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**Organisation:** University of New South Wales  
**Name:** Associate Professor Eileen Baldry  
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## **NSW District Court Conference 2010**

### **Background Paper: Pathways to prison for Mentally Ill Offenders**

Eileen Baldry, Leanne Dowse and Melissa Clarence  
UNSW

#### **Introduction**

The presence of people with mental health disorders and cognitive disability (MHDCD) in criminal justice systems (CJS) in Australia, and internationally is not a new phenomenon but the rate of people with MHDCD and of those with co-occurring disorders in the CJS appears to have increased. International and national evidence points to widespread over-representation of these persons in police work, the courts and juvenile and adult prisoner populations, both as victims and offenders. There is recognition that there is incongruence between human service and CJSs dealing with people with MHDCD. Little headway has been made in keeping these people out of the CJS and new insights into, and understandings of their involvement are required.

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

#### **Background**

##### *Mental health*

International studies indicate that the prevalence of MHD amongst prisoners is significantly higher than that found in the rest of the population. For example, Belcher (1988), Aderibigbe (1996), Harrington (1999), Baillargeon et al (2009) and Steadman et al (2009) all found that persons suffering from a serious mental illness or disorder were significantly over-represented in the USA jail and prison populations. Reed & Lyne (2000) confirmed the same for the UK prison population. NACRO (1992) and James et al (1999) in the UK and Lamb et al (1998, 2002, 2004) in the USA all confirmed that homeless mentally ill persons were much more likely to be incarcerated than non-homeless. People with severe mental illness are more likely to be convicted of

# **NSW District Court Annual Conference 2010**

## **Background Paper: Pathways to Prison for Mentally Ill and Cognitively Impaired Offenders**

**Eileen Baldry<sup>1</sup>, Leanne Dowse<sup>2</sup> and  
Melissa Clarence<sup>3</sup>**

**School of Social Sciences and  
International Studies**

**UNSW**



**UNSW**  
THE UNIVERSITY OF NEW SOUTH WALES

**Arts and  
Social Sciences**

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<sup>1</sup> Eileen Baldry PhD Associate Professor, School of Social Sciences and International Studies; Associate Dean (Education) Faculty of Arts and Social Sciences

<sup>2</sup> Leanne Dowse PhD, Lecturer, School of Social Sciences and International Studies

<sup>3</sup> Melissa Clarence BSocSc MIPH, Project Data Manager School of Social Sciences and International Studies

misdeemeanours than their mentally healthy counterparts, and tend to be incarcerated for longer periods (Lamberti et al 2001:64).

In Australia, Mullen et al (2000) and Mullen (2001) reported that around 25% of Victorian prisoners had had contact with mental health services prior to their imprisonment, and that males with schizophrenia and a coexisting substance abuse were over 12 times more likely to be convicted than males in the general population. A NSW Corrections Health Survey (Butler & Allnutt 2003) using the Composite International Diagnostic Interview (CIDI) which yields both DSM-IV and ICD-10 diagnoses of MHDCD, found a high prevalence of mental illness in the NSW prisoner population. The twelve-month occurrence of any psychiatric disorder (psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder or neurasthenia) was 74% amongst prisoners (86% for females; 72% for males) compared to 22% in the general population. Also almost half the reception inmates and one-third of sentenced inmates had suffered a mental disorder (9% prisoners Vs 0.42% general population suffered psychosis, 22% Vs 6% affective disorder, 43% Vs 10% anxiety disorder) in the 12 months prior to the survey. The most recent Inmate Health Survey (Justice Health 2009:17) indicates an increase in these figures. Inmates who have ever been assessed or treated by doctor or psychiatrist for a MH problem increased from 39% in 1996 to 43% in 2001 to 49% in 2009. This was due to men's increasing MH problems: 35% in 1996, to 41% in 2001, to 47% in 2009. The proportion of women remained steady at around 54%. An increasing proportion of participants also reported ever having been admitted to a psychiatric unit: from 13% in 1996, to 14% in 2001, to 16% in 2009, and this group contained a higher proportion of women (20%) than men (15%) in 2009.

### *Cognitive disability*

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

Australia follows the DSM IV diagnostic requirements for intellectual disability (ID) (learning disability in the UK) of >70 IQ and poor levels on two social adaptive scales. In NSW the high representation of people with an intellectual disability in the CJS has been well recognised (Department of Family & Community Service 1988; New South Wales Law Reform Commission 1993; Simpson et al 2001). In a survey of juvenile offenders in NSW, 17% had cognitive functioning scores consistent with a possible intellectual disability. Remarkably 74% scored below the average range of intellectual functioning,

compared to 25% from the standardised sample (NSW Department of Juvenile Justice 2003). In the most recent juvenile justice survey amongst those in custody, 13.5 % of the young people had IQ below 70 with a further 32% who have an IQ between 70 and 79 (borderline intellectual disability) compared with less than 9% of the general population. The NSW Sentencing Council (NSW Sentencing Council 2004) recognises the serious consequences of imprisonment for people with cognitive disabilities. Entrenchment within a culture of criminality due to the tendency of those with CD to want to be accepted by their peer group, readjustment problems post-release as people with ID inherently have impaired adaptive skills and vulnerability to assault and mistreatment in the mainstream prison environment are all highly problematic for these persons in the criminal justice system. A Victorian study revealed the gross disadvantages suffered by prisoners with ID and the over-representation of Aboriginal (in this case) men amongst ID prisoners (Glaser & Deane 1999).

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

### **Trajectories into prison**

Internationally there is a recognition that the police carry the major burden of attending to psychiatrically disturbed people behaving in an anti-social or criminal manner and that police must make the determination whether to take such persons to a psychiatric unit or to arrest them (Lamb et al 2004). Added to lack of training in recognising mental health disorders police often find such individuals may not be accepted into the mental health system due to lack of space, the person being deemed not ill enough or that they should be handled by the CJS (Lamb 2002). In NSW, Police report great concern at the demand and stress placed upon police attending mental health crises, that some mental health workers view police as de-facto mental health workers and the criminalizing of mental illness (NSW Legislative Council Select Committee on Mental Health 2002). Internationally, for people with cognitive disabilities, there is a higher incidence of remand or bail than for those without a disability (Lyall 1995). The lack of information and research on police and people with MHD/CD in Australia is most notable.

In NSW up to 23% of people appearing before NSW Local Courts on criminal charges may have severe to mild or borderline ID (New South Wales Law Reform Commission 1993). A much higher percentage is estimated to have a MHD with many having dual diagnosis (both ID or BID and MHD). Despite a variety of court and other diversion and transitional schemes in Australia and elsewhere, there appears to be limited success in the longer term, in either keeping people with MHD & CD already arrested by police, out of ongoing CJS entanglement and re-offending. This has been due to poor planning; inadequate identification and referral; lack of commitment from and integration with psychiatric services; inadequate resources and lack of suitable accommodation (James 1999; Baldry & Maplestone 2003; Rowlands et al 1996). On their own, such specialist

court diversions (the model of therapeutic jurisprudence) do not appear to have reduced the numbers of people with MHDCD in prison.

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

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

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

#### **Why the increase?**

There are a number of theories as to why there appears to have been a significant rise in the appearance of people with MHDCD in the CJS (Henderson 2003). Criminalisation of the mentally ill and cognitively disabled as an effect of deinstitutionalisation is commonly cited (Lamberti et al 2001). Nevertheless the lack of community mental health facilities *in itself* does not appear to be the only factor affecting the prevalence of mental illness in prisons (Fisher et al 2000). The rapid rise in the co-occurrence of substance abuse and mental illness has also been cited as a very strong contributing factor. Indeed, in an environment in which substance abuse so closely accompanies mental illness, low tolerance to drug crimes means an increase in the proportion of these people within the CJS.

In NSW, legislative changes increasing the use of remand and the likelihood of re-incarceration for community correction breaches may be having a disproportionate effect on people with MHDCD. The lack of appropriate accommodation for such released prisoners makes their chances of integration slim (Baldry 2005). Importantly the majority of research finds no inherent link between psychiatric disability or ID and *crime* (Simpson & Hogg 2001), but a strong causal link between psychiatric disability and *incarceration* (Henderson 2003) highlighting the impacts that social disadvantages such as homelessness, visibility, prejudice, fear, lack of support and services, and lack of family ability, capacity or will to assist may well be having on these people's life courses.

It has been suggested "offending by intellectually disabled persons is directly related to the levels of community care and support and the availability of specialist services" (Byrnes 1999:315).

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

### **MHDCD Study**

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

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

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

There were significant problems with matching the individuals in the cohort across all agencies as there were many aliases – 30,000 for the 2,731 in the cohort. Because data has been gathered for different purposes and in different forms (eg definitions vary substantially) it was difficult to clean the data for merging and use in a composite dataset. Eventually, when alias problems had been overcome and the data cleaned, each dataset from each agency was matched then uploaded onto a SQL server that allows relational merging of information.

## Study findings to date

### *Cohort description*

Full Cohort N=2,731

Intellectual disability N=680

Borderline cognitive disability N=783

Mental health N=965

Substance abuse disorder N= 1276

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

No MHCD diagnosis N=339

Women = 11%

Indigenous Australians = 25%

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

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

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

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

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

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

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

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

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

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

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

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

There are 1463 people in the cohort with CD:

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



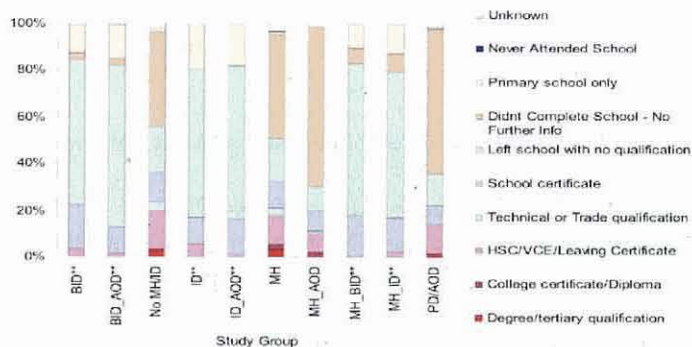
So approx 2/3<sup>rd</sup> of the CD group has complex needs.

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

### Education

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

**Figure 1** Education levels MHDCD cohort

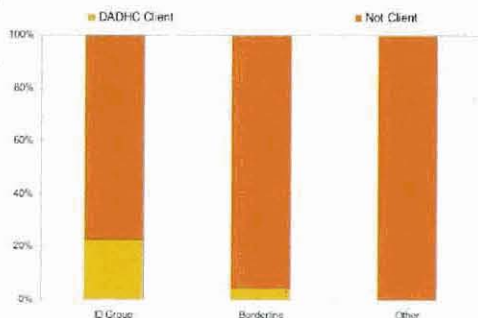


In particular it is clear that those with cognitive disability in combination with any other diagnosis have extremely poor school attainment with by far the majority either having only primary school or leaving school without any qualification.

### Disability Service

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

**Figure 2** Cohort members who are ADHC clients

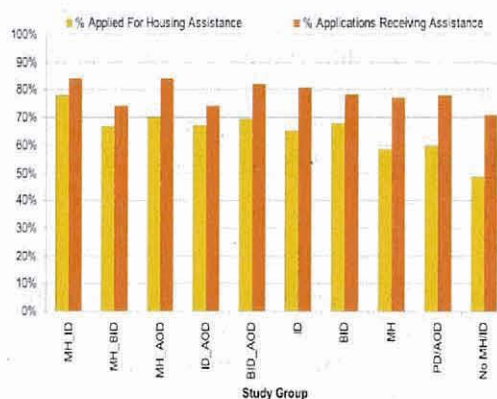


There was a high rate of this group who were first diagnosed whilst in prison. 79% of those who are now ADHC clients had been imprisoned prior to becoming a client; in other words they were diagnosed and referred for the first time whilst in prison.

### *Housing*

Not surprisingly, a majority of the cohort sought housing assistance at some stage as shown in Fig 3. Assistance includes both rental assistance and public/community housing provision. Those diagnosed had a high need for assistance (~65-75%) vs the non-diagnosed group of whom less than 50% had ever applied. Of those seeking assistance there was a high rate of provision (~70-80%) for the diagnosed groups.

**Figure 3** Need for and provision of housing assistance



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

### *Police Contact*

The average age at first police contact for the BID/ID/MH/AOD complex groups is significantly lower than those with single or no diagnosis as shown in Fig 4. Note that the averages are biased due to a few much older first contacts. This is highlighted by the fact that ~50% had first contact before age 18 (ie median age). The significantly higher age of first contact with police for those with MH only, is probably due to later onset of mental illness.

**Figure 4 First Police Contact**

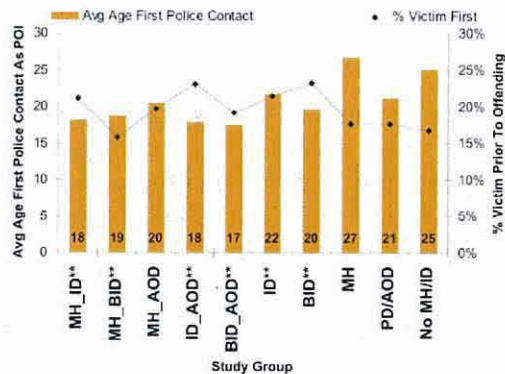
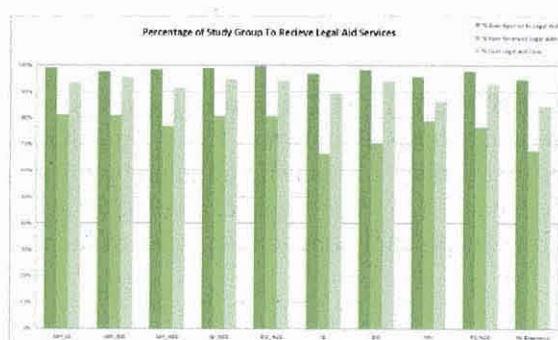


Fig 4 also shows levels of first time registered as a victim and percentage of those who were victims prior to offending. On the whole, again it is those with cognitive disability in various combinations who are more likely to be victims prior to offending. It must be noted that many children with disability who are not clients of ADHC may well not be reported as victims.

#### *Legal Aid*

Almost all in the cohort have applied to Legal Aid (LA) for assistance at some point in time (av. ~95%) (see Fig 5). A very high proportion of those who applied were represented by LA at least once at some point (av ~89%). A reasonably high proportion has also received legal advice over the phone (68%-80%).

**Figure 5 Cohort receiving Legal Aid services**



There are though significant differences between the groups in their use of LA. The complex groups have applied at a significantly higher rate than the ID only, MH only and no diagnosis groups. There is also a significant difference between those receiving legal

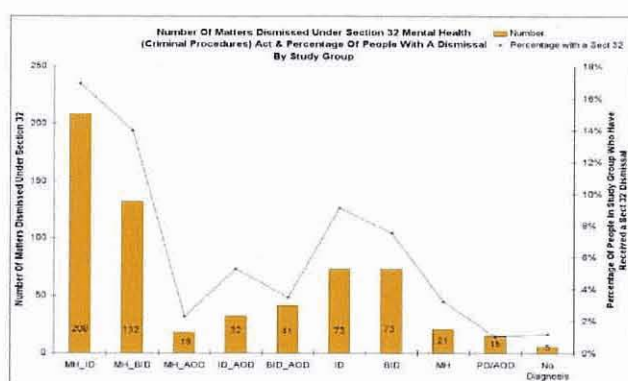




### Use of Section 32

There are a surprising low number of dismissals under Sec 32 of the Mental Health (Criminal Procedures) Act for a cohort such as this (see Fig 8). Altogether, for everyone in the cohort and across their whole history as adult offenders there were only 618 dismissals under Sec 32.

**Figure 8** Dismissals under Sec 32

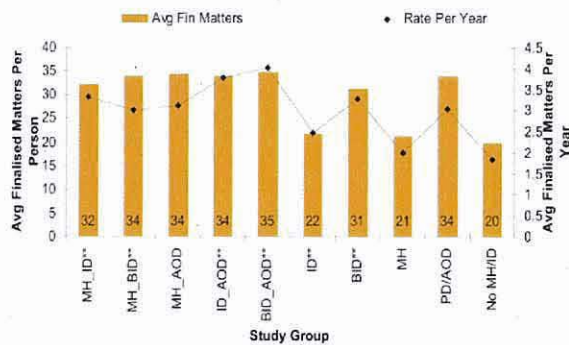


It is clear that a significantly higher proportion of those in the groups with MH/ID (17%) and MH/BID (14%) had matters dismissed under Sec 32 than any other groups. It is surprising that only 9% of the ID only group have ever had a matter dismissed using Sec 32 given that all members of this group have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

### Court Finalised Matters

Fig 9 shows the same pattern for court finalized matters as for police contact: those with cognitive complex needs have the highest rates of finalized matters overall and higher rates each year.

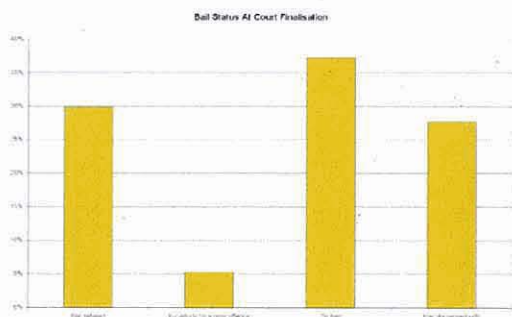
**Figure 9** Court finalized matters



### *Bail and Remand*

Across the whole cohort for all court finalized matters, there was a higher proportion on bail than on remand or bail dispensed with, nevertheless 30 % had bail refused and were remanded in custody (Fig 10).

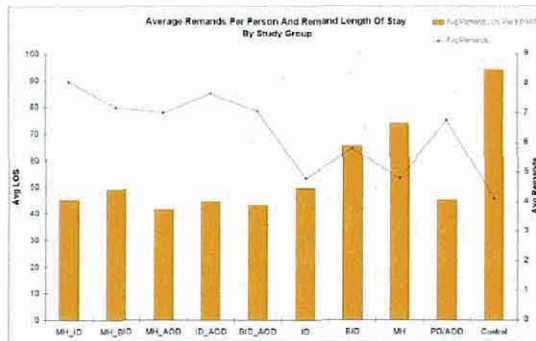
**Figure 10** Bail at Finalisation (includes juveniles)



There are though significant differences across the groups for bail/remand status. Those with ID only had a significantly lower proportion of their group have bail refused than the other groups.

There are significant differences between the groups regarding averages of episodes of remand and length of time spent on remand (see Fig 11). The Cognitive complex groups have significantly higher numbers of episodes of remand than the single and no diagnosis groups but significantly shorter periods spent in remand for each of those episodes.

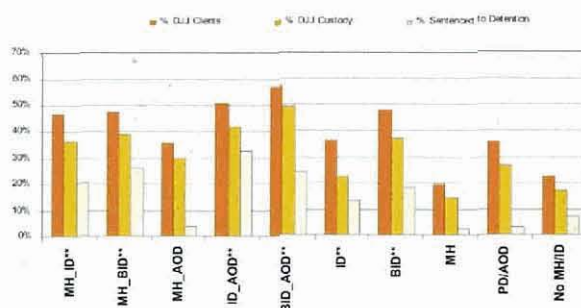
**Figure 11** Episodes of and time spent in Remand (adult system only)



### *Contact with Juvenile Justice*

Fig 12 shows there is a significantly higher contact rate for those with CD complex diagnoses with Juvenile Justice than for those without a diagnosis, with a single diagnosis or without a CD diagnosis of some sort.

**Figure 12** Contact with Juvenile Justice

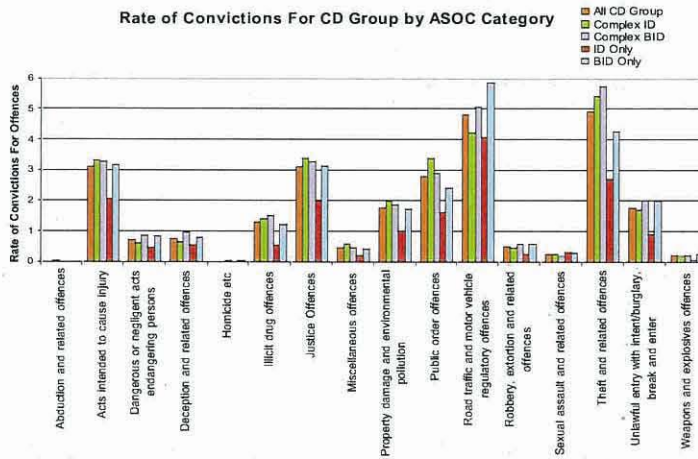


### *Offence types*

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

For the CD groups, rates of convictions are even more concentrated around theft, road traffic, public order and justice offences and acts intended to cause injury. As can be seen in Fig 13 traffic offences are the most consistent convictions across the groups.

**Figure 13** ASOC Category convictions for CD groups



### *Trajectories into the CJS*

For the Complex ID group, first police contact for ~80% was before age 21 and there was high and ongoing contact over time and age (see Fig 14). Prison rates continue through life. So prison episodes do not appear to have a rehabilitative effect on offenders or reduce police contact.

**Figure 14** Police contact for Complex ID group

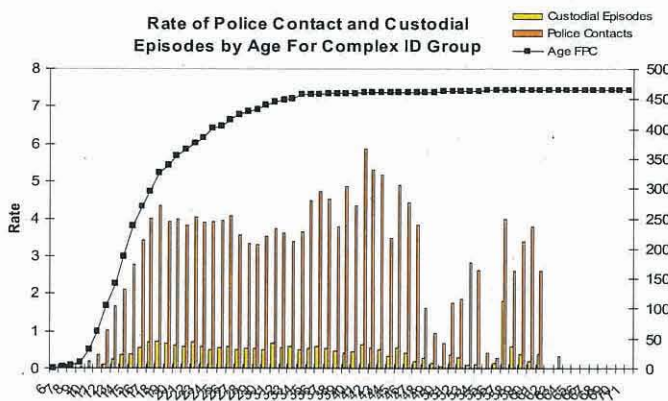
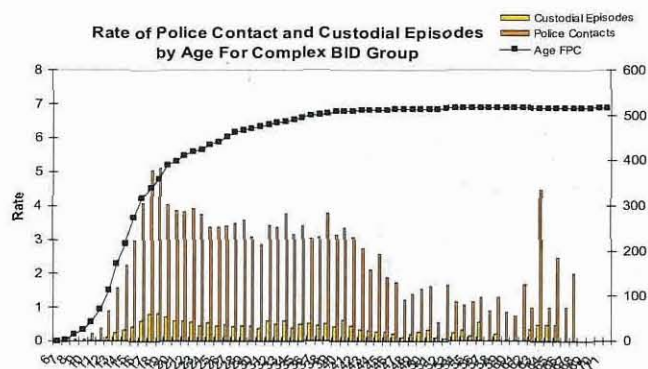


Fig 15 shows that, for the complex BID group, first police contact for ~ 80% was even earlier than for the ID complex group at before age 19 and with relatively high and ongoing contact but less than that for the ID complex group. The impact on re-offending and police contact, as with the complex ID group, appears minimal.



**Figure 15** Police contact for Complex BID group

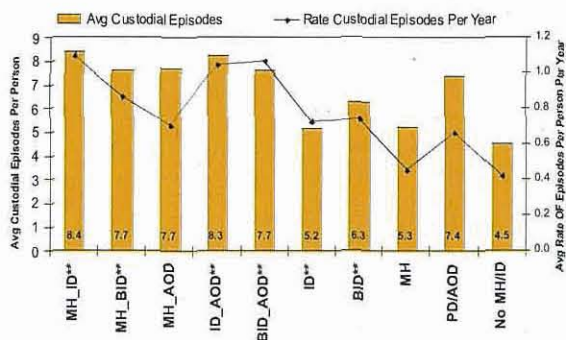


The ID only group had first police contact spread over longer period and significantly lower numbers of contacts. But still ongoing lifetime contact. The BID only group had a similar trajectory to the ID only group but a lower number of contacts and lower continuing contact.

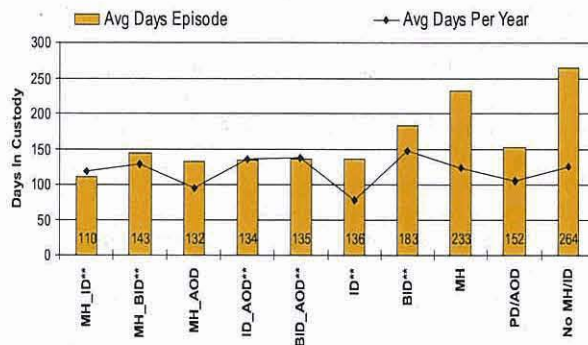
#### *Time in custody*

Those with complex needs have higher rates of episodes in custody but significantly shorter duration each time in custody than those with single or no diagnosis (see Figs 16 & 17).

**Figure 16** Custodial episodes



**Figure 17 Custodial lengths**



## Conclusions

These findings indicate that those with complex cognitive disability (ie comorbidity / dual diagnosis) are significantly more likely to have earlier contact with police, more police episodes, more episodes through life and more prison episodes than those with single, or no diagnosis and for this high and ongoing contact with the criminal justice system to lock them into the CJS rather than rehabilitate them.

Those with complex needs have significantly higher offences, convictions and imprisonments than single and non-diagnosis persons. Those with cognitive impairment in combination with any other disability had the highest rates of CJS involvement both early and ongoing into later years. They had had very poor school education and low disability service recognition and support and although there was strong housing response they do not appear to be able to maintain their tenancies. Those becoming clients of ADHC after going to prison fared much better than those who did not become clients.

It can be theorized that these groups become locked, early in their lives, into cycling around in a liminal, marginalised community/criminal justice space (Baldry et al 2008; Baldry 2009; Dowse et al 2009), a space that is neither fully in the community or fully in the prison. This suggests it is important to recognise the different space & need for different disability and rehabilitative supports and interventions at many points along these persons' pathways.

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# **Pathways to Prison: People with MHDCD**

**Presenters: Associate Professor Eileen Baldry, Dr Leanne  
Dowse**

Research Team: Eileen Baldry, Leanne Dowse, Melissa  
Clarence and Phillip Snoyman

ARC Linkage Grant

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## **Presentation Outline**

- Background: MHDCD project
- Description of persons participating
- Early Findings
- Conclusions

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## **Background**

- People with MHDCD over-represented in CJS
- Post-release high rates of homelessness, unemployment, low levels of family support and more likely to return to prison quickly.
- Interventions hampered by lack of overall and longitudinal system impacts
- Need for pathway understanding
- Study designed to integrate criminal justice and human service data.

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## **The Study**

- **Objectives:**
  - Create criminal justice life course histories, highlighting points of agency interactions, diversion and support
  - Identify gaps in policy, protocols and service delivery and areas of improvement for Criminal Justice and Human Service agencies
  - Describe individual and group experiences
  - Explore staff attitudes to and beliefs about people with MHDCD in the CJS

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## The Study - a new approach

- **Method:**

- ☐ Cohort: Prisoner Health Survey & DCS Disability database
- ☐ Data drawn from:
  - ☐ The Centre for Health Research in CJS Health NSW
  - ☐ NSW Department of Corrective Services
  - ☐ BOCSAR
  - ☐ NSW Police
  - ☐ Juvenile Justice
  - ☐ Housing NSW
  - ☐ ADHC
  - ☐ Legal Aid NSW
  - ☐ NSW Health (mortality, pharma., admissions) (on way)
  - ☐ Community Services (on way)

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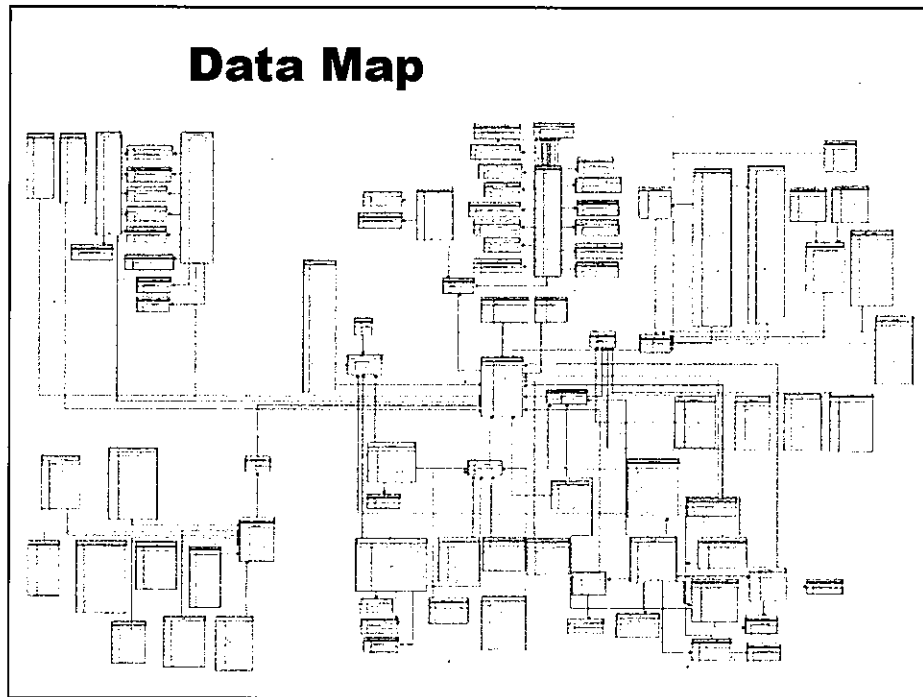
## Creating the Dataset

- Problem of aliases & different data gathering & entry forms
- All datasets from all agencies matched then uploaded onto SQL server
- Allows relational merging of information

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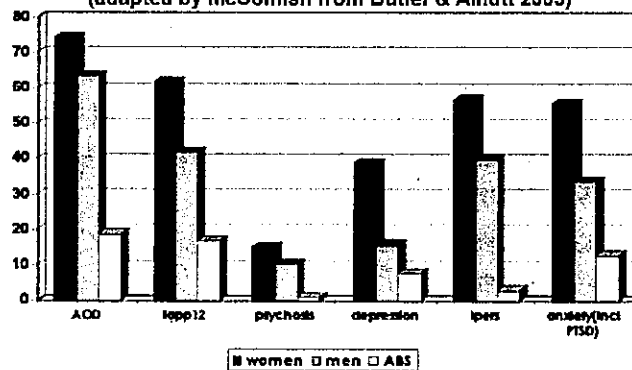




The problem

## The Mental State Of Women And Men In NSW Prisons

(adapted by McComish from Butler & Alnutt 2003)



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## MHD 2009 Survey

- Inmates ever been assessed or treated by doctor or psychiatrist for a MH problem increased from 39% in 1996 to 43% in 2001 to 49% in 2009. Due to men's increasing MH problems: 35% in 1996 to 41% in 2001 to 47%; proportion of women remained steady at around 54%.
- Increasing proportion of participants reported ever having been admitted to a psychiatric unit from 13% in 1996 to 14% in 2001 to 16% in 2009. A higher proportion of women (20%) than men (15%) in 2009.
- Source: 2009 NSW Inmate Health Survey: Key Findings Report p:17

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## Cognitive disability in NSW CJS

- DJJ 74% below av. range of intellectual functioning (V 25% standardised sample)
- ~1/3rd appearing in local court ID or BID
- Small ID but larger BID over-representation in NSW prisons
- But UK appears much higher: eg av IQ 84 (Hayes et al 2007)

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## Study Findings to date The Cohort

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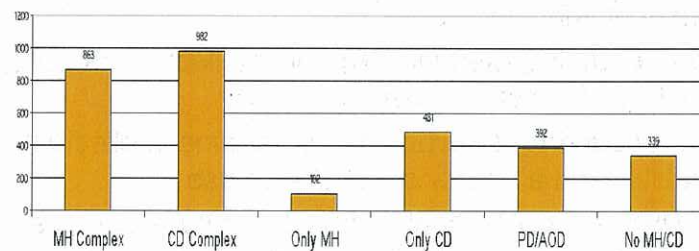
## Cohort - Summary

- ❑ Full Cohort N=2,731
- ❑ Intellectual disability N=680
- ❑ Borderline cognitive disability N=783
- ❑ Mental health N=965
- ❑ No MHCD diagnosis N=339
- ❑ Substance abuse disorder = 1276
- ❑ Women = 11%
- ❑ Indigenous Australians = 25%

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## MHDCD Study: Cohort - detail



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## MHDCD Study: Cohort - detail

- ❑ **Intellectual Disability** - IQ in the ID range less than 70.
- ❑ **Borderline Intellectual Disability** - IQ in the ID range between 70 & 80
- ❑ **Mental Health** - any anxiety disorder, affective disorder or psychosis in the previous 12 months
- ❑ **Dual diagnosis (a)** -history of mental health problems and an intellectual disability
- ❑ **Dual diagnosis (b)** -history of mental health problems and a borderline intellectual disability

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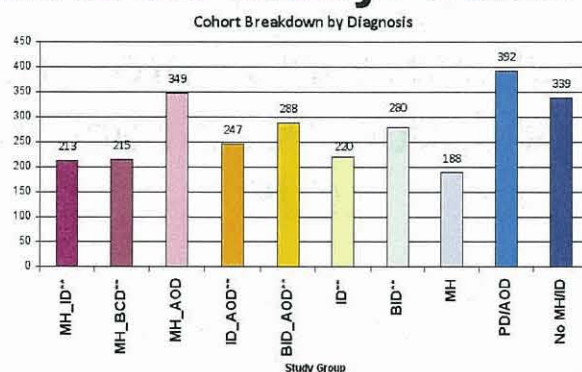
## MHDCD Study: Cohort - detail

- ❑ **Co - occurring disorder (a)** -mental health disorder and a history of substance use
- ❑ **Co - occurring disorder (b)** - an intellectual disability and a history of substance use
- ❑ **Co - occurring disorder (c)** - borderline intellectual disability and a history of substance use
- ❑ **AOD/PD** - any personality disorder or substance use disorder in the previous 12 months and an absence of other category
- ❑ **No diagnosis** - no Mental Health or Cognitive disability diagnosis

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## MHDCD Study: Cohort



N.B These groups are not mutually exclusive. People were assigned to a group on predominant presenting diagnosis from left to right. For instance the MH\_ID group may also have a substance abuse disorder

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## Cognitive Disability

- 1463 people in the CD cohort (All CD)
- 680 (46%) in the ID range (includes ABI >70 IQ)
  - 465 (68%) have multiple diagnoses (Complex)
  - 215 (32%) have no co-morbidity
- 783 (54%) in the BID range
  - 517 (66%) have multiple diagnoses (Complex)
  - 266 (34%) have no co-morbidity
- So approx 2/3<sup>rd</sup> in the CD group are complex

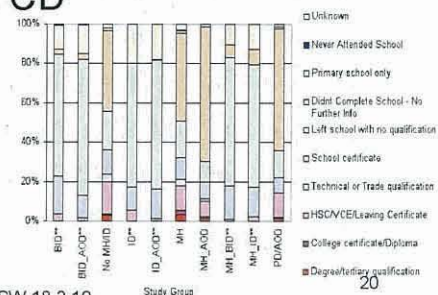
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## Pathways into, through, around, out of and back into CJS

### MHDCD Study: Education

- Although prison population in general has low levels of education, diagnosed groups have even lower levels – see non-diagnosed group
- Those with some form of CD have the worst levels of education.



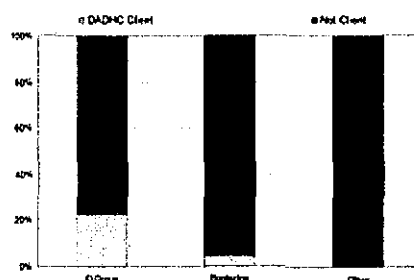
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Study Group

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## MHDCD Study: ADHC

- ❑ Of those diagnosed ID only 23% ADHC clients
- ❑ Of those borderline functioning 4% ADHC clients.
- ❑ So very high rate of persons in prison with ID & borderline not receiving services from ADHC
- ❑ Only 10/709 JJ CD group were ADHC clients
- ❑ 79% of ADHC clients imprisoned **prior** to becoming a client



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## Housing Assistance

- ❑ V High level of housing assistance sought across the cohort
- ❑ V high level of housing assistance given
- ❑ Problem appears to be in maintaining tenancy: eg frequent episodes in prison, frequent behavioural issues, failing tenancies.

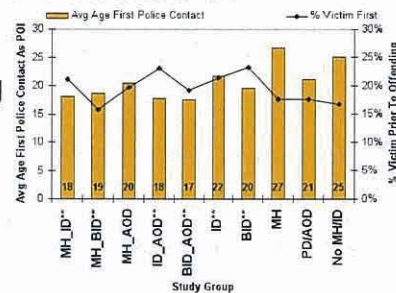
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### MHDCD Study: First Police Contact

- BID/ID/MH/AOD complex - lower age 1st contact
- Averages are biased by a few older age first contacts. ~50% had first contact before 18
- Low 1st contact as victim likely to be lack of reporting rather than lack of being a victim of child abuse

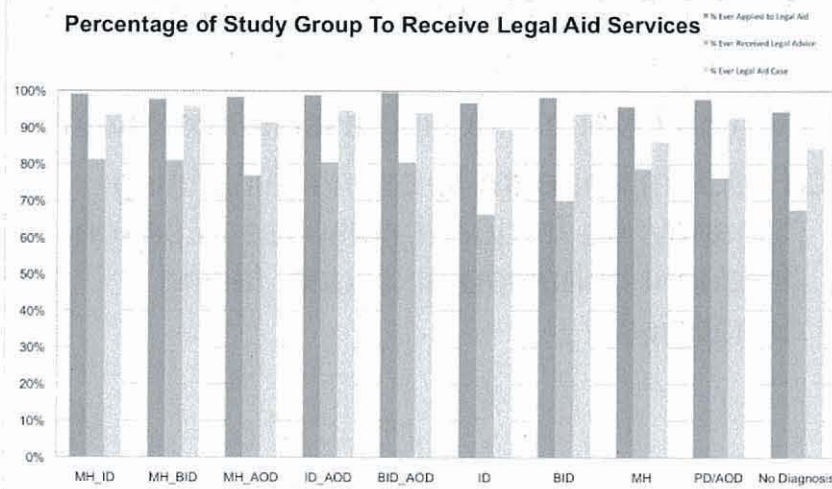


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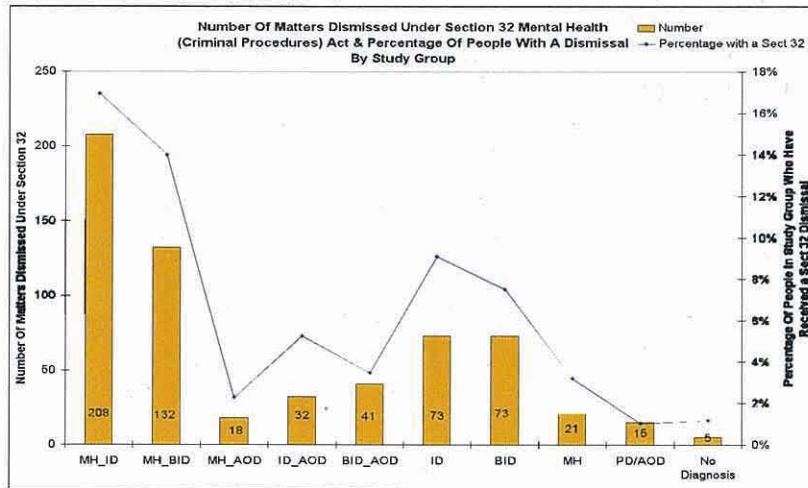
23

### Legal Aid Service

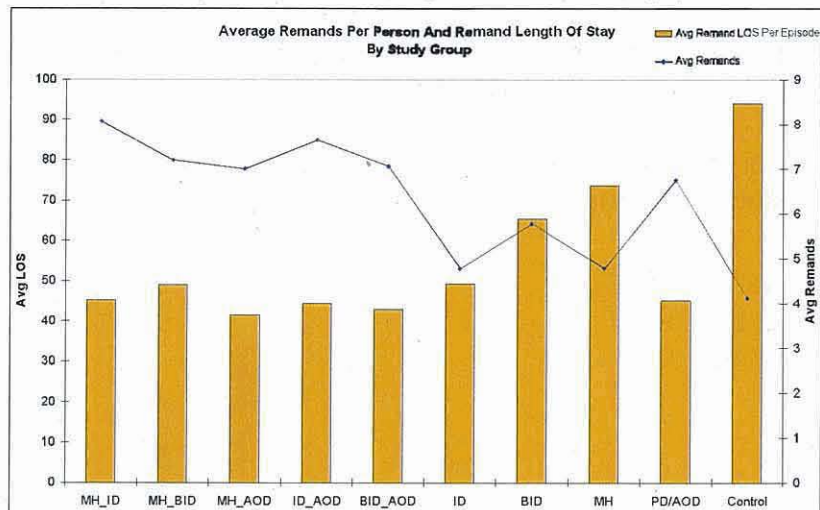
Percentage of Study Group To Receive Legal Aid Services



## Section 32 (at any time)

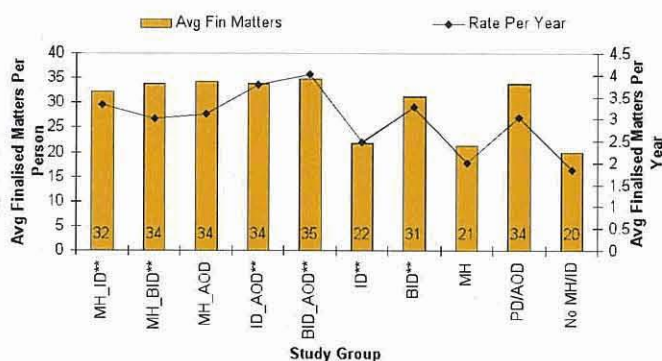


## Remands (adult only)



## MHDCD Study: Court Finalised Matters

Again those with complex CD have the highest rates of finalised matters



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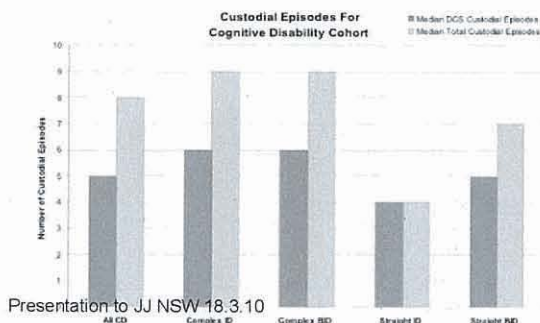
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## Custodial Episodes

Significant difference between the 2 complex groups and the 2 single diagnosis groups

The 2 complex needs groups have significantly more custodial episodes

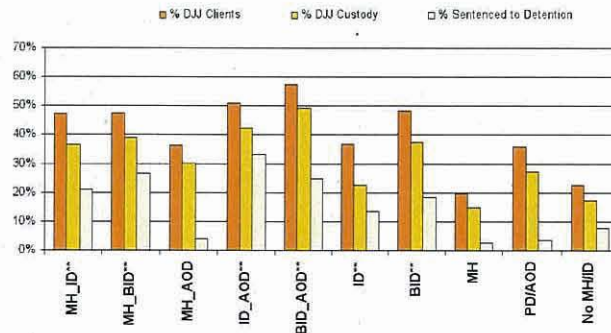
Total custodial  
(light yellow)  
includes JJ



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## MHDCD Study: DJJ

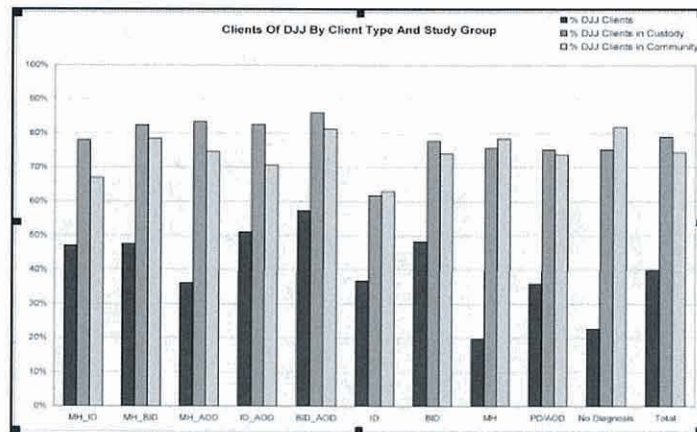
- Significantly higher JJ contact for ID/  
BID/AOD



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## Clients of JJ NSW by type

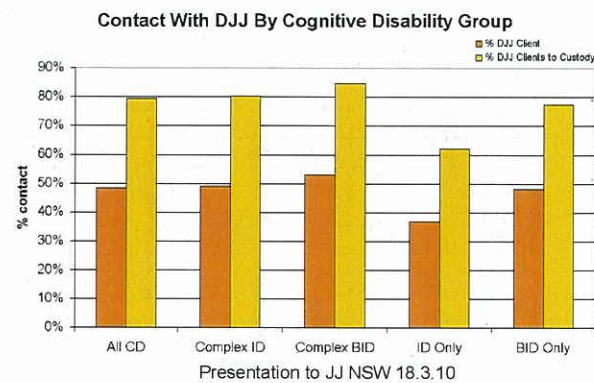


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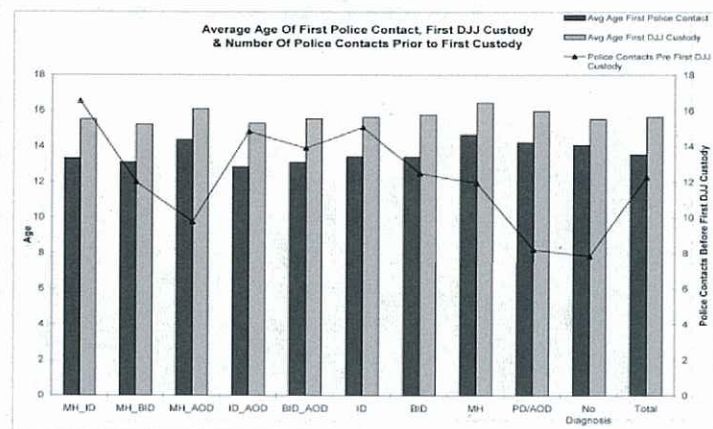
## JJ contact for CD groups

The same pattern as custodial episodes – sig. higher for CD complex groups



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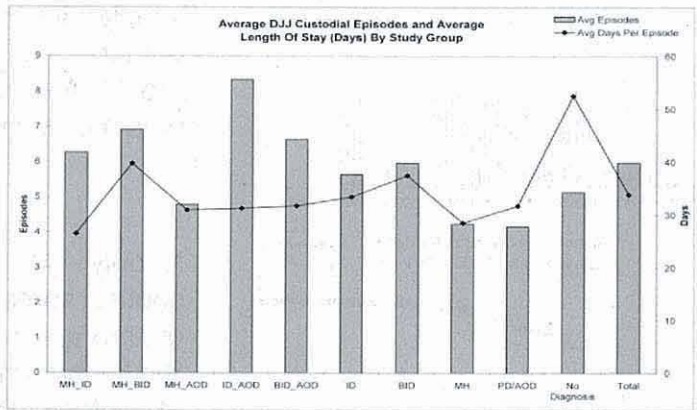
## 1<sup>st</sup> Police & JJ contact



32



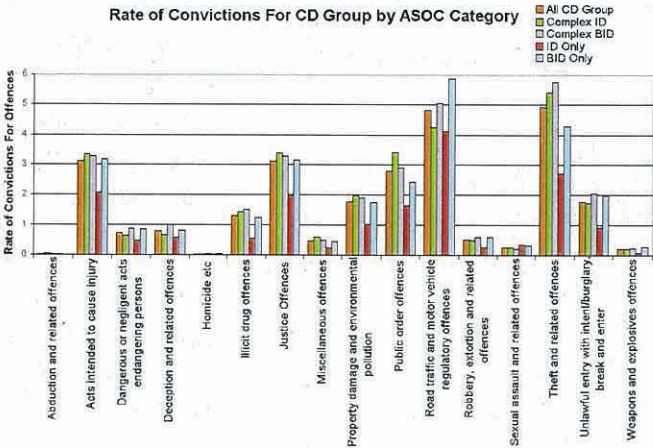
# JJ Custodial episodes & LOS



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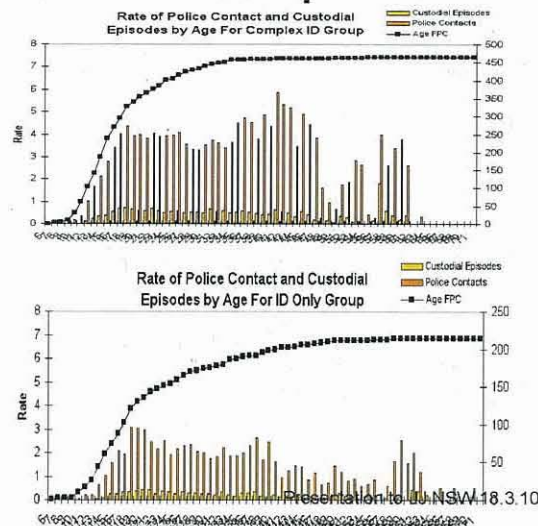
# Offences



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34

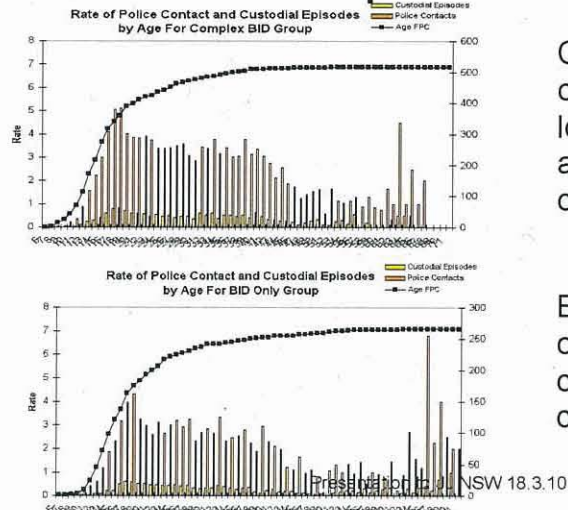
## ID Group CJS Trajectory



Complex ID 1<sup>st</sup> police contact —~80% before age 21. A lot of contact over time and age

ID only – 1<sup>st</sup> contact spread over longer period. Sig lower numbers of contacts. But still lifetime contact

## BID Group CJS Trajectory

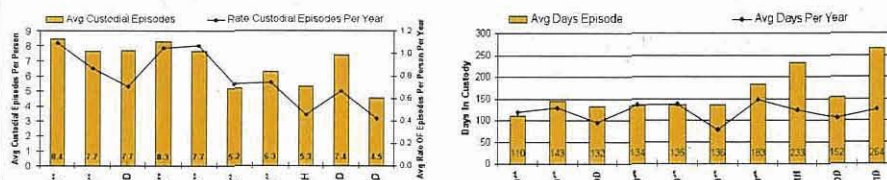


Complex BID 80% 1<sup>st</sup> contact by 19. Still a lot of contact while ageing but less than complex ID

BID only – similar to ID only – less number of contacts and less continuing

## Time in custody

- These 2 slides provide a picture of those with CD complex needs having higher rates of episodes in custody but significantly shorter duration each time in custody



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## Pathway for CD complex

- High JJ involvement (48%)
- Only 10 / 709 of JJ CD group were ADHC clients
- Numerous school exclusions / truants - expelled
- Early police contact
- AOD
- Homeless – Housing assistance but ? maintaining tenancies
- Recidivist/persistent offender/
- The CD complex groups are significantly higher on all the above

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## MHDCD Study: Conclusions

- ❑ Those with complex CD (dual/comorbid diagnoses and multiple combinations) have significantly higher offences, convictions, imprisonments than single and non-diagnosis

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## MHDCD Study: Conclusions

- ❑ Poor school education and low disability service recognition and support; strong housing response but unclear re maintaining tenancy
- ❑ Those becoming clients of ADHC after going to prison then fared much better
- ❑ Persons in these groups start cycling around in a **liminal marginalised community/ criminal justice space from an early age**

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## **Ways forward**

- ❑ Clear & Urgent need for range of early school interventions; juvenile and adult disability supported housing & services for those with complex diagnoses. Must have workers trained to work with complex needs persons.
- ❑ Programs like JTAP appear to work well with those with complex needs – need more such programs

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## **Ways forward**

- ❑ ADHC's Community Justice Program for persistent offenders with ID has good initial outcomes indicating appropriate disability supported accommodation is beneficial

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## Ways forward

- The Public Purpose grant to Legal Aid & IDRS to enhance legal representation for Sec 32 for those with ID a good step – need more use of Sec 32, more linking with appropriate disability services.