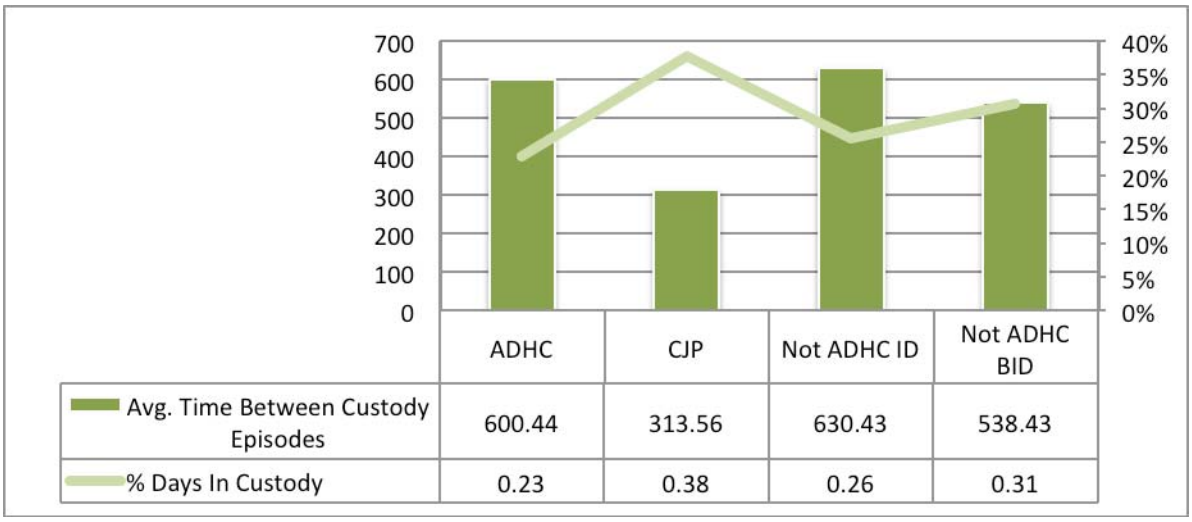
Figure 18: Average Of Victim Contacts And Average Of Person of Interest (POI) Contacts Across The Study Groups



	ADHC	CJP	Not ADHC ID	Not ADHC BID
Avg. POI Contacts	75.27	123.97	73.57	80.42
Avg. Victim Contacts	17.54	16.61	10.59	9.71
Avg. MHA Contacts	7.55	13.56	4.33	3.83
Rate Police Contact	6.14	8.54	4.80	5.48

Figure 19 shows that this higher contact with police results in much higher proportions of time spent incarcerated for individuals in the CJP group. This could suggest the CJP is working with the most complex and highest prison cycling group of people with cognitive impairment. The ADHC group has experienced a lower proportion of days in custody than all three other groups. Correspondingly, the CJP group also experienced on average much shorter periods between custodial episodes.

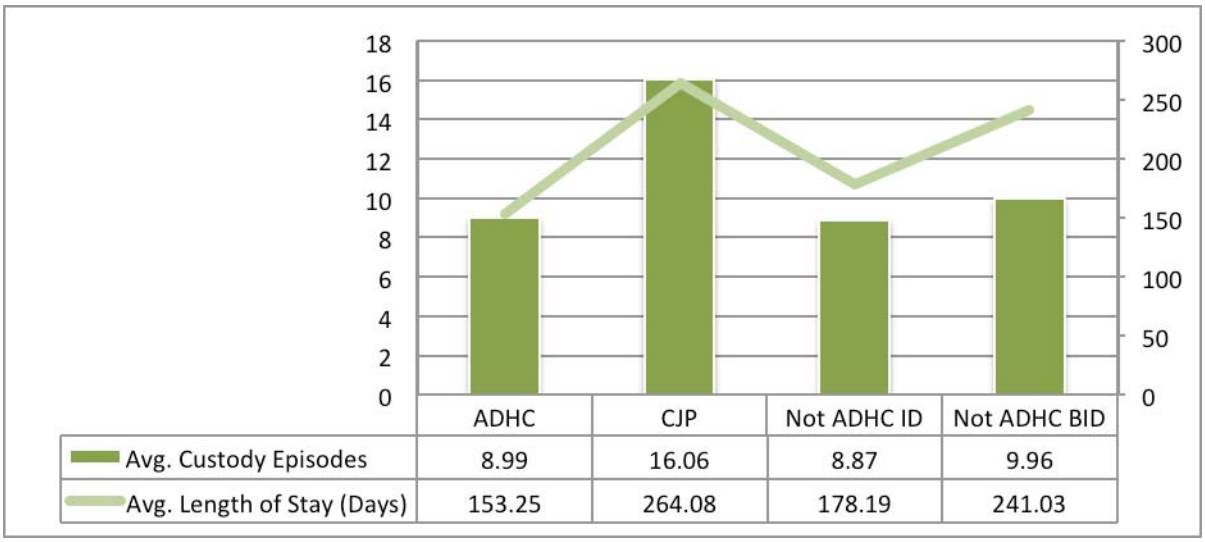
Figure 19: Proportion Time Incarcerated And Average Time Between Episodes By Group



	ADHC	CJP	Not ADHC ID	Not ADHC BID
Avg. Time Between Custody Episodes	600.44	313.56	630.43	538.43
% Days In Custody	0.23	0.38	0.26	0.31

Figure 20 details the nature of the custodial episodes and how these days were accrued. Clients of the CJP were incarcerated more frequently than the other three groups and these episodes were substantially longer in duration than those for the other groups. Those in the ADHC group on average had the shortest custodial episodes, over 100 days shorter than those clients of the CJP. This evidence supports the conclusion that the CJP has been working with those with cognitive impairment who have the highest level of contact with the CJS. It is important to remember that the CJP has been going only since 2005, so it is very likely than most of the police and other CJS events took place before persons who are in the CJP entered that program; and that the CJP only takes those who already have a reasonably extensive record of police and custody events.

Figure 20: Average Custody Episodes And Average Length Of Stay By Group

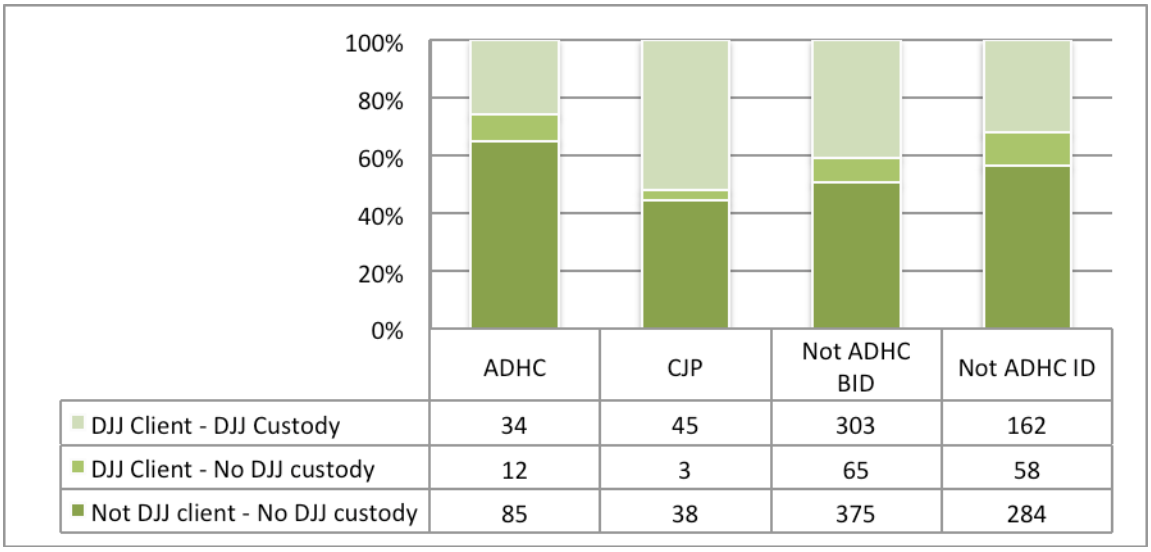


	ADHC	CJP	Not ADHC ID	Not ADHC BID
Avg. Custody Episodes	8.99	16.06	8.87	9.96
Avg. Length of Stay (Days)	153.25	264.08	178.19	241.03

3.3.2 Juvenile Justice (JJ)

Across the CI groups, individuals in the ADHC group had the lowest rates of being both a client of JJ and having been in custody as a juvenile 25.95% (34). One third of those with an ID who had not received an ADHC service (Not ADHC ID group) had been in JJ custody (162) with the highest proportion being the CJP group with a rate of over 50% having been in custody as a juvenile. Part Four provides analysis of four individuals who have JJ contact including Natalie (Case Study 1) who is an ADHC client and Matthew (Case Study 2), Eddie (Case Study 4) and Casey (Case Study 5) who are also CJP clients and have a BID, BID, ID and BID respectively.

Figure 21: Juvenile Justice (JJ) Client And Juvenile Justice (JJ) Custody By Study Group



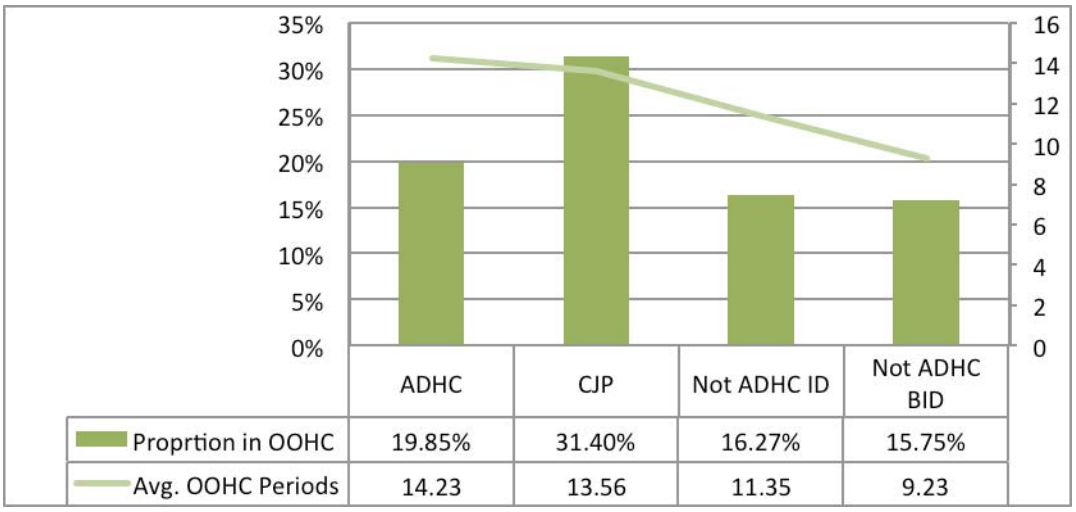
	ADHC	CJP	Not ADHC BID	Not ADHC ID
DJJ Client - DJJ Custody	34	45	303	162
DJJ Client - No DJJ custody	12	3	65	58
Not DJJ client - No DJJ custody	85	38	375	284

3.3.3 Agency Interactions

3.3.3.1 Community Services (CS)

Experience of Out of Home Care (OOHC) was evident in all four cognitive impairment groups. Figure 22 shows the highest proportion of individuals who had been in OOHC is in the CJP group with 31% having been in care, followed by the ADHC group with 19.85%, 16.27% in the ID group and 15.75% in the BID group. On average the ADHC and CJP groups had the most OOHC episodes with approximately fourteen OOHC episodes per child compared to the other groups where on average the ID group has had 11.35 episodes and the BID group 9.23 episodes. Natalie, an ADHC client (Case Study 1) and Eddie, a CJP client (Case Study 4) are documented to have spent large amounts of time in OOHC during their early years.

Figure 22: Community Services (CS) Out of Home Care (OOHC) Across The Study Groups



3.3.3.2 Health

Across the study groups there have been numerous contacts with health agencies, with the majority of each study group having had hospital admissions. The CJP group again had the highest proportion of individuals with a hospital admission, with over 80% having been admitted to hospital. In the ADHC group 75.56% (99) had hospital admissions while 73.34% (545) of the BID group and 69.99% (366) of the ID group had been hospitalised (Table 5). Table 5 shows the proportion of the cohort with a psychiatric admission; the CJP has the highest proportion with 40% having at least one psychiatric admission, followed by the ADHC group at 36% (47), the BID group with 28% (211) and the ID group with 28% (141).

The CJP group has the highest average of both hospital and psychiatric admissions with 14.7 and 10.6 respectively, followed by the ADHC group with 11.96 and 7.51. The BID group has the next highest average of hospital admissions with 9.36 followed by the ID group with 8.63. The ID group shows a slightly higher average rate of psychiatric admissions with 4.77 compared to 4.62 in the BID group.

Table 5: Health Admissions Across The Study Groups

Study Group	Total Hospital Admissions	Avg. Hospital Admissions	Avg. Hospital Days	Psychiatric Admissions	% Psych Admission	Avg. Psychiatric Admissions	Avg. Psych Days
ADHC	1184	11.96	98.04	353	35.88%	7.51	104.96
CJP	1029	14.70	78.66	361	39.53%	10.62	98.03
Not ADHC ID	3160	8.63	64.99	672	27.98%	4.77	93.93
Not ADHC BID	5102	9.36	65.81	974	28.40%	4.62	87.93

Table 6 shows a breakdown of the health categories for hospital admission of the study groups for both the primary and secondary diagnosis. Across all the four study groups, for both the primary and

secondary diagnosis the highest proportions fall into the 'Mental and behavioural disorders'. Casey's story in Case Study 5 (who is identified as having a BID, MH and 'behavioural' issues) and Eddie's story in Case Study 4 (who is identified as having MH and AOD issues) provide powerful insights into ongoing hospital admissions which often involve restraint and sedation, and little other forms of intervention in support of CD, MH, AOD and other needs.

Table 6: Health Categories Across The Ageing, Disability and Home Care (ADHC) Group, Not ADHC Intellectual Disability (ID) Group And The Not ADHC Borderline Intellectual Disability (BID) Group

Category	ADHC Service	Frequency 1st Diagnosis	%	Frequency 2nd Diagnosis	%
Mental and behavioural disorders	Not ADHC ID	1218	38.78	3102	33.0
	Not ADHC BID	1738	34.17	3982	31.7
	CJP	582	56.95	1102	40.8
	ADHC	575	48.77	1250	35.4
Injury, poisoning and certain other consequences of external causes	Not ADHC ID	637	20.28	927	9.88
	Not ADHC BID	782	15.38	1189	9.48
	CJP	142	13.89	157	5.82
	ADHC	236	20.02	359	10.1
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	Not ADHC ID	264	8.40	505	5.38
	Not ADHC BID	254	4.99	669	5.33
	CJP	57	5.58	171	6.34
	ADHC	84	7.12	264	7.48
Diseases of the digestive system	Not ADHC ID	213	6.78	323	3.44
	Not ADHC BID	218	4.29	343	2.73
	CJP	31	3.03	37	1.37
	ADHC	44	3.73	70	1.98
Factors influencing health status and contact with health services	Not ADHC ID	194	6.18	2870	30.5
	Not ADHC BID	1399	27.51	3954	31.5
	CJP	58	5.68	860	31.9
	ADHC	66	5.60	1087	30.8
Diseases of the nervous system	Not ADHC ID	150	4.78	234	2.49
	Not ADHC BID	136	2.67	255	2.03
	CJP	50	4.89	121	4.49
	ADHC	43	3.65	149	4.22
Diseases of the skin and subcutaneous tissue	Not ADHC ID	107	3.41	122	1.30
	Not ADHC BID	106	2.08	117	0.93
	CJP	25	2.45	18	0.67
	ADHC	31	2.63	17	0.48
Pregnancy, childbirth and the puerperium	Not ADHC ID	76	2.42	103	1.10
	Not ADHC BID	59	1.16	71	0.57
	CJP	3	0.29	2	0.07

	ADHC	16	1.36	17	0.48
Diseases of the circulatory system	Not ADHC ID	64	2.04	236	2.51
	Not ADHC BID	60	1.18	176	1.40
	CJP	5	0.49	10	0.37
	ADHC	9	0.76	53	1.50
Diseases of the musculoskeletal system and connective tissue	Not ADHC ID	58	1.85	75	0.80
	Not ADHC BID	58	1.14	104	0.83
	CJP	17	1.66	16	0.59
	ADHC	13	1.10	22	0.62
Diseases of the respiratory system	Not ADHC ID	54	1.72	173	1.84
	Not ADHC BID	98	1.93	181	1.44
	CJP	19	1.86	31	1.15
	ADHC	21	1.78	33	0.94
Diseases of the genitourinary system	Not ADHC ID	33	1.05	70	0.75
	Not ADHC BID	65	1.28	912	7.27
	CJP	11	1.08	8	0.30
	ADHC	17	1.44	25	0.71
Certain infectious and parasitic diseases	Not ADHC ID	21	0.67	251	2.67
	Not ADHC BID	42	0.83	284	2.26
	CJP	13	1.27	106	3.93
	ADHC	7	0.59	86	2.44
Endocrine, nutritional and metabolic diseases	Not ADHC ID	21	0.67	273	2.91
	Not ADHC BID	28	0.55	171	1.36
	CJP	5	0.49	37	1.37
	ADHC	2	0.17	53	1.50
Diseases of the eye and adnexa	Not ADHC ID	10	0.32	26	0.28
	Not ADHC BID	10	0.20	35	0.28
	CJP	1	0.10	1	0.04
	ADHC	2	0.17	-	-
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	Not ADHC ID	9	0.29	45	0.48
	Not ADHC BID	14	0.28	47	0.37
	CJP	-	-	5	0.19
	ADHC	5	0.42	17	0.48
Neoplasms	Not ADHC ID	9	0.29	15	0.16
	Not ADHC BID	8	0.16	6	0.05
	CJP	1	0.10	-	-
	ADHC	5	0.42	3	0.09
Congenital malformations, deformations and chromosomal abnormalities	Not ADHC ID	2	0.06	16	0.17
	Not ADHC BID	5	0.10	13	0.10
	CJP	1	0.10	5	0.19
	ADHC	2	0.17	12	0.34

Diseases of the ear and mastoid process	Not ADHC ID	1	0.03	18	0.19
	Not ADHC BID	6	0.12	36	0.29
	CJP	1	0.10	9	0.33
	ADHC	1	0.08	5	0.14
External causes of morbidity and mortality	Not ADHC ID	-	-	-	-
	Not ADHC BID	-	-	2	0.02
	CJP	-	-	-	-
	ADHC	-	-	5	0.14
Totals	**Not ADHC ID**	**3141**	**100**	**9384**	**100**
	Not ADHC BID	**5086**	**100**	**12547**	**100**
	CJP	**1022**	**100**	**2696**	**100**
	ADHC	**1179**	**100**	**3529**	**100**

The category of Mental and Behavioural Disorders is particularly broad and is comprised of an array of more specific conditions that are further explored in Table 7 below.

Table 7: Mental And Behavioural Disorders (Block Title) Primary And Secondary Diagnosis Across The Groups

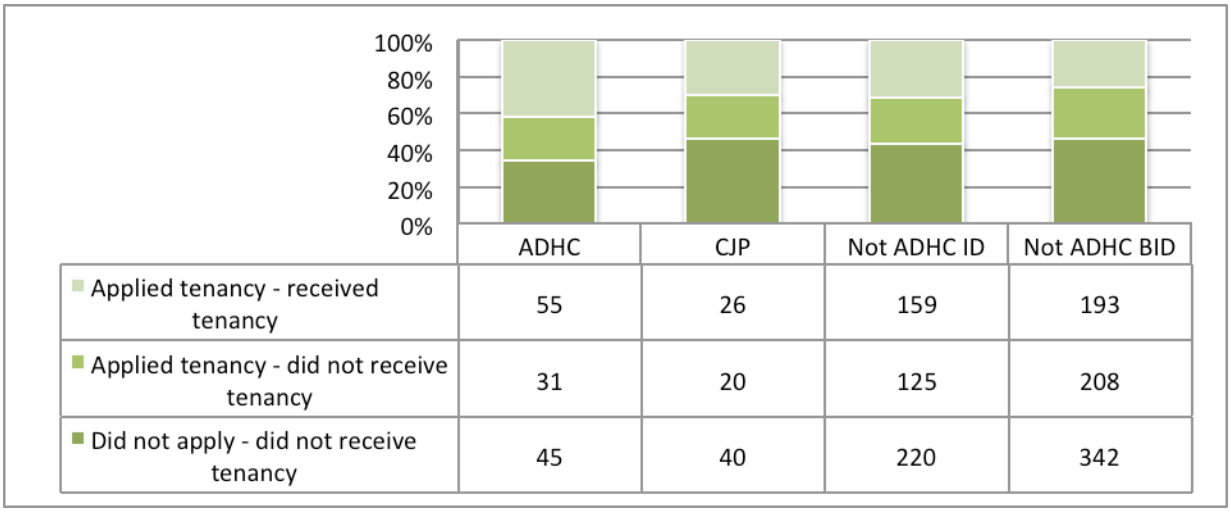
Category	ADHC Service	Frequency	Percentage	Frequency	Percentage
		Primary Diagnosis		Secondary Diagnosis	
Mental and behavioural disorders due to psychoactive substance use	ADHC	156	27.13	441	35.28
	CJP	114	19.59	385	34.94
	Not ADHC ID	460	37.77	1837	59.22
	Not ADHC BID	700	40.28	2527	63.46
Schizophrenia, schizotypal and delusional disorders	ADHC	118	20.52	123	9.84
	CJP	173	29.73	141	12.79
	Not ADHC ID	445	36.54	286	9.22
	Not ADHC BID	597	34.35	408	10.25
Disorders of adult personality and behaviour	ADHC	80	13.91	265	21.2
	CJP	80	13.75	131	11.89
	Not ADHC ID	106	8.70	386	12.44
	Not ADHC BID	88	5.06	388	9.74
Neurotic, stress-related and somatoform disorders	ADHC	66	11.48	50	4
	CJP	45	7.73	35	3.18
	Not ADHC ID	78	6.40	122	3.93
	Not ADHC BID	155	8.92	148	3.72
Mental retardation	ADHC	58	10.09	162	12.96
	CJP	45	7.73	242	21.96
	Not ADHC ID	14	1.15	167	5.38
	Not ADHC BID	7	0.40	76	1.91
Mood [affective] disorders	ADHC	51	8.87	73	5.84
	CJP	15	2.58	37	3.36

	Not ADHC ID	77	6.32	172	5.54
	Not ADHC BID	90	5.18	194	4.87
Disorders of psychological development	ADHC	23	4.00	84	6.72
	CJP	36	6.19	54	4.90
	Not ADHC ID	1	0.08	43	1.39
	Not ADHC BID	2	0.12	32	0.80
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	ADHC	11	1.91	35	2.8
	CJP	51	8.76	52	4.72
	Not ADHC ID	9	0.74	38	1.23
	Not ADHC BID	25	1.44	110	2.76
Unspecified mental disorder	ADHC	6	1.04	4	0.32
	CJP	11	1.89	2	0.18
	Not ADHC ID	15	1.23	8	0.26
	Not ADHC BID	20	1.15	9	0.23
Organic, including symptomatic, mental disorders	ADHC	5	0.87	11	0.88
	CJP	7	1.20	21	1.91
	Not ADHC ID	10	0.82	34	1.10
	Not ADHC BID	52	2.99	80	2.01
Behavioural syndromes associated with physiological disturbances and physical factors	ADHC	1	0.17	2	0.16
	CJP	5	0.86	2	0.18
	Not ADHC ID	3	0.25	9	0.29
	Not ADHC BID	2	0.12	10	0.25
Total	ADHC	575	100.00	1250	100
	CJP	582	100.00	1102	100.00
	Not ADHC ID	1218	100.00	3102	100.00
	Not ADHC BID	1738	100.00	3982	100.00

3.3.3.3 **Housing**

The ADHC group has been afforded the highest numbers of housing tenancies in comparison to the ID and the BID groups. The ADHC group had the highest rate of tenancy application with 65.65% (86), followed by the ID group with 56.35% (284) and the BID and CJP groups with 54%. The rates of success for tenancy application reveal the extent of the gap between individuals who applied and the actual rate of success in securing tenancy. Of all individuals who applied for tenancy it is the BID group that had the least success in securing tenancy with only 48.13% (193) of those applying actually receiving tenancy. The highest rate of receiving tenancy was the ADHC group with 63.95% (55). Each Case Study reports known Housing tenancy applications made by each individual, whether rejected or approved, at various points in time and offers insight into the experiences of these individuals at the time of making these applications, and how this interacts with their life pathways.

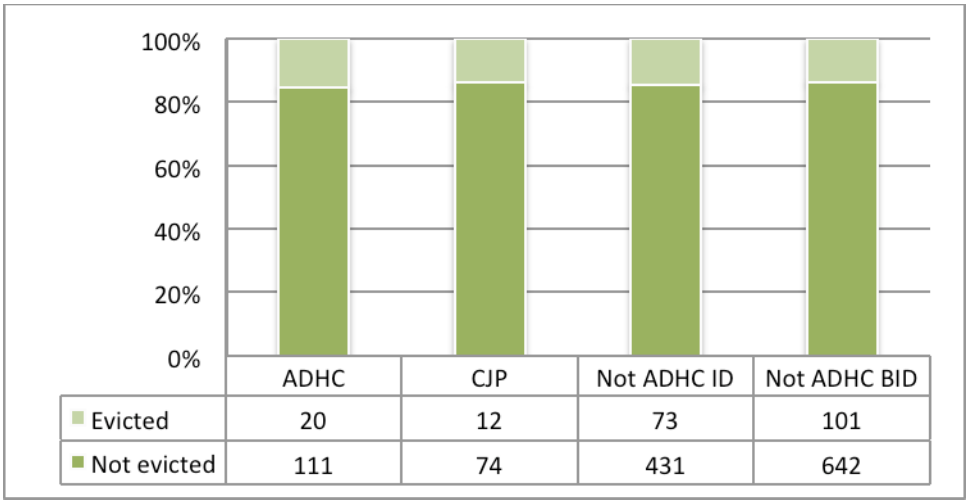
Figure 23: Rates Of Tenancy Applications And Outcomes Across The Groups



	ADHC	CJP	Not ADHC ID	Not ADHC BID
Applied tenancy - received tenancy	55	26	159	193
Applied tenancy - did not receive tenancy	31	20	125	208
Did not apply - did not receive tenancy	45	40	220	342

Individuals in all groups received rent assistance. The ADHC group had the highest proportion to have received rent assistance with 46.56% (61), followed by the BID group with 41.05% (305) and the ID group with 40.08% (202). Rates of special assistance subsidy were low across all groups: the ADHC group had five instances of emergency rent assistance granted, and the ID group and the BID group had two instances each. Across the groups the rates of eviction are similar (Figure 24): the ADHC group had a 18.01% (20) eviction rate, the ID group 14.48 % (73) and the BID group 13.59% (101). In terms of evictions from housing across the groups, there were similar proportions of individuals to have ever been evicted, with the highest proportion evident in the ADHC group at 15%.

Figure 24: Eviction Rates Across The Groups



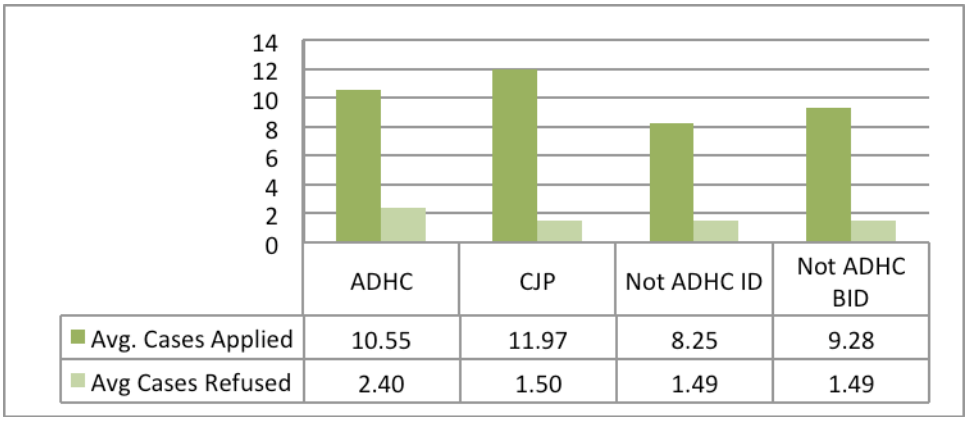
	ADHC	CJP	Not ADHC ID	Not ADHC BID
Evicted	20	12	73	101
Not evicted	111	74	431	642

3.3.3.4 Legal Aid

All groups have had high numbers of legal aid applications: the BID group had the highest number of applicants with 90% (671), followed closely by the CJP group with 89.5% (77) and then the ADHC group

with 85% (111). The average across the groups shows that the CJP group had the highest number of applications with an average of almost twelve per individual and one and a half matters refused on average, whilst the ADHC group had an average of 10.55 applications together with more cases being refused (2.40). The BID group had on average 9.3 applications and the ID group 10.84 applications, with both these groups having had the same average rejection rate of 1.49. Again, use of legal aid is documented for each individual in the five Case Studies.

Figure 25: Average Of Legal Aid Cases Applied And Refused Across The Study Groups.



	ADHC	CJP	Not ADHC ID	Not ADHC BID
Avg. Cases Applied	10.55	11.97	8.25	9.28
Avg Cases Refused	2.40	1.50	1.49	1.49

By far the greatest proportion of legal aid cases are criminal cases and this is so across all the groups; the CJP group had the highest proportion to have had a criminal case with legal aid, with 88% (76), followed by the BID group with 85% (630), the ID group 82.5% (416) and lastly, the ADHC group with 80% (105). Use of legal aid by the study groups for family and civil cases was substantially lower than criminal cases. Legal aid relating to family law was used most by the ID group at 19.44% (98), and then the BID group at 19.11% (142), the CJP group at 15% and the ADHC group at 12.98% (17). The CJP had the highest proportion of individuals to have had a civil case with Legal Aid (29%), followed by the ADHC group with 17.56% (23) of the group, followed by the ID group at 11.90% (60) and the BID group at 8.61% (64). All the groups had substantial proportions of individuals using legal aid for legal advice: 68.6% (59) of the CJP group, 67.56% (502) of the ID group, the BID group at 65.08% (328) and the ADHC group at 64.12% (84).

3.4 Borderline Personality Disorder

Individuals with a Borderline Personality Disorder (BPD) within the MHDCD have often been identified as some of the more difficult persons to work with (Dougherty et al 1999; Bagge et al 2004; Grohol 2007). Almost 500 individuals in the MHDCD study have been diagnosed with a BPD at some point. Females are more likely to have received a BPD diagnosis, with 39% of females having been diagnosed compared to 15% of males in the MHDCD study. An example of an individual with a BPD and their experiences is Eddie (Case Study 4), who has a primary diagnosis of BPD, but also an ID and an AOD history.

Table 8 highlights some key statistics for the group of individuals with a BPD across all the study groups. Females are proportionally over-represented in the group with a BPD in all study groups. Those in the CJP with a BPD, compared to individuals with a BPD not in the CJP, have much earlier police contact, a higher rate and total number of police contacts, more days in custody and a higher number of incidents dealt with under the Mental Health Act by police.

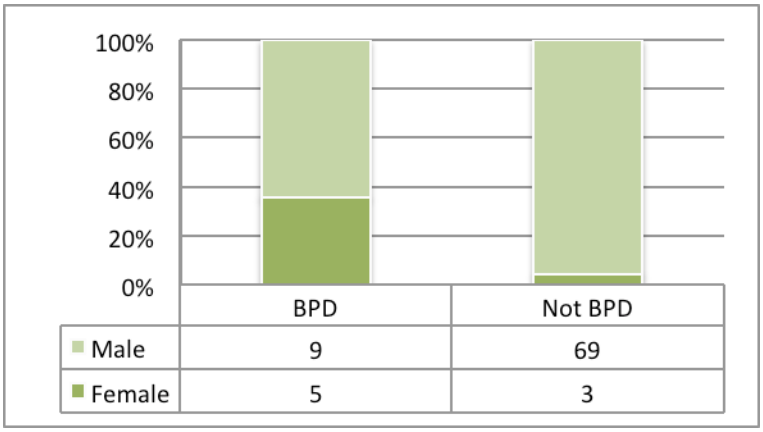
Table 8: Key Statistics For Individuals With A Borderline Personality Disorder (BPD) Diagnosis By Group

Group	% Group BPD	% BPD Female	% BPD ATSI	Age First Police Contact	Rate Police Contact	Avg. POI Contact	Avg. Custody Days	Avg. MHA Contacts	% MH Admission
ADHC	12%	50%	14%	23.04	9.22	101.13	843.75	17.63	81%
CJP	16%	36%	43%	13.61	10.78	155.79	1,633.21	27.71	86%
Not ADHC ID	8%	18%	27%	16.78	5.33	89.10	1,514.78	4.40	80%
Not ADHC BID	8%	39%	26%	16.58	4.89	76.79	1,223.41	6.10	77%
Not ID_BID	28%	23%	21%	17.04	4.27	73.86	1,336.39	0.53	20%
Total	18%	25%	22%	17.07	4.80	79.23	1,341.68	2.80	36%

3.4.1 The Community Justice Program (CJP) and Borderline Personality Disorder (BPD)

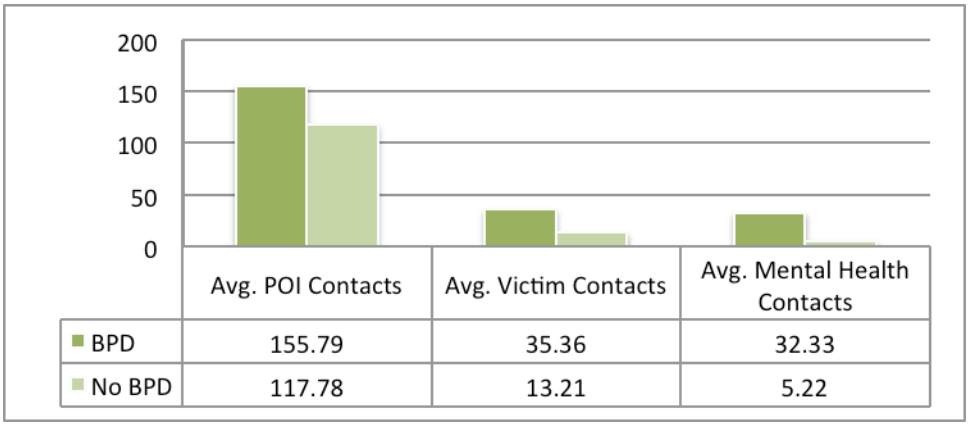
A comparative analysis between those with a BPD in the CJP and those who are not is important to distinguish between the pathways and the impacts of agency interactions these individuals have and their contexts. In the CJP group 16.28% (14) are individuals with a diagnosed BPD. Of those with a BPD in the CJP group Figure 26 highlights that nine individuals are male while five are female. This accounts for a larger proportion of females than those who are not diagnosed with a BPD as they consist of 69 males and three females.

Figure 26: Gender Breakdown For Individuals With Borderline Personality Disorder (BPD) In The Community Justice Program (CJP) Group



In the CJP both those with a BPD diagnosis and those without a BPD have had considerable police contact as a POI, as victims and under the *Mental Health Act*. The total volume of contact is greater for those with a BPD. While in both groups all the individuals have had POI contacts, victim contacts differed marginally: 100% (14) of individuals in the CJP group with a BPD have had contact as a victim compared to those without a diagnosis of a BPD where 97.22% (70) had contact as a victim. The average number of POI and victim contacts highlights that those in the BPD CJP group have a substantially higher average than the non-BPD group with an average of 35.36 victim contacts and 155.79 POI contacts compared to 12.86 victim contacts and 120.83 POI contacts over their lives for the no-BPD group. The proportion of people with a BPD to have a mental health contact was 85% compared to 38% for those without a BPD in the CJP group. Those who had a mental health contact in the BPD group had substantial total contacts, with an average of over 30 contacts per person dealt with by police under the MHA. This compares to the five contacts on average for those without a BPD in the CJP group who had ever had a matter dealt with under the MHA.

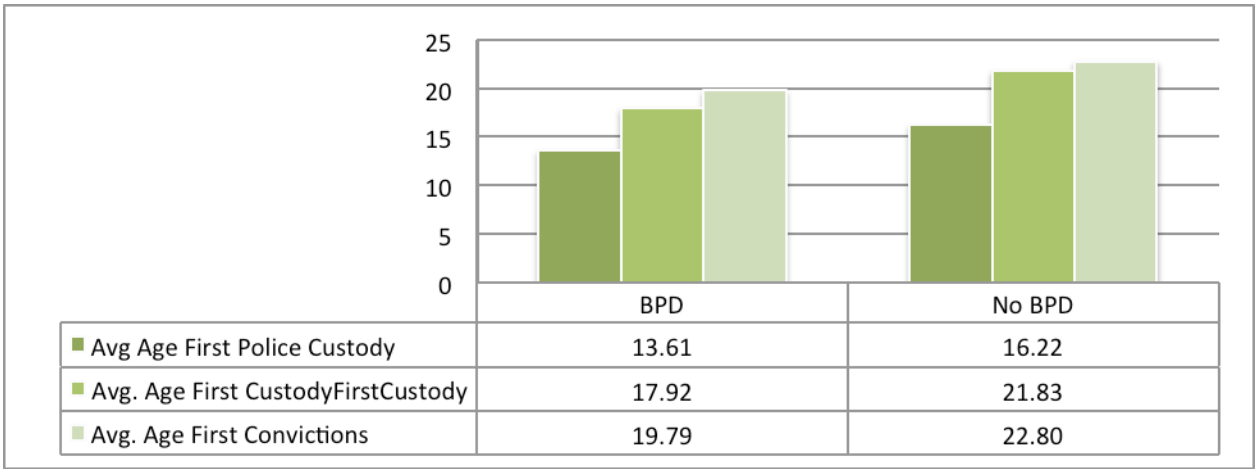
Figure 27: Average Person of Interest (POI), Victim And Mental Health Act (MHA) Contacts For Community Justice Program (CJP) Group



	Avg. POI Contacts	Avg. Victim Contacts	Avg. Mental Health Contacts
BPD	155.79	35.36	32.33
No BPD	117.78	13.21	5.22

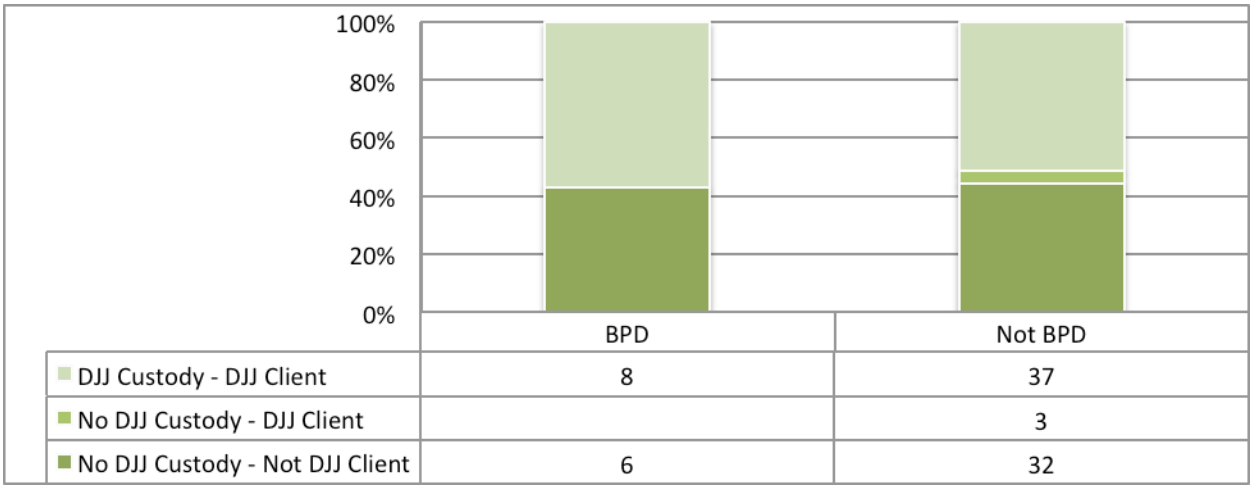
Figure 28 details the progression through the criminal justice system for people in the CJP grouped by BPD diagnosis. Those with a BPD have much earlier contact at all points in the CJS by about three years: first police contact on average by fourteen years of age; a custody episode as a juvenile; and convicted of their first offence prior to age twenty. Figure 29 details this earlier contact for those with a BPD in the CJP, with approximately 60% of these individuals having been incarcerated as a juvenile.

Figure 28: Average First Police Contact, First Conviction, And First Custody For The Borderline Personality Disorder (BPD) Group Across The Study Groups.



	BPD	No BPD
Avg Age First Police Custody	13.61	16.22
Avg. Age First CustodyFirstCustody	17.92	21.83
Avg. Age First Convictions	19.79	22.80

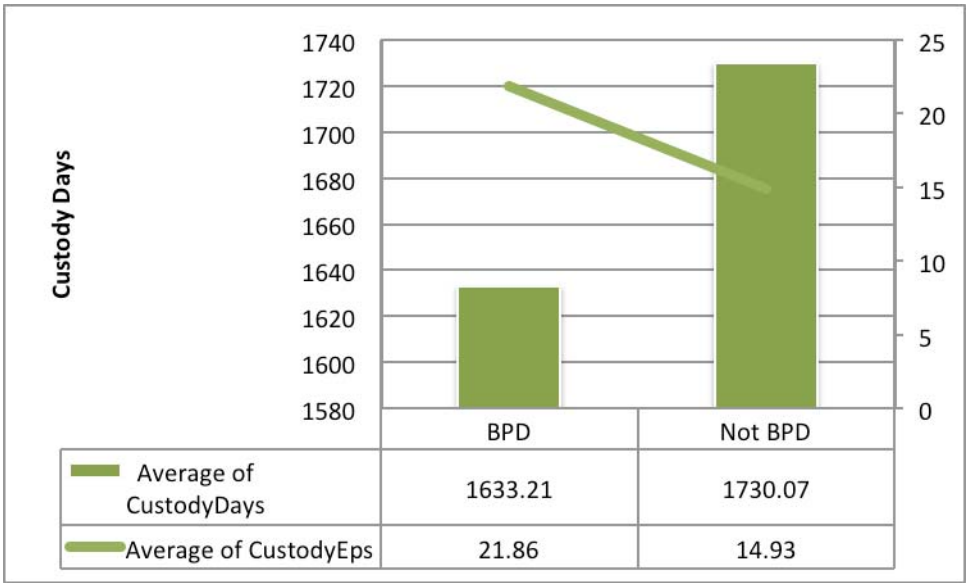
Figure 29: Borderline Personality Disorder (BPD) Group And Juvenile Justice (JJ) By Study Groups.



	BPD	Not BPD
DJJ Custody - DJJ Client	8	37
No DJJ Custody - DJJ Client		3
No DJJ Custody - Not DJJ Client	6	32

Individuals in the CJP who are diagnosed with a BPD, while having on average fewer days in custody at 1633.21 days compared to those not diagnosed with a BPD at 1730.07 days, have on average more custody episodes with an average of 21.86 compared to the no BPD individuals who had an average of 14.93 custody episodes.

Figure 30: Individuals With Borderline Personality Disorder (BPD) And Average Custody Episodes And Days By Study Groups.



Conclusion

The analyses of the data presented in this report suggest a number of conclusions and matters for further exploration. It is clear that having a cognitive impairment predisposes persons who also experience other disadvantageous social circumstances to a greater enmeshment early in life with the criminal justice system and that persons with cognitive impairment and other disability such as mental health and AOD disorders (complex needs) are significantly more likely to have earlier, ongoing and more intense police, juvenile justice, court and corrections episodes and events.

The cognitive complex needs groups in the study have experienced low rates of disability support as children, young people and adults with Indigenous members of the cohort having the lowest levels of service and support. It is evident that those who are afforded ADHC support do better, with less involvement in the criminal justice system compared with those with cognitive disability who do not receive ADHC services.

As detailed data on the CJP group was not available at the time of analysis, some key factors regarding the CJP group's pathways were not included. For example the date of entry to the CJP would provide a different picture of the CJP clients' pathways. It is evident that CJP clients are at the more complex and 'deeply enmeshed in the CJS' end of the MHDCD cohort, that the CJP is engaging the most complex cognitive impairment individuals, and it may be the case that their significantly greater police, court and

imprisonment events may have been before their entry into the CJP. It is recommended that this further analysis be undertaken.

It is also evident that particular aspects of persons with cognitive impairments' lives and contexts are 'markers' of their deeper CJS histories: contexts such as their family's capabilities and resources, their lack of access to disability services, their school education, their being in out of home care, their events in juvenile justice and their housing circumstances are all important in determining their pathways. Those with borderline personality disorder are also evidently more likely to have deeper CJS histories and this area deserves greater analysis.

This report is provided in the knowledge that there are further areas of investigation suggested in the findings, but for which this report was not funded or tasked.

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4. Brief Case Studies

Brief interpretive discussions are given at the end of each case study.

4.1 Case Study 1: Natalie

This is a case study of an individual chosen from the MHDCD dataset in order to bring into focus the impact that having complex needs may have on an individual's interactions with criminal justice and human service agencies.

To identify Natalie a range of increasingly restrictive criteria were applied to the dataset. These criteria were:

- a diagnosis of BID;
- a diagnosis of a psychiatric condition;
- a history of substance use;
- having been in JJ custody;
- having had a tenancy with NSW Housing;
- having been an ADHC client; and
- having had higher numbers of police contact and episodes in custody.

Natalie's history

Natalie is a young woman in with a borderline intellectual disability (total IQ 73), a history of substance abuse and who has various mental health disorders. She attended a special class but left school at 14 without any qualifications. Natalie receives a disability support pension.

Natalie had hundreds of days in out of home care as well as hundreds of incidents with police as a young person in relation to a number of offences but also as a 'young person at risk'. This is predominately as a result of her inability to stay at her parents' home due to the aggravated nature of her relationship with a family member who is reported to have a mental illness. As a young person, on numerous occasions police note that she is homeless. Natalie makes full admissions to offences when confronted by police, and is cautioned on a number of occasions. Natalie's behaviour appears to the police to be seriously disturbed and they attempt often to have her admitted to a psychiatric unit under the *Mental Health Act* but each time the psychiatric assessments indicates she does not have a mental health disorder and she is refused admission.

Police records regularly detail their frustration regarding unsuccessful attempts to find support and accommodation for Natalie, particularly from DoCS: for example one Friday afternoon before a long weekend her unsafe circumstances were left until the next week. Natalie was returned to her father,

who was intoxicated and abusive. Despite repeated attempts at finding her accommodation Police recorded that Natalie's history of aggressive behaviour resulted in her being refused admission or thrown out of many youth refuges/temporary accommodation so she was often homeless.

Natalie has had numerous self harm attempts and is known to commit an offence so she can be safe in prison. She has a number of children all of whom were eventually removed due to Natalie's incapacity to care for them. She was granted priority housing a number of times but lost her tenancies. Natalie smokes dozens of cannabis cones a day. She was assessed as having 'mental retardation unspecified', 'emotionally unstable personality disorder', 'dissocial personality disorder', 'histrionic personality disorder' and high-risk pregnancy due to social problems'.

She received minor assistance from ADHC as an adult for therapy and counselling, but appears not to receive the high level of intervention she clearly needs. None of Natalie's children stay in her custody for more than a few months.

Conclusion

Natalie's lifecourse interventions and contact with almost all human and criminal justice services and agencies are frequent but not very helpful and in many cases lead to further harm. A pattern emerged early in her life of police, rather than support and care services, being the frontline of control for her due to her escalating difficult and oppositional behaviour, even though she clearly has disabilities and is a victim of abuse from an early age. Police have no capacity to support, treat, house or provide the social and family care she clearly needs. No agency took serious responsibility for her when she was young as evidenced by police frustration at so often trying in vain to find a safe place to take her and this also has become a pattern. This is somewhat understandable as what is clearly needed is an integrated and cross sector response to Natalie's disabilities and highly disadvantageous circumstances; such services and approaches are in very short supply. Natalie has lived in a marginal and liminal community and criminal justice space (see Baldry 2010) where ineffective very short-term interventions and 'controls' are constantly being setup and then failing. Her pleas to be 'bail refused' so that she can be 'housed' safely in prison speak eloquently to her sense that she has no safe community space.

4.2 Case Study 2: Matthew

This is a case study of an individual chosen from the MHDCD dataset in order to bring into focus the impact that being homeless may have on an individual's interactions with criminal justice and human service agencies.

To identify Matthew a range of increasingly restrictive criteria were applied on the dataset. These criteria were:

- Contact with Housing NSW;

- Had housing tenancy;
- Come into police contact because of his homelessness;
- ATSI;
- Had a mental health diagnosis;
- Youngest age of first police contact; and
- Moderate number of custodial episodes.

Matthew's history

Matthew, now in his early twenties was diagnosed with 'behaviour defiance syndrome' as a child and has been diagnosed subsequently with a borderline intellectual disability with an overall IQ of 70 and substance use disorder. He attended school on and off until year 8 but his school attendance was very poor and he effectively ceased to engage with school around fourth class. Both Matthew's parents came from highly disadvantaged backgrounds and used alcohol to excess. He was surrounded from birth with drugs and alcohol. A number of times before the age of 12 police noted that Matthew was with one or other of his parents, who were intoxicated, at a pub. Matthew lived between the streets and various relatives from very early in his life and had 'no fixed address,' a fact noted often by police and community services.

At age seven Matthew had his first police event and was also known to them for being a child at risk, with police recording sadistic and threatening behaviour. As he was under the age of ten no formal action was taken. He started to go in and out of state care eventually coming under permanent out of home care (OOHC). But all his foster care arrangements broke down quickly due to his behaviour. Between the ages of 7 and 11 Matthew had over 70 contacts with police as a person of interest (POI), often for minor thefts of money and retail items (usually food) and some for more serious matters.

Matthew went on to have hundreds of contacts with police for both offending and being a child at risk, and many juvenile justice orders before the age of eighteen and then hundreds more police events and many adult custody episodes to date, as an adult. He has not lived in an ordinary community space as a small child, youth or adult but has been in marginal community/criminal justice spaces controlled by the criminal justice system, with police his frontline 'carers'. He did not receive disability support as a child or adult. By the time he was 14 he had become entrenched in this criminal justice management system.

Conclusion

As with Natalie's lifecourse involvement with agencies and services, Matthew has very early and usually short and crisis driven interventions that do not address his substantive and long term issues as a child with cognitive disability, experiencing child abuse and neglect, very early alcohol and drug use and living in highly unsafe and disadvantageous circumstances. At no point does it appear that there is any concerted effort to bring Indigenous community services, school education, disability services and community services together to assess Matthew's needs and situation and provide a positive approach.

The only point at which it seems his behaviour improves is when he sent away from his hometown to familial care in another town. This approach seems to have positive outcomes so it is possible that he could have been better cared for in the longer term, but it is not persisted with or supported vigorously so it breaks down. The lack of options in some areas of NSW may be playing a part in Matthew's precipitate entry into serial detention and incarceration, as there appear to be no other options. Matthew, like Natalie, never lives in an ordinary community space as a small child, youth or adult but is in marginal community/criminal justice spaces controlled by the criminal justice system. All but the police (and they cannot do that) wash their hands of him by the time he is 14. His cognitive disability is never addressed.

4.3 Case Study 3: Ned

This is a case of an individual chosen from the MHDCD dataset in order to bring into focus the impact that the presence of an intellectual disability may have on an individual's interactions with criminal justice and human service agencies.

To identify Ned a range of increasingly restrictive criteria were applied on the dataset. In order, these criteria were:

- IQ in the ID range;
- Early police contact;
- In custody as a juvenile;
- Resided in public housing; and
- Substantial number of days in custody.

Ned's history

Ned is an Indigenous man who has an IQ of 65, placing him in the intellectual disability range. Ned has a history of mental illness including diagnoses of personality and behaviour disorders, schizophrenia and mental illness related to psychoactive substance use. He is from a regional town and has a number of children with his partner. Ned moved between his mother, father and other relatives' houses when young. He stopped attending school at age 13. Ned began to have regular contact with police after leaving school, accumulating numerous incidents and custody events.

As an adult Ned has sometimes been itinerate. He often has AVOs against him and constantly breaches them. He has a vicious drug habit, suffers from severe depression and often attempts suicide. He has had 53 finalised court matters, 135 police incidents and over 2,200 days in adult custody. He has been on methadone many times. He goes in and out of hospital for a range of health issues in particular for drug and self harm matters, nevertheless doctors refuse to schedule him.

After involvement by an Aboriginal program worker, Ned has completed an intervention program, and a course of study. He started to apply for and receive more services and support. Participation on the methadone maintenance program and treatment for drug and alcohol and psychiatric problems through Justice Health supported a change in behaviour. His subsequent psychiatric treatment through the Aboriginal Medical Service and continuation on the methadone program has led to a period of desistance from offending behaviour.

Conclusion

Although Ned is diagnosed with under 70 IQ nowhere does it appear that this is recognised by police, school education or juvenile justice or at least if it is, it is not recorded and no action, such as referring to ADHC, is taken to provide disability services. Ned's life course exemplifies the management role police play in controlling someone with multiple diagnoses who from birth, is deeply affected by Indigenous dispossession, disadvantage and trauma. In fact he is so completely enmeshed in police control that he is often stopped and searched without there being good reason for suspicion other than he is known well to them. A strong disability response to Ned earlier in life may well have provided an intervention that would have channelled him into a community support service and context. Instead, everything done for and to Ned is crisis driven.

4.4 Case Study 4: Eddie

This is a case of an individual chosen from the MHDCD dataset in order to bring into focus the impact that the presence of borderline personality disorder (BPD) may have on an individual's interactions with criminal justice and human service agencies. Eddie was chosen for this case study, using selection criteria specific to an individual who has been a client of ADHC.

To identify Eddie a range of increasingly restrictive criteria were applied to the dataset. In order, these criteria were:

- Male;
- Primary diagnosis of a BPD;
- Received services from ADHC;
- In out of home care as a child; and
- A client of the Juvenile Justice (DJJ).

Eddie was then chosen above another man for this case study as he had the spent the most days in custody.

Eddie's history

Eddie is an Indigenous man who has an intellectual disability, with a reported IQ of 69. He has a long history of problematic drug use beginning at the age of six, including prescription drugs, amphetamines, alcohol, cannabis, heroin, methadone and buprenorphine. Much of his contact with police is in relation

to his drug use and break and enter and robbery offences, often violent. He regularly attempts self-harm from a young age. Eddie attended a special class but is not known to have attended school past the age of twelve. Members of his family are known for their problematic use of drugs and alcohol. From age nine, Eddie begins frequent short periods in out of home care.

Eddie often breached bail as a young person as his bail conditions required that he be with a responsible adult – an impossibility in his family circumstances. He spent considerable time in JJ custody, where he was raped. He attended the local hospital emergency department, usually for self harm or attempted suicide. He was often scheduled under the *Mental Health Act* but rarely spent more than a few days in a psychiatric unit. When he wasn't in custody Eddie was mainly homeless but was has received disability supported accommodation.

From a young age, Eddie was portrayed as 'uncontrollable' and 'attention seeking' rather than as a young person in need of care and protection. Despite extensive diagnoses, he received little effective intervention as a young person or adult until very recently.

Conclusion

It appears that Eddie does not receive appropriate or sufficient support for his intellectual disability, personality and other mental and behavioural disorders, problematic drug use or offending behaviour throughout his young life. The places and spaces in which he lives from birth are unsafe and are characterised by violence, chaotic living and crisis responses. This is the antithesis of what is appropriate for someone with cognitive impairment, where long term structured and stable circumstances are required. The area in which he lives appears to play a part in the lack of support services and responses afforded to Eddie. As in all the other cases discussed, the police are the de-facto social and community workers, with control of Eddie's often very agitated and oppositional behaviour as a child and a teenager falling to them. The amount of police time, energy and number of disproportionate responses to his actions can be seen in some respects as displacement from human services onto police services.

4.5 Case Study 5: Casey

This is a case of an individual chosen from the MHDCD dataset in order to bring into focus the impact that the presence of borderline personality disorder (BPD) and ID may have on an individual's interactions with criminal justice and human service agencies.

To identify Casey a range of increasingly restrictive criteria were applied to the dataset. In order, these criteria were:

- Female;
- An ADHC client;

- Has an intellectual disability;
- Diagnosis of a borderline personality disorder;
- In out of home care as a young person; and
- Contact with a range of different agencies.

From the list of individuals that met these criteria, Casey was chosen because she has the most police contacts.

Casey's history

Casey is a young Aboriginal woman, who has been multiply diagnosed with a range of mental and cognitive conditions, including behavioural and emotional conditions emerging in childhood and adolescence. These include ADHD, Conduct Disorders, Adjustment Disorders, Personality Disorder and Bipolar Affective Disorder. Casey has also been identified as having a developmental delay and intellectual disability (IQ 64). She has a long history of self-harm, physical abuse and trauma. She has used alcohol and other drugs from a young age and after the age of 13 she barely attended school.

She began to be noted by the Police as disturbed, suicidal and homeless in her early teens. She was admitted to hospital under the *Mental Health Act* on numerous occasions where she was usually sedated and restrained and released the following morning. In one year alone Casey was the subject of 87 Police events, as a result of which she was taken into police custody 35 times and charged on 56 different counts. On numerous occasions services, such as Community Services and the local hospital say they cannot support Casey. In one six month period, she was held in Juvenile detention from one to 39 days, with a total of 128 days spent in custody.

Police noted that Casey needed medical and mental treatment but instead was being bounced around between Police and the Hospital. Although her mother was completely unable to support her, bail conditions continued to require that she live with her mother – she constantly breached bail. The only time Casey was not being picked up police or held in detention was during a respite placement for 6 months during which time Casey did not come into contact with Police, DJJ or hospitals. This arrangement though came to an end and Casey resumed her frequent police contact. After this Casey was again imprisoned in DJJ detention and was repeatedly admitted to psychiatric facilities under the *Mental Health Act* where she was restrained and sedated. Recently Casey was transferred into a residential setting with a disability focus.

Casey is the youngest individual profiled in the case studies and has the highest lifecourse institutional costs of all the individuals detailed in this study. Her intellectual disability and personality disorders together with her traumatic childhood appear to be the key factors precipitating her institutional contact. Casey was a client of Community Services, ADHC, DJJ and a number of other community-based agencies and services from a young age, and yet due to her 'problematic behaviour', she was left to the

police to manage. The supported accommodation she receives now reduces significantly police and other criminal justice contacts for the first time in her life.

Conclusion

Casey is an individual who has obviously high support needs from a young age. Evidence of trauma and neglect is clear throughout her life. Her experiences of violence, evidenced by repeated restraint by police and carers and her subsequent use of violence and aggression herself, appear a key central theme in her life. The presence of cognitive impairment clearly underlies the trauma, behaviours and experiences and while a key characteristic noted by many service providers, it appears that little intervention and service provision is directed to her support needs in this area. Her frequent and escalating mental health episodes are, initially, the object of a range of interpretations by service providers. Many indicate a belief that rather than genuine mental health issues, they are simply 'attention seeking'. There appears a relationship between the severity of these instances, which, from an early age involve increasingly serious incidents of self-harm, and recognition by the system.

Aside from medication and scheduling under the Mental Health Act, there appears to be little sustained or effective intervention with Casey for her mental health issues. In the early years interventions amount to repeated short admissions (usually of one or two nights) to hospitals and mental health units where the common treatment is restraint and sedation. The one period of remission from these events occurs when she is in respite care.

Casey's lack of, for most of her life, a safe community space in which to live is an experience seen in the other case studies. From an early age Casey and the others in the case studies with cognitive disability and other compounding diagnosis, and who experience severe disadvantage, and for Indigenous persons, the legacy of colonial oppression and trauma, live in liminal marginal community-criminal justice spaces. These are usually characterised by control and are spaces in which continual breaches of human and disability rights occur and where incarceration is the norm of management.