



**Indigenous Australians with Mental Health Disorders  
and Cognitive Disabilities in the Criminal Justice System**



## A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system

Never Stand Still

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The IAMHDCD Project logo was created by Melonie Hawke.

The logo represents the predictable and preventable pathways in and out of the criminal justice system – police, courts and prison – for increasing numbers of Aboriginal and Torres Strait Islander Australians who have mental health and wellbeing issues and/or limited cognitive functioning. Knowledge, understanding and intent are the key steps to addressing the complex support needs of those that ask only to be safe and well in community settings and not ‘just a big vicious cycle that swallows them up’. This report has been developed to provide that knowledge for helping professionals to aid Aboriginal and Torres Strait Islander Australians to claim their own recovery and have different pathways in their lives. The understanding and intent is a personal and professional responsibility and making that move is important for changing the status quo.

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# ACRONYMS

ADHC	NSW Department of Ageing, Disability and Home Care
AOD	Alcohol and other drugs
BID	Borderline intellectual disability
CD	Cognitive disability
CI	Cognitive impairment
CJS	Criminal justice system
FASD	Fetal Alcohol Spectrum Disorder
IAMHDCCD	Indigenous Australians with mental health disorders and cognitive disability
ID	Intellectual disability
JJ	NSW Department of Juvenile Justice
MHDCCD	Mental health disorders and cognitive disability







# EXECUTIVE SUMMARY

A predictable and preventable path:  
Aboriginal people with mental and cognitive  
disabilities in the criminal justice system

Aboriginal and Torres Strait Islander peoples with mental and cognitive disabilities are significantly over-represented in Australian criminal justice systems. However there has been a lack of critically informed evidence, analysis and co-ordinated policy and service response on this most pressing human rights issue. The Indigenous<sup>1</sup> Australians with Mental Health Disorders and Cognitive Disability in the Criminal Justice System (IAMHDCD) Project<sup>2</sup> brings an innovative Indigenous-informed mixed method research approach that provides, for the first time, a critical analysis of systems interactions and responses to the complex needs of Indigenous people with disability in criminal justice. It draws on the mental health disorder and cognitive disability MHDCD Dataset, which contains lifelong administrative information on a cohort of 2,731 persons who have been in prison in NSW and whose mental health and cognitive impairment diagnoses are known. All NSW criminal justice agencies (Corrective Services, Police, Juvenile Justice, Courts, Legal Aid) and human service agencies (Housing, Ageing Disability and Home Care, Community Services, Justice Health and Health NSW) have provided data relating to these individuals. A quarter (676) of the cohort is Aboriginal and/or Torres Strait Islander: 583 Indigenous men (21% of the whole cohort and 86% of the Indigenous sub-cohort) and 93 Indigenous women (3% of the whole cohort and 14% of the Indigenous sub-cohort). This has enabled the compilation of administrative de-identified lifecourse 'pathway' case studies for Aboriginal people in the Dataset, providing a broad, dynamic, trans-criminal justice and human service understanding of their involvement in the criminal justice system. It also reports on a qualitative investigation of the experiences of Aboriginal women and men who have mental and cognitive disability and who have been in the criminal justice system undertaken in four communities in NSW and one community in the NT. Analyses and interpretation of these quantitative and qualitative findings are informed by the conceptual tools of decolonisation, complexity and critical methodologies in the fields of criminology, race, feminist and disability studies.

Our research team has developed an in-depth picture of the interactions of diagnoses, vulnerabilities, complex support needs and intensive interventions and how these coalesce for Aboriginal people with mental and cognitive disabilities in the criminal justice system. New understandings of the interactions amongst criminal justice and social, health, disability and other human services for Aboriginal people with complex support needs in two Australian criminal justice systems (NSW and NT) are detailed. This report sets out detailed quantitative analysis of the 676 Indigenous women and men in the MHDCD cohort as well as views of community members regarding systemic and social challenges, service failures, positive program interventions, and culturally responsive approaches and remedies. This project provides innovative theoretical and applied knowledge that can assist in the reduction of the unacceptably high level of Aboriginal people with mental and cognitive disabilities in Australian criminal justice systems.

<sup>1</sup> This project uses the term 'Indigenous Australians' to be consistent with government data collection terminology in our quantitative dataset. We understand that some people find this term problematic and refer to themselves as Aboriginal, Torres Strait Islander and/or by their clan or language group. In the qualitative findings and discussion sections of this report we primarily use 'Aboriginal' as this was how the communities we spoke to identified.

<sup>2</sup> We use the term 'mental health disorders' to refer to a 'temporary or continuing disturbance of thought mood, volition perception or memory that impairs emotional wellbeing, judgment or behavior so as to affect functioning in daily life to a material extent' (NSW LRC, 2012, 138). We use 'cognitive disability' to refer to an 'ongoing impairment in comprehension, reason, adaptive functioning, judgment, learning or memory that is the result of any damage to, dysfunction, developmental delay or deterioration of the brain or mind' (NSW LRC, 2012, 136). While 'impairment' relates to an individual condition, 'disability' denotes ways in which a person with impairment may be excluded from full participation in society. Both the terms 'impairment' and 'disability' are used in this report depending on the context (Baldry 2014, 373-374).





## QUANTITATIVE FINDINGS

Indigenous people in the MHDCD cohort are significantly more likely to have experienced earlier and more frequent contact with the criminal justice system and greater disadvantage than non-Indigenous people. Indigenous people in the cohort were significantly more likely to: have been in out-of-home-care, to come into contact with police at a younger age and at a higher rate as a victim and offender, to have higher numbers and rates of convictions, more episodes of remand, and higher rates of homelessness than non-Indigenous people. People in the cohort with complex support needs (multiple diagnoses and disability) in particular are significantly more likely to have earlier contact with police, to have been Juvenile Justice clients, and to have more police and prison episodes throughout their lives than those with a single or no diagnosis. Yet the data also highlights that most of the offences by Indigenous people in the cohort were in the less serious categories of offences – theft and related offences, public order offences, offences against justice procedures, government security and government operations, and traffic and vehicle regulatory offences.

Indigenous women in the cohort experienced the highest rate of complex needs. Indigenous women were significantly more likely than non-Indigenous women to have been in out-of-home care as children. They experienced their first police contact at a younger age and had a significantly higher number of police contacts and convictions across their lives than non-Indigenous women in the cohort.

Indigenous women were more likely than non-Indigenous women to have been in custody as juveniles. They had significantly more remand episodes and custodial episodes over their lifetime. Indigenous women with complex needs in particular have significantly higher convictions and episodes of incarceration than their male and non-Indigenous peers. They were more likely to have been homeless and to have been victims of crime than non-Indigenous women in the cohort.

This analysis confirms and extends initial findings that Indigenous women and men in the MHDCD cohort experience multiple, interlocking and compounding disadvantageous circumstances, and highlights their early and frequent contact with criminal justice agencies. The needs of Indigenous people in the cohort emerge as particularly acute and poorly serviced by past and current policy and program approaches.





## QUALITATIVE FINDINGS

Institutional racism, stigma and discrimination are common, marginalising and destructive experiences for Aboriginal people with mental and cognitive disabilities. Interviewees reported discrimination and stigma experienced on the basis of their Aboriginality, their disabilities, and in regard to the criminalisation of their behaviour, affecting their access to education, employment, housing and just legal outcomes.

An assimilationist approach was perceived as still pervasive amongst many of those working within criminal justice and human service agencies, with little recognition of the ongoing impact of colonisation, intergenerational trauma, and grief and loss for Aboriginal peoples. The lack of understanding and recognition around cognitive impairment was perceived as a key problem exacerbating contact with the criminal justice system. The over-representation of Aboriginal people with mental and cognitive disabilities in the criminal justice system was described as normalised in every community and context we investigated. Disability emerged as part of the accepted overall presentation of Aboriginal people with multiple and complex support needs in the criminal justice system. The view that Aboriginal people with disability should be managed by criminal justice agencies, that this is 'just how it is', permeates all agencies' practice. What emerged strongly from the data was the systemic normalisation of disadvantage, disability and offending, with the conflation of these seen most clearly in people with complex support needs.

Many Aboriginal people who end up in the criminal justice system have early lives marked by poverty, instability and violence, without access to good primary health care or early childhood education. What emerged from the qualitative interviewees is the way that an Aboriginal child with an intellectual disability or Fetal Alcohol Spectrum Disorder (FASD) rarely receives early diagnosis or positive intervention, resulting in their disengagement or expulsion from school at a relatively young age. Drug and alcohol misuse by young people is a common experience, along with emerging mental health issues. Frequent out of home care placements, which break down resulting in homelessness, are often experienced. Aboriginal people with mental and cognitive disabilities were described as particularly at risk of physical and sexual violence from a young age, Aboriginal girls and women in particular. Increased police contact as a person of interest in relation to minor theft or public order offences is a common pathway, with the likelihood of a number of court appearances before a juvenile justice custodial period. Moving into adulthood, drug and alcohol misuse and mental health-related illnesses tend to worsen, often accompanied by increased experience of violence and self-harm, more serious offending and longer periods in custody. Trauma and violence emerged as common and pervasive experiences for Aboriginal people with mental and cognitive disabilities in the criminal justice system.

Other than occasional crisis-related admissions into hospital, there are reportedly few positive health and wellbeing options for this group. Drug and alcohol rehabilitation is often only available in a regional centre, which may be many hundreds of kilometres away, and even then, excludes people with a cognitive impairment. Mental health services are unable to accept people with drug or alcohol addiction. The few diversionary programs that aim to assist people whose offending is connected to their drug and alcohol addiction will not accept those with a history of violence. Incarceration becomes the default option in the absence of available or appropriate community-based care, housing or support. The multiple and complex support needs experienced by many Aboriginal people in the criminal justice system can then be understood as emerging from the siloed institutional responses to their circumstances; as in effect created from those responses. Negative, punitive criminal justice interventions rather than positive human or community based service interactions are the norm. Aboriginal people articulated the need for a holistic, integrated, culturally responsive model of care with rigorous client and community accountability to support Aboriginal people with multiple and complex support needs to reduce contact with the criminal justice system.



## WHAT THESE FINDINGS MEAN

The findings of this project unequivocally demonstrate that pathways into and around the criminal justice system for many Aboriginal people with mental and cognitive disabilities in NSW and the NT are embedded and entrenched by the absence of coherent frameworks for holistic disability, education and human services support. Aboriginal people with mental and cognitive disabilities are forced into the criminal justice system early in life in the absence of alternative pathways. Although this also applies to non-Indigenous people with mental and cognitive disabilities who are highly disadvantaged, the impact on Aboriginal people is significantly greater across all the measures and experiences gathered in the studies across the project. Interrogation of the MHDCD Dataset and information gathering through interviews was purposive and selective rather than representative, yet the synchronicity across the findings points to a commonality of experience for Indigenous people with mental and cognitive disabilities. Together these findings indicate that thousands of Aboriginal people with mental and cognitive impairment are being ‘managed’ by criminal justice systems in lieu of support in the community. Systems of control rather than care or protection are being invoked for this group, often from a very young age. The findings of this project highlight the ways that Aboriginal people with mental and cognitive disabilities experience multiple, interlocking and compounding disadvantageous circumstances.

The serious implications of poor diagnosis and unclear definitions of mental and cognitive disability are starkly highlighted in this research. The findings demonstrate that there is a severe and widespread lack of appropriate early diagnosis and positive culturally responsive support for Indigenous children and young people with cognitive impairment. This is connected to schools and police viewing certain kinds of behaviour through a prism of institutional racism rather than disability, as well as Indigenous community reluctance to have children assessed using particular criteria that are perceived as stigmatising and leading to negative intervention in Aboriginal families. For adults in the criminal justice system, cognitive impairment is either not recognised at all, or if recognised, poorly understood. For many Aboriginal people, diagnosis of their cognitive impairment comes with assessment on entry to prison. However such a diagnosis rarely leads to appropriate services or support while in prison; analysis of the data reveals that subsequent interventions tend to continue to foreground offending behaviour rather than complex social disadvantage or disability, mental health or alcohol and other drug (AOD) support needs. Our findings illuminate the particular challenges and vulnerabilities facing Indigenous women with mental and cognitive disabilities as the most disadvantaged group in our cohort in terms of their multiple and complex support needs.

During the course of the project, our research influenced and was in turn informed by the work of the Aboriginal Disability Justice Campaign and reports by the Australian Human Rights Commission and NSW and Victorian Law Reform Commissions (Baldry 2014). There is a growing awareness of the devastating impacts of current legislation, policies and practices on Indigenous people with mental and cognitive impairment and a need for an evidence-informed response by political leaders, policy makers, people working in criminal justice systems (police, magistrates, correctional officers, parole officers) and service providers. This report articulates a clear agenda for action.



# SOLUTIONS FROM THE COMMUNITY ●●●●

Based on the qualitative and quantitative findings of our study, we recommend that the following five principles and associated strategies should underpin policy review and implementation:

## Principle 1: Self-Determination

Self-determination is key to improving access to and exercise of human rights and to the wellbeing of Aboriginal and Torres Strait Islander people with mental and cognitive disability, especially for those in the criminal justice system.

### Strategies:

- Indigenous-led knowledge and solutions and community-based services should be appropriately supported and resourced.
- The particular disadvantage faced by women and people in regional and remote areas should be foregrounded in any policy response to this issue.
- Resources to build the cultural competency and security of non-Indigenous agencies, organisations and communities who work with Aboriginal and Torres Strait Islander people with mental and cognitive impairment who are in contact with the criminal justice system should be provided.

## Principle 2: Person-Centred Support

Person-centred support which is culturally and circumstantially appropriate is essential for Aboriginal and Torres Strait Islander people with mental and cognitive disability, placing an individual at the centre of their own care in identifying and making decisions about their needs for their own recovery.

### Strategies

- Disability services in each jurisdiction, along with the NDIS should ensure there is a complex support needs strategy supporting Aboriginal and Torres Strait Islander people with disability in contact with criminal justice agencies.
- Specialised accommodation and treatment options for Aboriginal and Torres Strait Islander people with mental and cognitive disability in the criminal justice system should be made available in the community to prevent incarceration and in custodial settings to improve wellbeing.
- Aboriginal and Torres Strait Islander people with mental and cognitive disability who are at risk of harm to themselves or others and who have been in the custody of police or corrections should not be returned to their community without specialist support.

## Principle 3: Holistic and Flexible Approach

A defined and operationalised holistic and flexible approach in services for Aboriginal and Torres Strait Islander people with mental and cognitive disability and complex support needs is needed from first contact with service systems.

### Strategies

- Early recognition via maternal and infant health services, early childhood and school education, community health services and police should lead to positive and preventive support allowing Aboriginal and Torres Strait Islander children and young people with disability to develop and flourish.
- A range of 'step-down' accommodation options for people with cognitive impairment in the criminal justice system should be available. The NSW Community Justice Program (CJP) provides a useful template.
- Community based sentencing options should be appropriately resourced, integrated and inclusive so they have the capacity and approach needed to support Indigenous people with mental and cognitive disability.

## Principle 4: Integrated Services

Integrated services are better equipped to provide effective referral, information sharing and case management to support Aboriginal and Torres Strait Islander people with mental and cognitive disability in the criminal justice system.

### Strategies

- Justice, Corrections and Human Services departments and relevant non-government services should take a collaborative approach to designing program pathways for people with multiple needs who require support across all the human and justice sectors.
- All prisoners with cognitive impairment must be referred to the public advocate of that jurisdiction.

## Principle 5: Culture, Disability and Gender-informed practice

It is vital that Aboriginal and Torres Strait Islander people's understandings of 'disability' and 'impairment' inform all approaches to the development and implementation of policy and practice for Indigenous people with mental and cognitive disability in the criminal justice system, with particular consideration of issues facing Aboriginal and Torres Strait Islander women.

### Strategies

- Better education and information are needed for police, teachers, education support workers, lawyers, magistrates, health, corrections, disability and community service providers regarding understanding and working with Aboriginal and Torres Strait Islander women and men with cognitive impairment, mental health disorders and complex support needs.
- Information and resources are needed for Indigenous communities, families and carers, provided in a culturally informed and accessible way.
- The distinct and specific needs of Aboriginal and Torres Strait Islander women should be foregrounded in such education and information.





# I. INTRODUCTION

Aboriginal and Torres Strait Islander peoples with mental health disorders and cognitive disability (MHDCD)<sup>2</sup> are significantly over-represented in Australian criminal justice systems. Despite this, there has been a lack of critically informed evidence, analysis and co-ordinated policy and service response on this most pressing human rights issue. The *Indigenous Australians with Mental Health Disorders and Cognitive Disability in the Criminal Justice System (IAMHDCD) Project*<sup>3</sup> brings an innovative Indigenous-informed mixed method research approach that provides, for the first time, a critical analysis of systems interactions and responses to the complex needs of Indigenous people with disability in criminal justice. The project used data from the mental health disorder and cognitive disability (MHDCD) Dataset as well as gathering qualitative information. The MHDCD Dataset contains lifelong administrative information on a cohort of 2,731 persons who have been in prison in NSW and whose MHDCD diagnoses are known. All NSW criminal justice agencies (Corrective Services, Police, Juvenile Justice, Courts, Legal Aid) and human service agencies (Housing, Ageing Disability and Home Care, Community Services, Justice Health and Health NSW) have provided data relating to these individuals, including residential addresses. A quarter (676) of the cohort is Indigenous: 583 Indigenous men (21% of the whole cohort and 86% of the Indigenous sub-cohort) and 93 Indigenous women (3% of the whole cohort and 14% of the Indigenous sub-cohort). Ethics permissions for the Dataset compilation were given by the UNSW Human Research Ethics Committee (HREC), Aboriginal Health and Medical Research Council of NSW and each agency's data custodian or ethics committee.<sup>4</sup>

The first phase of the project involved a quantitative analysis of the pathways Aboriginal and Torres Strait Islander people with MHDCD take into, around and through the human service and criminal justice systems. The second phase of the project was a qualitative investigation of the experiences of Aboriginal people with mental and cognitive disabilities in the criminal justice system, as well as specialist Aboriginal agencies and Aboriginal communities regarding these pathways and how system, policy and program dynamics impact on Indigenous people and their communities. The third phase of the project has been the in-depth analysis of the interconnections between the qualitative and quantitative data, drawing on the project's critical methodological approach. This project has developed an in-depth picture of the interactions of diagnoses, vulnerabilities, complex support needs and intensive interventions and how these coalesce for Aboriginal people with mental and cognitive disabilities in the criminal justice system.

The project has developed new understandings of the interactions amongst criminal justice and social, health, disability and other human services for Indigenous Australians with MHDCD in two Australian criminal justice systems (NSW and NT). This report presents quantitative analysis of data for 676 Indigenous people who have been incarcerated in NSW, 15 case studies drawn from this group's administrative data, the outcomes of qualitative interviews investigating the experiences of Indigenous women and men who have MHDCD and who have been in the criminal justice system, and of the views of Indigenous community members and service providers in four communities in NSW and one community in the NT regarding systemic and social challenges, service failures, positive program interventions, and culturally appropriate approaches and remedies. This project provides innovative theoretical and applied knowledge that can assist in the reduction of the unacceptably high level of Indigenous persons with MHDCD in Australian criminal justice systems.

<sup>2</sup> We use the term 'mental health disorders' to refer to a 'temporary or continuing disturbance of thought mood, volition perception or memory that impairs emotional wellbeing, judgment or behavior so as to affect functioning in daily life to a material extent' (NSW LRC, 2012, 138). We use 'cognitive disability' to refer to an 'ongoing impairment in comprehension, reason, adaptive functioning, judgment, learning or memory that is the result of any damage to, dysfunction, developmental delay or deterioration of the brain or mind' (NSW LRC, 2012, 136). While 'impairment' relates to an individual condition, 'disability' denotes ways in which a person with impairment may be excluded from full participation in society. Both the terms 'impairment' and 'disability' are used in this report depending on the context (Baldry 2014, 373-374).

<sup>3</sup> 'Indigenous' is the primary term used in this report to refer to Aboriginal and Torres Strait Islander people in Australia, for reasons of consistency with government data. Where people use 'Aboriginal' or other terms of self or community identification, those are used in context.

<sup>4</sup> UNSW HREC Ethics No. 06214, AH&MRC Ethics No. 569/06.





## 2. BACKGROUND

### 2.1 INDIGENOUS AUSTRALIANS WITH MENTAL HEALTH DISORDERS AND COGNITIVE DISABILITY IN THE CRIMINAL JUSTICE SYSTEM

Indigenous Australians are grossly over-represented in Australian criminal justice systems and in prisons in particular, where they make up 27% of the prison population and they are 13 times more likely than non-Indigenous Australians to be incarcerated (Australian Bureau of Statistics 2014). Findings from the 2001 NSW Inmate Health Survey (Butler and Milner 2003) and from a previous study conducted by the investigators<sup>5</sup> indicate that a higher proportion of Indigenous Australian people in prison have MHDCD when compared with non-Indigenous people. However obtaining accurate data on the prevalence of mental and cognitive impairment in Indigenous communities is difficult: a lack of access to professionals for competent diagnosis is one difficulty, as well as misdiagnosis of certain disorders, and under-diagnosis of others due to cultural bias in testing affecting accuracy (MacGillivray and Baldry 2013; Calma 2008).

What is known is that Indigenous Australians experience higher rates of mental illness than other Australians (AIHW 2011) and this appears to be mirrored in criminal justice systems and prisons (Heffernan et al 2012). Indigenous women in custody experience particularly poor mental health, with common histories of multiple traumatic events (Heffernan et al 2015; Baldry & McEntyre 2011; Indig, McEntyre, Page & Ross 2009). Cognitive impairment is also more common amongst Indigenous populations than other Australians; for example, ABS data indicates that 8% of Indigenous Australians have an intellectual disability (ABS 2011) compared with 2.9% of the general population (ABS 2012). Indigenous people with cognitive impairment are over-represented in criminal justice settings across Australia (Baldry, Dowse, Clarence 2012; Rushworth 2011; Simpson and Sotiri 2004). Recent research indicates that Indigenous Australians with cognitive impairment are more likely to come to the attention of police; more likely to be charged; and more likely to be imprisoned (Victorian Legal Aid 2011); spend longer in custody (Hunyor & Swift 2011); have few opportunities for program pathways when incarcerated (Martin 2011); be less likely to be granted parole (Victorian Legal Aid 2011) and have substantially fewer options in terms of access to programs and treatments (Rushworth 2011) than Indigenous people without cognitive impairment (Sotiri, McGee & Baldry, 2012). Those with Fetal Alcohol Spectrum Disorder (FASD) have been noted to be particularly vulnerable due to low levels of understanding and diagnosis (Sotiri, McGee & Baldry 2012). Indigenous people with more than one type of impairment or disability with significant social disadvantages experience particular difficulty in finding appropriate service provision and are more likely to be imprisoned or involved in the criminal justice system (NSW Law Reform Commission 2012).

<sup>5</sup> ARC Linkage Grant (Project LP0669246), 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.





Research suggests that an array of problematic impacts, including loss of land, culture and spirituality; social disadvantages; discrimination; lifestyle; perceptions; and system arrangements and failures all contribute to the higher likelihood that Indigenous Australians with MHDCD come into contact with the criminal justice system, compared with any other disadvantaged group (Aboriginal and Torres Strait Islander Social Justice Commissioner 2008; AIHW 2011). Significantly poorer physical health (AHRC 2009) may also be a contributing factor. The majority of Indigenous women in prison have experienced sexual assault and/or domestic and family violence and post-traumatic stress disorder, and their needs are particularly poorly understood and not supported either in the community or in prison (Heffernan et al 2014; Baldry & McEntyre 2011; Lawrie 2003). It has been demonstrated that the therapeutic needs of Indigenous persons are significantly different from non-Indigenous persons, as the trauma resulting from ongoing colonisation must be understood and addressed (Westerman 2002; Atkinson 2002; Sherwood 2009). Despite this research, system and agency responses are often poorly integrated and inappropriate, resulting in inadequate service and support across the lifecourse of individuals concerned (Baldry & McEntyre 2011, Aboriginal and Torres Strait Islander Social Justice Commissioner 2002, 2004, 2008).

Previous work has attempted to conceptualise likely risk factors and possible responses to these individuals' complex needs. This is limited by the absence of a clear picture of their context and circumstances such as the impacts of colonial and intergenerational trauma; the actual pathways individuals take from the earliest points of interaction; and the possible multiple interventions by agencies such as school education, police, juvenile justice, health, community services and welfare (Westerman and Wettinger 1997a, 1997b). Hence there is no overall appreciation or understanding of the lifecourse pathways taken by Indigenous people with MHDCD into the criminal justice system or of the meaning, experience and impact of their cycles of imprisonment and re-imprisonment.

A large number of policy and legislative changes over the past 20 years have had negative and disproportionate effects on Indigenous persons, women and those with mental and cognitive impairment who are poor, disadvantaged and racialised, thereby increasing their rates of imprisonment (Baldry & Cunneen 2014, 2012; Cunneen et al 2013; Australian Prisons Project 2009; NSW Legislative Council 2001, 2002; Pratt et al, 2005). These include changes in sentencing law and practice leading to increased penalties and more frequent use of imprisonment as a sentencing option; restrictions on judicial discretion; punitive changes to bail eligibility; changes in administrative procedures and practices in relation to classification and access to programs; changes in parole eligibility and post-release surveillance; limited availability of non-custodial sentencing options; limited availability of suitable and appropriate rehabilitative programs; judicial, administrative and political perceptions of the need for 'tougher' penalties; and the greater use of remand and more restrictive use of parole (Baldry & Cunneen 2014; Baldry 2014; Cunneen et al 2013). Baldry & Cunneen note that these policy and legislative changes have also emerged in parallel with a significant cultural change which has seen the apparent acceptability of the overcrowded prison itself as an institutional response to those with mental and cognitive impairment who are seriously disabled by social arrangements. They also note the continuity in the use of incarceration for Indigenous people as a fundamental colonial strategy of control, as well as the ascendancy of the prison as a major place of contemporary confinement for Indigenous people (Baldry & Cunneen 2014).

People with cognitive impairment are often confused with those with a mental disorder and are less recognised as an over-represented and vulnerable group in prison (Baldry & Cunneen 2014). Generally, cognitive impairment is elided in the law with mental health impairment; that is, people with cognitive impairment usually have been dealt with under mental health legislation (Baldry 2014). Many staff in criminal justice agencies are unsure of what cognitive impairment is (Snoyman 2010) and there is an under recognition of the need for special supports for this group (IDRS 2008). There are serious consequences of imprisonment for people with cognitive disabilities, and those with borderline intellectual disability (BID) face particular difficulties because they have not been recognised as having a disability for the purposes of receiving support and assistance from state disability services (Hayes et al 2007) and may also be excluded from the new Commonwealth Government's National Disability Insurance Scheme (NDIS). The classification of people with cognitive impairment into categories determined by whether they have an IQ score above or below 70 IQ, have deficits in at least two social adaptive functions and were diagnosed before the age of 18 is an injurious practice for many, especially Indigenous Australians; moreover this categorisation has been used to determine whether an individual gets a disability service or how he or she is treated by the police and in court and prison (Baldry et al 2013). People from poor, disadvantaged and abusive backgrounds may well have intellectual disability that is not recognised and are assumed to be just 'too difficult', or they may have an acquired brain injury that impairs their intellectual and behavioural responses significantly but which has not come to the attention of services. Because they do not fit into the limiting categories required for a disability service many in this group are not recognised until they are assessed in prison (Dowse et al 2009; Baldry & Cunneen 2014).

Across Australia, thousands of people with mental and cognitive disability are being 'managed' by criminal justice systems rather than being supported in the community, a disproportionate number of them Indigenous (Baldry & Dowse 2013). Children and young people from already racialised and criminalised communities and families who struggle with cognitive or mental impairment are not supported in the community, in school or in the child and family support systems in the way middle class young people are; instead they are increasingly dealt with by systems of control rather than systems of care and support (Baldry 2010; Baldry, Dowse, McCausland and Clarence 2012). Indigenous young people are particularly vulnerable to this practice, and are vastly over-represented in the care and protection and juvenile justice systems in every jurisdiction in Australia (SCRGSP 2014). The criminalisation of disability related behaviours and responses to life circumstances is described as particularly evident for Indigenous children and young people (Baldry 2014).

The label 'complex needs' (Rosengard 2007) is often applied to people with dual diagnosis (both mental and cognitive impairment), comorbidity (mental or cognitive impairment with a substance abuse disorder) or multiple diagnoses (Hayes et al 2007; Kavanagh et al 2010), many of whom form a large and neglected group in the criminal justice system (Herrington 2009; Baldry 2010). However, this label should be understood as a creation of state agencies and social institutions rather than as an individual's problem (Baldry & Dowse 2013) with the term being more appropriately 'complex support needs'. There is an almost universal lack of community support places for persons with complex support needs since their needs often cannot be met by any one agency in the currently siloed human service system, meaning that prisons become 'institutions of default – the place people end up because there is nowhere else for them to go' (Sotiri, McGee and Baldry, 2012). This group is often denied parole, and when they are released (usually from short sentences or remand) there is almost no appropriate support for them, which perpetuates the cycle of re-offending, being breached and returning to prison quickly (Baldry 2014). Cycling in and out of prison in this way leaves this group even more vulnerable to compounding disadvantageous factors such as homelessness. Social and health services are more limited in rural and remote places, therefore it is more likely that a person living in a disadvantaged community outside a large urban area and with a number of impairments and disability will be subjected to criminal justice control rather than mental health and disability support (Baldry & Cunneen, 2014); again, this has a disproportionately negative effect on Indigenous Australians.

## 2.2 THE MHDCD STUDY

### 2.2.1 Context for the MHDCD Study

The study presented in this report builds on an ARC Linkage project, *People with mental health disorders and cognitive disability (MHDCD) in the criminal justice system in NSW*<sup>6</sup> conducted 2006-09. The MHDCD Project created a merged Dataset containing lifelong administrative information on a cohort of 2,731 persons who have been in prison in NSW and whose MHDCD diagnoses are known. The cohort is a purposive sample drawn from the NSW Inmate Health Survey 2001 and the Statewide Disability Database of Corrective Services NSW, with data on the 2,731 individuals provided by criminal justice and human service agencies. Project partnerships and/or collaborations were established with all NSW criminal justice agencies (Corrective Services, Police, Juvenile Justice, Courts, Legal Aid) and human service agencies (Housing, Ageing Disability and Home Care, Community Services, Justice Health and NSW Health through the Centre for Health Record Linkage giving access to Mortality, Pharmacotherapy and Admitted Patient databases).

The MHDCD project team developed an innovative method of collecting, merging and analysing data relating to complex individuals and populations. Each individual in the cohort was matched in each agency and all matches for each person for that agency were added to the database as an agency-specific subset. This allows merging of data related to each individual from any subset with any other subset, with the potential to create specifically compiled subsets of interest, overall administrative de-identified life course 'pathway' case studies for individuals in the Dataset, aggregated subset pathways and patterns of effects of agency interactions with individuals, subgroups and other agencies. Merging data across the criminal justice sub-systems and with relevant human services provides a broad, dynamic, trans-criminal justice and human service understanding of the involvement of vulnerable people in the criminal justice system. It sidesteps the problem of prospective approaches, which potentially require up to 30 years or more and risk yielding very limited numbers of persons in the groups of interest. The data gathered in the MHDCD Dataset is of extraordinary richness and depth. For example, it includes information on all police incidents in which an individual was a person of interest or victim; all charges and their outcomes; all court appearances; all episodes of juvenile and adult custody; all housing applications and their outcomes; and all hospital admissions and associated diagnoses, thus allowing for detailed and powerful analysis.

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<sup>6</sup> ARC Linkage Project 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.



## 2.2.2 Findings of the MHDCD study

Of the full cohort of 2,731 people, the primary diagnosis for 25% (n=680) is recorded as intellectual disability (ID), for 29% (n=783) it is borderline intellectual disability (BID) and for 35% (n=965) it is a mental health disorder (MHD). Substance abuse disorder is diagnosed in 47% (n=1276) of the cohort<sup>7</sup> and for 12% (n=339) no diagnosis is recorded (Baldry, Dowse, Xu & Clarence 2013, 7). There are overall 1463 people in the cohort with cognitive disability (CD):<sup>8</sup> The majority of the 465 (68%) individuals who have ID also have other MHD or AOD diagnoses (identified here as complex needs) while 215 (32%) have no other diagnosis. Of those 783 (54%) individuals in the BID range, 517 (66%) have additional MHD or AOD diagnoses (complex) and 266 (34%) have no other diagnosis. Taken together these figures indicate that approximately two-thirds (67%) of those with a cognitive disability have complex needs.

Men make up the majority of the MHDCD cohort at 89% (n= 2,431), with a smaller proportion of 11% (n= 300) being women. In terms of Indigenous representation 25% (n=676) of the total cohort are Indigenous. Of these individuals 86% (n=583) are men (21% of the whole cohort) and 14% (n=93) are women (3% of the whole cohort). A total of 91% of the Indigenous sub-cohort have at least one identified cognitive disability or mental health diagnosis, with most having complex needs – for example, of those with MHD, 77% have AOD and 36% also have a CD.

Findings from the MHDCD study revealed significant systemic and social disadvantage. In relation to educational attainment, people with mental and cognitive impairment were found to have achieved lower levels of education when compared with the already low levels of attainment found in the general prison population, with those with some form of CD having the worst levels. The study also found a very high rate of persons in prison with ID and BID not receiving a disability service and in fact for a significant proportion, their cognitive impairment was first diagnosed whilst in prison. The proportion of the cohort who had been in out-of-home-care (OOHC) at some time in their childhood was also found to be significantly higher than the general population and to have significantly higher rates of CD and complex support needs.

Analysis of the MHDCD Dataset reveals how individuals have been shaped and directed into particular pathways by failures and deliberate arrangements in policy and program approaches and systems. There is evidence of avoidance by human service agencies of working with children and adults with complex needs resulting in criminal justice services, particularly Police, being used as frontline child protection, housing, mental and cognitive disability services (Baldry, Dowse, McCausland & Clarence, 2012, 7).

The needs of Indigenous Australians were found to be particularly acute and poorly serviced by past and current policy and program approaches. Indigenous persons in the MHDCD Dataset have the highest rates of complex needs (multiple diagnoses and disability) and Indigenous women with complex needs have significantly higher convictions and episodes of incarceration than their male and non-Indigenous peers. They experience multiple, interlocking and compounding disadvantageous circumstances. This analysis provided the imperative for seeking to undertake further quantitative and qualitative investigation of the pathways and experience of Indigenous persons with MHDCD in the criminal justice system.

<sup>7</sup> Note the substance abuse and mental health groups overlap with each other and with the ID and BID groups.

<sup>8</sup> 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.



## 3. THEORETICAL PERSPECTIVES

The project's theoretical perspective is informed by the conceptual tools of decolonisation, complexity and critical methodologies from race, feminist, disability and criminology studies underpin our approach.

### 3.1 DECOLONISATION

Maori woman, academic and author Linda Tuhiwai Smith describes research with Indigenous communities as a site of significant ongoing contestation, not only at the level of epistemology or methodology but also as an organised scholarly activity that is deeply connected to power (2005, 87). She has proposed the use of a 'decolonization framework' (1999; 2005, 88) as a means of challenging the reproduction of social relations of power in research involving Indigenous communities, and refocusing the institution of research. Shedding colonialism for both the 'colonised' and 'coloniser' evokes a process of overturning the dominant way of seeing the world and representing realities in ways that do not replicate colonial values and worldviews (McLeod, 2000, 37-39 in Green & Baldry 2008, 397). Adopting a decolonisation framework in a research context means 'taking apart the story, revealing underlying texts, and giving voice to things that are often known' (Smith 1999, 3) by Indigenous peoples as a means to 'redress the constructs used by academics and governments' (Sherwood 2010, 121). Aboriginal academic Juanita Sherwood has set out the way that Aboriginal researchers with like-minded non-Indigenous researchers are able to 'shift the paradigm of research from one that silences and problematises to a praxis that is safe and respectful and encourages informants to share their wisdom, since they know they will be heard' (2010, 120).

From such praxis a process can emerge that becomes a 'two-way sharing and learning encounter that contributes to the building of valid and meaningful data' (Sherwood 2010, 120).

The IAMHDCD Project team is made up of both Indigenous and non-Indigenous researchers seeking to contribute to a research space that is safe and respectful for Indigenous participants, and that privileges Indigenous narratives and lived experiences. The project is premised on an acknowledgement of the ways that research has been marked by the problematising, pathologising and marginalising of Indigenous voices. We seek to develop new understandings of how Indigenous persons with MHDCD who are or have been in the criminal justice system experience and interpret the conglomeration of events and interventions in their lives through a qualitative investigation of the experiences and views of Indigenous men and women who have been in these circumstances, as well as family and community members and service providers. Qualitative research protocols and procedures developed as part of the project provide the framework for engaging in and developing active partnerships with Indigenous Community Controlled Organisations in the qualitative research process.





## 3.2 COMPLEXITY

The experiences of Indigenous Australians with MHDCD in contact with the criminal justice system are characterised by complex trauma related to disadvantage, racism, marginalisation and harm. Such experiences include multiple elements and processes which are interconnected and interdependent and are difficult to disentangle from one another since they intersect and dynamically interact. These make up a complex system (Bar-Yam 1997; Byrne, 1998). In order to conceptualise this complex system, emerging approaches in the social sciences that engage with complexity theory have informed the study approach. Encompassing a range of diverse disciplinary bases and intellectual traditions, complexity approaches are at the cutting edge of new work in a number of fields and although beginning to emerge in criminological scholarship (see Pycroft & Barollas, 2014), as yet, there has been little direct and systematic engagement with complexity analyses in disability. The lives of Indigenous Australians with mental and cognitive disability in contact with the criminal justice system are replete with experiences that tie the presence of disability to complex experiences of disadvantage, marginalization and harm. A complexity analysis allows us to grasp the interconnections between multiple identities and levels of social disadvantage which overcome the limitations of traditional cause and effect and/or deficit thinking that has dominated the field.

A complexity approach allows the consideration of the impact of multiple systems including institutional and social relations on individuals, families and communities and promotes a focus on power relations in systemic mechanisms that force people and groups into pathways by controlling opportunity and knowledge (Baldry & Dowse 2013: 224). This approach overcomes the tendency to individualise experience and moves the analysis beyond the effects of criminogenic or impairment related individual characteristics. A complexity analysis offers several key insights which have informed our approach. These broadly include recognition that:

- Causation is complex and outcomes are not the product of any single cause but rather the effects of interaction of multiple factors.
- Systems are characterised by many elements and processes that are interconnected and interdependent and these elements can feedback into each other.
- Complex issues cannot be understood as linear problems broken down into pieces, with each piece analysed separately to give the answer to the problem (Ramalingam et al., 2008). Small causes can have large effects and vice-versa (Cilliers, 1998) and can have effects that are dynamic, non-linear and unpredictable.
- The results are something that cannot be predicted from what is known of the component parts or by separately analysing various causes and effects i.e. the whole is more than the sum of its parts (Baldry & Dowse 2013: 222-4).

Adopting a complexity approach allows an understanding of the 'chaotic synergy at play across multiple contextual, situational and identity factors, which often amounts to system-based oppression' (McPherson & McGibbon 2014,160).



### 3.2.1 Complex Support Needs

In relation to human lives and support needs, 'complexity' is a product of the compounding of individual life situations and the lack of capacity of support structures to respond appropriately over time, that is, they are creations of social systems and organisation, not the fault of an individual person (Hamilton 2010). In applying a complexity analysis to the lived experience of Indigenous Australians with MHDCD in contact with the criminal justice system, an applied conceptual framing of the multiple domains of disadvantage identified as 'complex support needs' has been utilised in the research. While there remains a lack of agreement around terminology in the area, the term 'complex support needs' moves beyond limited categorizations defined by the presence of a primary medical diagnosis, and which attributes the presence of a particular characteristic, impairment or dysfunction or combinations to the individual.

As an overarching concept, complex support needs provides a framework for understanding multiple interlocking (Rankin & Regan 2004: i) experiences and factors that span disability, health and social issues, and captures their nature as simultaneousness, multifaceted and compounding (Baldry & Dowse 2013: 222-3). Broadly those with complex support needs are seen as people who require high levels of health, welfare and other community based services and include individuals who experience various combinations of mental illness, intellectual disability, acquired brain injury, physical disability, behaviours that are a risk to self or others, social isolation, family dysfunction, have problematic drug and/or alcohol use, insecure or inadequate housing; cultural, circumstantial or intergenerational disadvantage; family and domestic violence and contact with the criminal justice system (Baldry, Dowse, & Clarence, 2012; Carney, 2006; Draine & Salzer, 2002; Hamilton, 2010; Keene, 2001 MacDonal, 2012).

Important for the analysis presented in this report is the recognition that complex support needs are not static and have a temporal dimension, such that heightened need for support is more likely to emerge during certain situations, episodes or life stages including transitions around out of home care, engagement with or release from the criminal justice system, in times of family stress such as illness, death, family conflict, or removal of children. The experience is particularly characterised by lack of support in a crisis and may be exacerbated in situations, which require negotiation of multi-agency support. Those with complex support needs are also frequently defined in the context of their relationship or otherwise to service systems. These systems, such as the child protection, health, housing and criminal justice systems struggle to work collaboratively with and support effectively such individuals and so people with complex support needs are often marginalised and disadvantaged within the service system and in the community (Hamilton 2010; Baldry & Dowse 2013).





## 3.3 CRITICAL RESEARCH METHODOLOGIES

The methodological foundations of this research draw on key ideas from critical Indigenous, feminist, disability and criminology studies. A critical perspective offers the possibility of better understanding the complex interactions of individual, social and systemic factors and compounding disadvantages that operate to deliver Indigenous women and men with mental health disorders and cognitive disabilities into the criminal justice system.

### 3.3.1 Indigenous methodology

The methodology of the IAMHDCD project takes these critiques as central and is informed by the work of critical Indigenous theorists such as Rigney (1999), Tuhiwai Smith (1999, 2012), Sherwood (2010) and Moreton-Robinson (2013). Great harm has been caused as a result of research that was done 'on' or 'to' or 'for' Indigenous communities rather than 'with' Indigenous people and 'with' Indigenous communities. For example, Sherwood (2010, 30-31) has documented the ways in which many non-Indigenous researchers do not examine their own cultural biases nor explore the systems and circumstances that have contributed to Indigenous people's poor health status, and as a result produce ill-informed constructions of Indigenous people that enable government departments and health professionals to implicitly and explicitly blame Indigenous people for their own poor health. As the research is decolonising, empowering and Indigenist, the commonly used approaches by those in the academy and elsewhere to researching Indigenous peoples in Australia are deconstructed and the project's methodology is embodied with cultural and professional integrity (McEntyre, forthcoming). Indigenous academics have led the critique of colonising methodologies and practices in research, challenging academics to produce research that is 'more respectful, ethical, sympathetic and useful' (Tuhiwai Smith 1999; 2012) in relation to Indigenous peoples. Privileging the worldviews, contexts and voices of Indigenous individuals, organisations and communities was a primary consideration in conducting this research, given the ongoing complexity of trauma, marginalisation and disadvantage experienced by Indigenous people as a result of colonisation (Baldry and Cunneen 2014; Rowe et al 2015). Indigenous critical feminist scholarship is prescient, particularly given the disproportionately high levels of violence experienced by Indigenous women and children (Davis & McGlade 2006; Payne 1992; Atkinson 1990), in particular those with mental and cognitive impairments.

### 3.3.2 Intersectionality

Since the 1980s an 'intersectionality' analysis emerging from critical race and feminist scholarship has been influential, in particular Kimberlé Crenshaw's framing of the term which has been interpreted, applied and expanded across disciplines and often employed primarily as a critique of identity-based essentialism (Crenshaw 1989, 1991 in Ribet 2010). Critiques of this position point to its failure to take account of the particular experiences of non-white women. Critical race theorists challenge notions of biological inferiority underpinning social and legal discrimination against people of colour, and identify the structural and more subtle forms of racism that maintain the subordination of non-white persons (Delgado 1995). Critical feminist theorists highlighted the gendered nature of politics and policy-making and the particular human rights issues facing women, though were criticised for not sufficiently understanding or incorporating the experience of non-white women, and Indigenous women in particular (Moreton-Robinson, 2000). In Crenshaw's words, 'black women are marginalized in feminist politics as a consequence of race, and they are marginalized in antiracist politics as a consequence of gender'; when feminism does not explicitly oppose racism, and antiracism does not explicitly oppose patriarchy, 'race and gender politics often end up being antagonistic to each other and both interests lose' (1991, 1243). In particular, Crenshaw's critical analysis contends that the consequence of intersectional vulnerability results in the specific persecution of identity groups who are experiencing compounded and intersectional subordination (Crenshaw 1989, 1991 in Ribet 2010).

### 3.3.3 Social Conceptualisations of Disability and Offending

Embedded in the project also is a social conceptualisation of disability. Here the distinction is drawn between 'impairment' as a condition of the individual body or mind (such as experiencing schizophrenia, intellectual disability or brain injury) and 'disability' as the social experience flowing from the presence of impairment, including the range of barriers to full participation that exist in a society (Oliver and Barnes 1998; Baldry 2014). Critical disability studies has built on the social approach to understanding disability by bringing a closer examination of the dynamic interaction of social, political, cultural and economic factors to the analysis, and by exploring the ways that they define disability and shape personal and collective responses to difference. Critical disability studies problematises the relegation of impairment to the domain of the medical, rehabilitative, private and personal and questions its dislocation from the social (Dowse et al 2009, 38). Similarly the critical criminological approach locates and understands the reasons for crime within wider structural and institutional contexts, with crime and social responses to it seen as deeply political and cultural matters. These contexts may be conceived of in various ways, including socioeconomic, class-based, cultural, racialised and gendered forms (Anthony and Cunneen 2008; Baldry 2014).





## 4. THE IAMHDCCD PROJECT

The IAMHDCCD project focuses on the experience of Indigenous people with multiple, co-occurring mental and cognitive impairments – very often exacerbated by abuse of alcohol and other drugs and resultant challenging behaviours. This group is often viewed as not being the responsibility of any one agency. In systemic terms, this failure of service integration results in the criminal justice system serving as the default institution into which they are funnelled (Baldry et al 2008b; Dowse et al 2009, 39; Baldry & Dowse 2013). New conceptual and methodological territory is being forged with this project, integrating a critical disability perspective with critical criminology, as well as critical race, Indigenous and feminist theory. Bringing critical perspectives together has opened up new ways to identify conceptualisations and interventions that enable the support and development of new individual, systemic and political levels of engagement (Dowse et al 2009, 39; Baldry 2014). It is designed to illuminate the multiple, interlocking and compounding disadvantageous circumstances experienced by Australian Indigenous men and women with mental and cognitive disability in Australian criminal justice systems, and to bring critically informed tools of evidence in response. Ethics permissions for the IAMHDCCD were given by UNSW HREC, NSW AHMRC and individual Aboriginal organisations with which the team worked.<sup>9</sup>

### 4.1 PROJECT DESIGN

The overall IAMHDCCD study employed a multi-method design featuring both quantitative and qualitative components comprising:

1. A *quantitative study* in which statistical analytic techniques were applied to the MHDCCD Dataset to provide a description of the experiences of a cohort of Indigenous Australians with MHDCCD in contact with the CJS and a comparison with their non-Indigenous peers.
2. A series of *case studies* were developed drawing on data from the MHDCCD Dataset providing narrative accounts of the experiences of selected individuals in their system contacts and pathways into and through the criminal justice system.
3. A *geographic distribution study* using the MHDCCD Dataset to investigate concentrations of disadvantage by examining the geographic distribution of members of the MHDCCD Dataset cohort, providing comparison on the basis of Indigenous status and gender.
4. A series of *nested studies* have been undertaken by affiliated researchers drawing on the MHDCCD Dataset.
5. A *qualitative study* in which Indigenous people who have MHDCCD and who have been in the criminal justice system and their families, Aboriginal Community members and service providers were interviewed about their experiences of and views on Indigenous people with MHDCCD's involvement in the criminal justice system.

The approaches in each of these five areas were developed in dialogue with each other. Findings from one form of interrogation informed the approach to data collection and analysis undertaken in the others. In this way the five elements combine to provide a coherent and comprehensive account of the experiences of Indigenous Australians with MHDCCD in their contact with the CJS and the critical issues identified to address their over-representation. The following sections set out each study, detailing the specific methods used and findings emerging. This is followed by a discussion examining the overarching themes and issues, which have emerged from the separate project elements.

<sup>9</sup> UNSW HREC Ethics No. 10401, AH&MRC Ethics No. 858/12





# 5. QUANTITATIVE STUDY

## 5.1 METHOD

As set out in section 2.2, the MHDCD Dataset is made up of a cohort of 2,731 individuals who have been in prison in New South Wales and whose mental health disorder and cognitive disability diagnoses are known. The MHDCD cohort is drawn from the NSW Inmate Health Survey (2001, 2009) and the NSW Corrective Services Statewide Disability Service database. Using linked but de-identified extant administrative records from criminal justice and human services agencies in NSW, the Dataset allows for the building of multilevel analysis of the experiences of this cohort through their contact with criminal justice and human service agencies. Each individual in the cohort was matched in each agency and all matches for each person for that agency were added to the database as an agency-specific subset. The data linking and matching took place in 2010 but with considerable reanalysis over the following two years to address anomalies that emerged as the data were merged.

There were significant barriers in achieving this linkage. For example, it was not possible to gain consent from all those in the potential dataset due to likely incapacitation of many and lack of information as to their present whereabouts. Advice was sought from the NSW Privacy Commissioner who ruled the public benefit outweighed the risk of identification of individuals. The project team was given permission from each ethics body to draw and link the data ensuring strict privacy and confidentiality of the data. As the initial data was being drawn it became clear that some in the dataset had numerous aliases, some as many as 50. Altogether the average for aliases was 10 per person. This meant that it was not possible for standard linkage keys to be used to ensure the right person in each dataset was matched. Problems with aliases and incorrect individual matching were found even in the internal data from Courts, Police and Corrective Services. The project team had to develop a cascade of verifying methods in order to be certain the right individual was linked with his or her data in each dataset.

The method allowed for the linking of data related to each individual from any subset with any other subset, which enabled the creation of specifically compiled subsets of interest, overall administrative de-identified lifecourse 'pathway' case studies for individuals in the dataset, aggregated subset pathways and patterns of effects of agency interactions with individuals, subgroups and other agencies. Linking data across the criminal justice sub-systems and with relevant human services provides a broad, dynamic, trans-criminal justice and human service understanding of the involvement of vulnerable people in the criminal justice system.

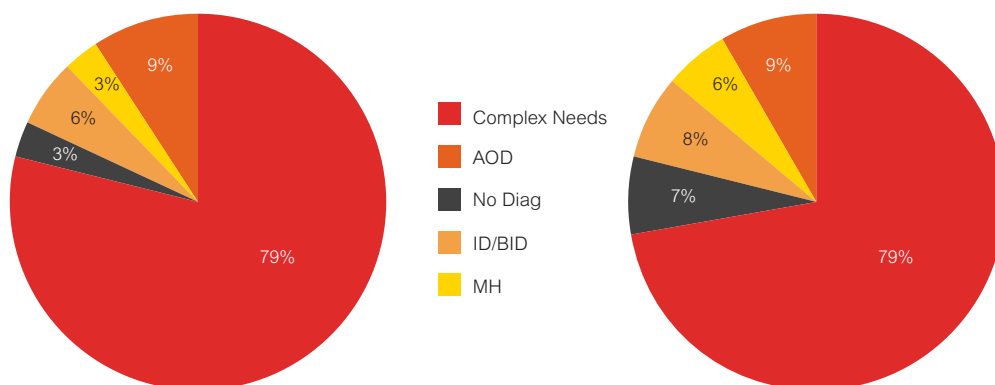
Initial analyses indicated that Indigenous persons in the cohort had a higher rate of multiple diagnoses and disability. This provided the imperative for seeking to undertake further quantitative investigation of the pathways and experiences of Indigenous persons with MHDCD in the CJS.



## 5.2 SAMPLE

The MHDCD cohort is a purposive rather than a representative sample, intentionally focusing on those individuals with diagnosed mental health disorder and cognitive disability diagnoses who have been in prison. The cohort also contains a small group of individuals who have no recorded MHDCD diagnosis (n= 174) allowing for some comparison. Men make up the majority of the MHDCD cohort at 89% (n= 2,431), with a smaller proportion of 11% (n= 300) being women. The individuals in the sample were on average 35.7 years old at the time of data collection in 2008, and ranged from age 17 to 75. The fact that a number in the cohort were over 60 biased the average ages calculated and provided at various points in this report.

**Figure 1: Indigenous vs. Non-Indigenous sub-cohorts by study group**



## 5.3 PROCEDURE

The MHDCD Dataset was established using a confirmed cohort of interest compiled into a relational database using MS SQL server 2008. Data were drawn from Police, Corrections, Justice Health, Courts, Juvenile Justice, Legal Aid, Disability, Housing, Health and Community Services on each individual from as far back as each agency's electronic records allow (generally from around the mid 1980s) up to the date of data extraction between 2008 and 2012. The data comprising the cohort were gathered at different times over a number of years from the various data sources. We used 30th April 2008 as the census date in order to calculate age groups consistently. These data were linked to allow detailed description and analysis of the pathways by which people with diagnoses of mental health disorders and cognitive disability enter, move through, exit and return to the criminal justice system and an understanding of the interactions between the justice and human service agencies affecting them (Baldry et al. 2013).

## 5.4 QUANTITATIVE ANALYSES OF INDIGENOUS VS. NON-INDIGENOUS PERSONS IN THE MHDCD COHORT: RESULTS AND DISCUSSION

As detailed above, we conducted a range of comparative analyses on the MHDCD Dataset to investigate the differences between the Indigenous and non-Indigenous members of the cohort. Presented below are key selected results that highlight significant findings and differences between those groups by Indigenous status. For each of the selected key metrics, two comparative analyses have been performed and reported separately:

1. Overall: Comparing the Indigenous and non-Indigenous sub-cohort in all diagnostic groups; and
2. Complex Needs Specific: Comparing the Indigenous and non-Indigenous sub-cohort within the complex needs diagnostic group.

We refer to these analyses as 'overall' (1 above) and 'complex needs specific' (2 above) in relation to key metrics in the data that were identified as indicating levels of vulnerability and likelihood of early and frequent contact with the criminal justice system. Adjusted odds ratio tests are used to reveal the likelihood that a particular outcome will occur for any group given a particular exposure, compared to the odds of the outcome occurring in the absence of that exposure. T-tests are used to compare the differences in the averages of events or occurrences in each group.

### 5.4.1 Out-of-home-care (OOHC)

The data on OOHC identify persons who were removed at some point from their family of origin by the Department of Community Services after being identified as a child at risk. They may have been placed in foster care, kinship care or a group home and may have had a number of these episodes as children.

#### **Overall:**

An adjusted Odds Ratio test shows that, after adjusting for age and sex, Indigenous people in the cohort are 2.6 ( $p < 0.0001$ , 95% CI[2.1,3.4]) times more likely to have been in OOHC compared to their non-Indigenous counterparts, with all other factors being equal.

#### **Complex needs specific:**

An adjusted Odds Ratio test shows that, after adjusting for age and sex, Indigenous people with complex needs in the cohort are 2.5 ( $p < 0.0001$ , 95% CI[1.9,3.3]) times more likely to have been in OOHC compared to their non-Indigenous counterparts, with all other factors being equal.



## 5.4.2 Police contact and custody

### Age of first police contact<sup>10</sup>

These data indicate how young a person was when they first had contact with police as a victim or offender.

#### Overall:

A T-test shows that Indigenous people in the cohort have a significantly lower age of first police contact than their non-Indigenous counterparts (14.9 vs 18.3)  $t(1867) = 13.890, p < .001$ .

#### Complex needs specific:

A T-test shows that Indigenous people with complex needs in the cohort have a significantly lower age of first police contact compared to their non-Indigenous counterparts (14.6 vs 17.0),  $t(1303.385) = 10.098, p < .001$

### Number of police contacts

These data indicate the number of police contacts a person has had over their lifetime, up to the point at which the data was drawn for this study. The figure provided is the average number of contacts found for each group.

#### Overall:

A T-test shows that Indigenous people in the cohort have a significantly higher number of police contacts than their non-Indigenous counterparts (81.8 vs. 59.8),  $t(2729) = -9.549, p < .0001$ .

#### Complex needs specific:

A T-test shows that the Indigenous people with complex needs in the cohort have a significantly higher number of police contacts than their non-Indigenous counterparts (99.2 vs. 73.6),  $t(1115) = -8.44, p < 0.0001$ .

### Rate of police contact

These data indicate the yearly rate of police contact for a person. This is calculated by dividing the number of total police contacts by the number of years between the first recorded police contact and the last recorded police contact for an individual.

#### Overall:

A T-test shows that Indigenous people in the cohort have a significantly higher rate of police contacts per year than their non-Indigenous counterparts (5.3 vs. 4.1),  $t(1061.9) = -7.155, p < 0.0001$ .

#### Complex needs specific:

A T-test shows that Indigenous people with complex needs in the cohort have a significantly higher rate of police contact per year than their non-Indigenous counterparts (7.8 vs. 6.4),  $t(644.5) = -4.42, p < 0.0001$ .

<sup>10</sup> It should be noted that average ages in the following analyses make it seem as if many in the cohort are adults with they come into contact with the criminal justice system. However these averages are biased due to a few much older first contacts (i.e. there is a significantly higher age of first contact with police for those people in the cohort with MH only, possibly due to later onset of mental illness). Calculating the median age indicates that ~50% had their first contact before the age of 18 (Baldry et al 2013, 10).

### Victim contacts

These data indicate the number of police contacts a person has had over their lifetime where they have been identified as a victim.

#### Overall:

A T-test shows that Indigenous people in the cohort have a significantly higher number of police contacts as a victim than their non-Indigenous counterparts (9.1 vs. 8.0),  $t(2729) = -2.327$ ,  $p < 0.05$ .

#### Complex needs specific:

A T-test shows that Indigenous people with complex needs in the cohort have similar number of police contacts as a victim as their non-Indigenous counterparts (9.8 vs. 9.7),  $t(1646) = -.175$ ,  $p = 0.865$  (not statistically significant).

### Rate of victim contacts

These data indicate the yearly rate of police contact for a person identified as a victim, calculated by dividing the number of total victim contacts by the number of years between the first recorded police contact and the last recorded police contact for an individual.

#### Overall:

A T-test shows that Indigenous people in the cohort have a slightly higher rate of police contacts as a victim per year than their non-Indigenous counterparts (0.58 vs. 0.55),  $t(2699) = -.945$ ,  $p = 0.345$  (not statistically significant).

#### Complex needs specific:

A T-test shows that Indigenous people with complex needs in the cohort have a similar rate of victim contacts per year to their non-Indigenous counterparts (0.60 vs. 0.64),  $t(998.762) = .742$ ,  $p = 0.458$  (not statistically significant).

### Age of first police custody

These data indicate how young a person was when they first spent time in police custody. It should be noted that these averages are affected by the group in the cohort who did not have contact with the criminal justice system until their middle age.

#### Overall:

A T-test shows that Indigenous people in the cohort have a significantly lower age of first police custody than their non-Indigenous counterparts (23.7 vs 26.8)  $t(1351.65) = 7.709$ ,  $p < 0.001$

#### Complex needs specific:

A T-test shows that Indigenous people with complex needs in the cohort have a significantly lower age of first custody compared to their non-Indigenous counterparts (23.0 vs 25.5),  $t(1100) = 5.556$ ,  $p < 0.001$



## 5.4.3 Convictions

### Age of first conviction

These data indicate how young a person was when they first received a conviction for an offence. Convictions are derived from data indicating finalised court matters.

#### **Overall:**

A T-test shows that Indigenous people in the cohort have a significantly lower age of first conviction than their non-Indigenous counterparts (17.2 vs 19.8)  $t(2690)=9.487$ ,  $p<0.001$

#### **Complex needs specific:**

A T-test shows that Indigenous people with complex needs in the cohort have a significantly lower age of first conviction compared to their non-Indigenous counterparts (16.9 vs 18.9),  $t(1373.678) = 8.733$ ,  $p<.001$

### Number of convictions

These data indicate the number of convictions a person has had over their lifetime until the data was drawn for this study. The figures given are for the average number of convictions found for each cohort.

#### **Overall:**

A T-test shows that Indigenous people in the cohort have a significantly higher number of convictions than their non-Indigenous counterparts (19.5 vs. 15.6),  $t(2729) = -6.483$ ,  $p < 0.0001$ .

#### **Complex needs specific:**

A T-test shows that Indigenous people with complex needs have a significantly higher number of convictions than their non-Indigenous counterparts (20.3 vs. 17.6),  $t(1132.62) = -3.89$ ,  $p < 0.001$ .

### Rate of convictions

These data indicate the yearly rate of convictions for a person identified, calculated by dividing the number of total convictions by the number of years between the first recorded conviction and the last recorded conviction for an individual.

#### **Overall:**

A T-test shows that Indigenous people in our cohort have a higher rate of convictions than their non-Indigenous counterparts (1.3 vs. 1.1),  $t(2702) = -4.232$ ,  $p<.0001$ .

#### **Complex needs specific:**

A T-test shows that Indigenous people with complex needs in the cohort have a slightly higher rate of conviction per year than their non-Indigenous counterparts (1.4 vs. 1.3),  $t(956) = -1.24$ ,  $p = 0.214$  (not statistically significant).



## 5.4.4 Juvenile Justice

### Likelihood of being a Juvenile Justice client

These data indicate the odds of a person becoming a client Juvenile Justice. Being a client indicates those who received a service from Juvenile Justice including supervision of community orders.

#### **Overall:**

An adjusted Odds Ratio test shows that after adjusting for age and sex, Indigenous people in the cohort are 2.2 ( $p < 0.0001$ , 95% CI[1.9, 2.6]) times more likely to be Juvenile Justice clients compared to their non-Indigenous counterparts, with all other factors being equal.

#### **Complex needs specific:**

An adjusted Odds Ratio test shows that after adjusting for age and sex, Indigenous people with complex needs in the cohort are 2.0 ( $p < 0.0001$ , 95% CI[1.6, 2.6]) times more likely to be Juvenile Justice clients compared to their non-Indigenous counterparts, with all other factors being equal.

### Likelihood of being in Juvenile Justice custody

These data indicate the odds of a person being in Juvenile Justice custody.

#### **Overall:**

An adjusted Odds Ratio test shows that, after adjusting for age and sex, Indigenous people in the cohort are 2.4 ( $p < 0.0001$ , 95% CI[2.0, 2.9]) times more likely to have been in Juvenile Justice custody compared to their non-Indigenous counterparts with all other factors being equal.

#### **Complex needs specific:**

An adjusted Odds Ratio test shows that, after adjusting for age and sex, Indigenous people with complex needs in the cohort are 2.0 ( $p < 0.0001$ , 95% CI[1.6, 2.6]) times more likely to have been in Juvenile Justice custody compared to their non-Indigenous counterparts with all other factors being equal.





## 5.4.5 Adult Corrections

### Number of Corrective Services custody episodes

These data indicate the number of custodial episodes a person has had in adult corrections until the data was drawn for this study. Figures indicate the average number of episodes for each group.

#### **Overall:**

A T-test shows that Indigenous people in the cohort have a significantly higher number of adult corrections custody counts than their non-Indigenous counterparts (8.3 vs. 6.4),  $t(2729) = -6.860$ ,  $p < 0.0001$ ).

#### **Complex needs specific:**

A T-test shows that Indigenous people with complex needs in the cohort have a significantly higher number of adult corrections custody counts than their non-Indigenous counterparts (8.9 vs. 7.4),  $t(1147) = -4.75$ ,  $p < 0.0001$ .

### Rate of Corrections custody

These data indicate the yearly rate of custodial episodes for a person, calculated by dividing the number of total adult corrections custody by the number of years between the first recorded adult corrections custody and the last recorded adult corrections custody for an individual.

#### **Overall:**

A T-test shows that Indigenous people in the cohort have a slightly higher rate of DCS custody than their non-Indigenous counterparts (1.3 vs. 1.2),  $t(2481) = -1.972$ ,  $p < 0.05$ .

#### **Complex needs specific:**

A T-test shows that Indigenous people with complex needs have a slightly higher rate of DCS custody per year than their non-Indigenous counterparts (1.43 vs. 1.38),  $t(1090) = -0.93$ ,  $p = 0.351$  (not statistically significant).





## 5.4.6 Remand

These data indicate the number of episodes of remand a person has experienced. Figures indicate the average number of episodes found for each group.

### **Overall:**

A T-test shows that Indigenous people in the cohort have significantly more remand episodes compared to their non-Indigenous counterparts (6.7 vs. 5.2)  $t(2627) = -6.399$ ,  $p < 0.001$ .

### **Complex needs specific:**

A T-test shows that Indigenous people with complex needs in the cohort have significantly more remand episodes compared to their non-Indigenous counterparts (7.2 vs 6.0),  $t(1840) = -3.952$ ,  $p < 0.001$

## 5.4.7 Homelessness

Homelessness markers are not consistent across the Dataset. As a proxy marker we have drawn out data where a person is recorded as having no fixed place of abode (NFPA). This is likely to result in an under-representation of the incidence of homelessness as there appear to be others in the cohort who have been homeless (based on police comments and number of addresses, for example) but this has not been captured in the available agency data.

### **Overall:**

An adjusted Odds Ratio test shows that after adjusting for age and sex, Indigenous people in the cohort are 1.2 ( $p < 0.05$ , 95% CI[1.0, 1.4]) times more likely to have been homeless at some point in life compared to their non-Indigenous counterparts, with all other factors being equal.

### **Complex needs specific:**

An adjusted Odds Ratio test shows that after adjusting for age and sex, Indigenous people with complex needs in the cohort are roughly equally likely (1.1,  $p = 0.206$ , 95% CI[.92, 1.4]) (not statistically significant) to have been homeless at some point in life compared to their non-Indigenous counterparts, with all other factors being equal.





## 5.4.8 Women

These data indicate the comparative data on Indigenous and non-Indigenous women in the cohort.

### 5.4.8.a Out-of-home-care (OOHC)

The data on out-of-home-care identify persons who were removed at some point from their family of origin by the Department of Community Services after being identified as a child at risk. They may have been placed in foster care, kinship care or a group home and may have had a number of these episodes as children.

#### **Overall:**

An adjusted Odds Ratio test shows that, after adjusting for age, Indigenous females in the cohort are 3.7 ( $p < 0.0001$ , 95% CI[1.9, 7.2]) times more likely to have been in OOHC compared to their non-Indigenous counterparts with all other factors being equal.

#### **Complex needs specific:**

An adjusted Odds Ratio test shows that, after adjusting for age, Indigenous women with complex needs in the cohort are 2.7 ( $p < 0.001$ , 95% CI[1.3, 5.7]) times more likely to have been in OOHC compared to their non-Indigenous counterparts with all other factors being equal.

### 5.4.8.b Women's police contact and custody

#### Age of first police contact

These data indicate how young a woman was when she first had contact with police as a victim or offender. The figures provided indicate the average age at first police contact found for each group.

##### **Overall:**

A T-test shows that Indigenous women in the cohort have a significantly lower age of first police contact than their non-Indigenous counterparts (16.8 vs 21.2)  $t(311) = 4.319, p < .001$ .

##### **Complex needs specific:**

A T-test shows that Indigenous women with complex needs in the cohort have a significantly lower age of first police contact compared to their non-Indigenous counterparts (16.4 vs 20.5),  $t(214)=3.789, p < .001$ .

#### Number of police contacts

These data indicate the number of police contacts a woman has had over her lifetime until the data was drawn for this study. The figures provided indicate the average number of police contacts found for each group.

##### **Overall:**

A T-test shows that Indigenous women in the cohort have a significantly higher number of police contacts than their non-Indigenous counterpart (99.54 vs.64.97),  $t(311)=-5.849, p < .0001$ .

##### **Complex needs specific:**

A T-test shows that the Indigenous women with complex needs in the cohort have a significantly higher number of police contact than their non-Indigenous counterparts (101.8 vs. 73.3),  $t(214) = -4.271, p < 0.0001$ .

#### Rate of police contact

These data indicate the yearly rate of police contact for a woman. This is calculated by dividing the number of total police contacts by the number of years between her first and last recorded police contact.

##### **Overall:**

A T-test shows that Indigenous women in the cohort have a significantly higher rate of police contacts than their non-Indigenous counterparts (6.2 vs. 4.7),  $t(311) = -2.982, p < 0.001$ .

##### **Complex needs specific:**

A T-test shows that Indigenous women with complex needs in the cohort have a slightly higher rate of police contact per year than their non-Indigenous counterparts (6.1 vs. 5.2),  $t(214) = -1.489, p = .138$ . (Not significant)

## Victim contacts

These data indicate the number of police contacts a woman has had over her lifetime where she have been identified as a victim.

### Overall:

A T-test shows that Indigenous women in the cohort have a significantly higher number of police contacts as a victim than their non-Indigenous counterparts (23 vs. 16.1),  $t(311) = -3.170$ ,  $p < 0.05$ .

### Complex needs specific:

A T-test shows that Indigenous women with complex needs in the cohort have significantly higher number of police contacts as a victim as their non-Indigenous counterparts (23.2 vs. 18.7),  $t(214) = -1.697$ ,  $p < 0.05$ .

## Rate of victim contacts

These data indicate the yearly rate of police contact for a woman identified as a victim, calculated by dividing the number of total victim contacts by the number of years between her first and last recorded police contact.

### Overall:

A T-test shows that Indigenous women in the cohort have a slightly higher rate of police contacts as a victim per year than their non-Indigenous counterparts (1.4 vs. 1.1),  $t(303) = -1.917$ ,  $p = 0.056$  (not statistically significant).

### Complex needs specific:

A T-test shows that Indigenous women with complex needs in the cohort have a similar rate of victim contacts per year to their non-Indigenous counterparts (1.4 vs. 1.3),  $t(210) = -.388$ ,  $p = 0.699$  (not statistically significant).

## Age of first police custody

These data indicate how young a woman was when she first spent time in police custody. It should be noted that these averages are affected by the group in the cohort who did not have contact with the criminal justice system until their middle age.

### Overall:

A T-test shows that Indigenous women in the cohort have a significantly lower age of first police custody than their non-Indigenous counterparts (23.8 vs 28.3)  $t(215.630) = 4.424$ ,  $p < 0.001$ .

### Complex needs specific:

A T-test shows that Indigenous women with complex needs in the cohort have a significantly lower age of first custody compared to their non-Indigenous counterparts (23.6 vs 27.5),  $t(211) = 3.161$ ,  $p < 0.05$ .

### 5.4.8.c Women's Convictions

#### Age of first conviction

These data indicate how young a woman was when she first received a conviction for an offence.

##### **Overall:**

A T-test shows that Indigenous women in the cohort have a significantly lower age of first conviction than their non-Indigenous counterparts (18.4 vs 22.4)  $t(244.985)=4.438$ ,  $p<0.001$

##### **Complex needs specific:**

A T-test shows that Indigenous women with complex needs in the cohort have a significantly lower age of first conviction compared to their non-Indigenous counterparts (18.5 vs 22),  $t(213) = 3.571$ ,  $p<.001$

#### Number of convictions

These data indicate the number of convictions a woman has had over her lifetime until the data was drawn for this study.

##### **Overall:**

A T-test shows that Indigenous women in the cohort have a significantly higher number of convictions than their non-Indigenous counterparts (23 vs. 15.2),  $t(134.277) = -4.556$ ,  $p < 0.0001$ .

##### **Complex needs specific:**

A T-test shows that Indigenous women with complex needs have a significantly higher number of convictions than their non-Indigenous counterparts (24.5 vs. 17.2),  $t(214) = -3.434$ ,  $p < 0.001$ .

#### Rate of convictions

These data indicate the yearly rate of convictions for a woman, calculated by dividing the number of total convictions by the number of years between her first recorded and last recorded police conviction.

##### **Overall:**

A T-test shows that Indigenous women in the cohort have a significantly higher rate of convictions than their non-Indigenous counterparts (3.2 vs. 1.7),  $t(282) = -2.962$ ,  $p<.005$ .

##### **Complex needs specific:**

A T-test shows that Indigenous women with complex needs in the cohort have a slightly higher rate of conviction per year than their non-Indigenous counterparts (2.1 vs. 1.8),  $t(151.721) = -1.838$ ,  $p = 0.066$  (not statistically significant).



#### 5.4.8.d Women and Juvenile Justice

##### Likelihood of being a Juvenile Justice client

These data indicate the odds of a person being a Juvenile Justice client.

##### **Overall:**

An adjusted Odds Ratio test shows that, after adjusting for age, Indigenous women in the cohort are 2.9 ( $p < 0.0001$ , 95% CI[1.7, 4.9]) times more likely to be DJJ clients compared to their non-Indigenous counterparts with all other factors being equal.

##### **Complex needs specific:**

An adjusted Odds Ratio test shows that, after adjusting for age, Indigenous women with complex needs in the cohort are 2.4 ( $p < 0.01$ , 95% CI[1.3, 4.5]) times more likely to be DJJ clients compared to their non-Indigenous counterparts with all other factors being equal.

##### Likelihood of being in Juvenile Justice custody

These data indicate the odds of a woman having been in Juvenile Justice custody.

##### **Overall:**

An adjusted Odds Ratio test shows that, after adjusting for age, Indigenous women in the cohort are 3.2 ( $p < 0.0001$ , 95% CI[1.8, 5.5]) times more likely to be in DJJ custody compared to their non-Indigenous counterparts with all other factors being equal.

##### **Complex needs specific:**

An adjusted Odds Ratio test shows that, after adjusting for age, Indigenous women with complex needs in the cohort are 2.7 ( $p < 0.001$ , 95% CI[1.4, 5.0]) times more likely to be DJJ custody compared to their non-Indigenous counterparts with all other factors being equal.

### 5.4.8.e Women in Adult Corrections

#### Number of Corrective Services custody episodes

These data indicate the number of custodial episodes a woman has had in adult corrections until the data was drawn for this study.

##### **Overall:**

A T-test shows that Indigenous women in the cohort have a significantly higher number of DCS custody counts than their non-Indigenous counterparts (10.2 vs. 6.4),  $t(311) = -4.738$ ,  $p < 0.0001$ .

##### **Complex needs specific:**

A T-test shows that Indigenous women with complex needs in the cohort have a significantly higher number of DCS custody counts than their non-Indigenous counterparts (10.9 vs. 7.2),  $t(214) = -3.823$ ,  $p < 0.0001$ .

#### Rate of Corrections custody

These data indicate the yearly rate of custodial episodes for a woman, calculated by dividing the number of total adult corrections custody by the number of years between her first and last recorded adult corrections custody.

##### **Overall:**

A T-test shows that Indigenous women in the cohort have a significant higher rate of DCS custody than their non-Indigenous counterparts (1.7 vs. 1.3),  $t(187.483) = -2.748$ ,  $p < 0.05$ .

##### **Complex needs specific:**

A T-test shows that Indigenous women with complex Needs have a slightly higher rate of DCS custody per year than their non-Indigenous counterparts (1.6 vs. 1.25),  $t(148.448) = -2.517$ ,  $p < 0.05$

#### 5.4.8.f Women and Remand

These data indicate the number of episodes of remand a woman has experienced.

##### **Overall:**

A T-test shows that Indigenous women in the cohort have significantly more remand episodes compared to their non-Indigenous counterparts (8.5 vs.5.4)  $t(299) = -4.367$ ,  $p < 0.001$ .

##### **Complex needs specific:**

A T-test shows that Indigenous women with complex needs in the cohort have significantly more remand episodes compared to their non-Indigenous counterparts (9.2 vs 6.0),  $t(211) = -3.663$ ,  $p < 0.001$

#### 5.4.8.g Women and Homelessness

Homelessness markers are not consistent across the Dataset. As a proxy marker we have drawn out data where a person is recorded as having no fixed place of abode (NFPA). This is likely to result in an under-representation of the incidence of homelessness as there appear to be others in the cohort who have been homeless (based on police comments and number of addresses, for example) but this has not been captured in the available agency data.

##### **Overall:**

An adjusted Odds Ratio test shows that, after adjusting for age, Indigenous women in the cohort are 2.2 ( $p < 0.05$ , 95% CI[1.3, 3.6]) times more likely to have been homeless at some point in life compared to their non-Indigenous counterparts with all other factors being equal.

##### **Complex needs specific:**

An adjusted Odds Ratio test shows that, after adjusting for age, Indigenous women with complex needs in the cohort are 1.9 ( $p < .05$ , 95% CI[1.1, 3.4]) to have been homeless at some point in life compared to their non-Indigenous counterparts with all other factors being equal.

### 5.4.9 Offence categories for Indigenous people

These data indicate the top ten categories of offences by Indigenous people in the cohort, using the Australian Standard Offence Classification (ASOC). Frequency indicates the number of individuals who have committed this offence type.

Number	Top level classification	Offence type	Frequency
1	Theft and related offences	Theft (except motor vehicles), other (413); Receiving or handling proceeds of crime (394); Illegal use of motor vehicle (270); Theft from retail premises (221); Theft of motor vehicle (185)	1,483
2	Public order offences	Offensive behaviour (332); Criminal intent (209); Trespass (309); Offensive language (287)	1,137
3	Offences against justice procedures, government security and government operations	Resist or hinder police officer or justice official (341); Breach of justice order, other (287); Breach of bail (262); Breach of domestic violence order (216)	1,106
4	Traffic and vehicle regulatory offences	Driving without a licence (343); Registration offences (230); Driving while licence cancelled, suspended or disqualified (212); Regulatory driving offences, other (208);	993
5	Acts intended to cause injury	Non-aggravated assault	561
6	Property damage and environmental pollution	Property damage, other	458
7	Unlawful entry with intent/ burglary, break and enter	Unlawful entry with intent/burglary, break and enter	415
8	Illicit drug offences	Possess illicit drug	319
9	Robbery, extortion and related offences	Aggravated robbery	201
10	Dangerous or negligent acts endangering persons	Dangerous or negligent driving	176

## 5.5 DISCUSSION OF QUANTITATIVE FINDINGS

Key findings emerging from the statistical analysis indicate that Indigenous people in the MHDCD cohort are significantly more likely to have experienced earlier and greater contact with the criminal justice system and to have experienced greater disadvantage than non-Indigenous people. Indigenous people in the cohort were significantly more likely than their non-Indigenous peers to: have been in out-of-home-care, to come into contact with police at a younger age and at a higher rate as a victim and offender, to have higher numbers and rates of convictions, more episodes of remand, and higher rates of homelessness than non-Indigenous people. Analysis of the MHDCD cohort has indicated that people with complex needs (multiple diagnoses and disability) in particular are significantly more likely to have earlier contact with police, be more likely to have been Juvenile Justice clients, and to have more police and prison episodes throughout their lives than those with single or no diagnosis.

The findings of this study indicate that Indigenous people have the highest rates of complex needs in the cohort, and that Indigenous people with complex needs are significantly more likely to: have been in OOHC, to have a lower age of first police contact, custody and conviction, to have a higher number of police convictions, to be Juvenile Justice clients and in juvenile custody, and to have a higher number of adult corrections custodial episodes than non-Indigenous people with complex needs. Indigenous people with complex needs in the cohort also have a higher average number of remand episodes than non-Indigenous people with complex needs. The data also highlights that the top four categories of offences by Indigenous people in the cohort were not in the most serious range – theft and related offences, public order offences, offences against justice procedures, government security and government operations, and traffic and vehicle regulatory offences.

Indigenous women in the cohort experienced the highest rate of complex needs. Indigenous women were significantly more likely than non-Indigenous women to have been in out-of-home care as children. They experienced their first police contact at a younger age and had a significantly higher number of police contacts and convictions across their lives than non-Indigenous women. Indigenous women were more likely than non-Indigenous women to have been in custody as juveniles. They had significantly more remand episodes and custodial episodes over their lifetime. Indigenous women with complex needs in particular have significantly higher convictions and episodes of incarceration than their male and non-Indigenous peers. They were more likely to have been homeless and to have been victims of crime than non-Indigenous women in the cohort.

This analysis confirms and extends initial findings that Indigenous women and men in the MHDCD cohort experience multiple, interlocking and compounding disadvantageous circumstances, and highlights their early and frequent contact with criminal justice agencies. The needs of Indigenous people in the cohort emerge as particularly acute and poorly serviced by past and current policy and program approaches. This quantitative analysis informs this study's broader findings in the Discussion chapter.



# 6. CASE STUDIES

## 6.1 METHOD

In order to provide an in-depth picture of the pathways captured in the aggregate quantitative analysis, de-identified case studies of Indigenous people in the MHDCD Dataset were developed. These case studies provide a narrative account of individual lived experience to a level of detail that is not available in the aggregate data. Individuals were selected for case study according to a series of specific criteria developed on the basis of the key findings of the aggregate data analyses to enable the identification of relevant illustrative cases. The depth and breadth of the MHDCD Dataset provides an opportunity to develop cases without relying on memory or estimates. These data provide details of the number, length and types of agency events and interactions as well as the observations of the officers or workers (e.g., Police, Disability, Legal Aid, Health) at the time of the event via case notes or narratives. This allows the development of a picture of the longitudinal pathways and agency-based interactions of these individuals tracked through their contact with agencies across their lives. Summarised narratives of each individual's trajectory and institutional engagement were produced. Potentially identifying characteristics have been removed or changed to ensure individuals cannot be identified.

The data on which the case studies are developed also has a number of limitations, which should be noted. First, the data used in developing the case studies was collected for administrative rather than research purposes. This means that data are only available for the times when the individual was interacting with the agencies and so is not a complete picture of all events and issues occurring at all times in the individual's life. Second, the data are derived via administrative running records including both episodes of service and where available, case notes associated with that episode. While these have reliability in terms of their immediacy to the event and their completion by agency personnel who were present during the event recorded (including Police Officers, health personnel and case workers), they capture only information relevant to the agency or function. This means that the content is necessarily shaped by the institutional context in which the data are gathered and does not capture the perspective of the individual themselves (except where recorded from the perspective of the agency personnel). Finally, the case studies are historical, variable and limited to specific time periods and therefore do not capture a lifelong picture. Instead the time span is different for each individual, determined by the data capture capabilities of the agencies over time and the point at which each individual initially came into contact with an agency providing data to the MHDCD Dataset. All case studies are compiled with available data to the point at which the data was drawn from each agency. Generally this means that data spans events from around the mid 1980s up to the date of data extraction between 2008 and 2012. Taken together these data caveats mean that the case studies provide a partial and incomplete picture of any one person's life experience. Nonetheless, the case studies are informative in providing, for the first time, a chronology and narrative of individual experiences of multiple systems' involvement which would be difficult if not impossible to obtain from any one agency or individual alone.



## 6.2 SAMPLE

The IAMHDCD project team developed 15 case studies of Indigenous individuals drawn from the Dataset based on the application of particular criteria. These criteria included combinations of Indigenous status, diagnoses, gender, history of substance use, homelessness, and agency and service system events and interactions (see Table 1 below). The sample includes five Indigenous women and ten Indigenous men who have histories of extensive contact with criminal justice and human service agencies. These case studies have been used to inform and illustrate a number of studies examining the lifecourse interactions of people with mental and cognitive disability in the criminal justice system, including McCausland, Baldry, Johnson & Cohen (2013); Baldry, Dowse, McCausland & Clarence (2012) and the nested studies outlined in the following section.

**Table 1: Indigenous Case Studies from the MHDCC Dataset**

	Case Study Name	Sex	Diagnostic Category
1.	“Matthew”	M	BID_MH_AOD
2.	“Hannah”	F	MH_AOD
3.	“Roy”	M	BID_MH_AOD
4.	“Ned”	M	ID_MH_AOD
5.	“Casey”	F	ID_MH
6.	“Alex”	M	ID_MH_AOD
7.	“Kevin”	M	ID_AOD
8.	“Michael”	M	ID_MH_AOD
9.	“Winston”	M	ID
10.	“Robert”	M	ID_AOD
11.	“Sarah”	F	ID_MH_AOD
12.	“Jimmy”	M	BID_MH
13.	“Ryan”		ID_MH_AOD
14.	“Wendy”	F	BID_MH_AOD
15.	“Michelle”	F	BID

## 6.3 PROCEDURES

Once selected, all available data relating to each individual were drawn from the sub-sets of agency data where information and a chronology of events and service interactions were compiled. This approach is identified methodologically as a form of ‘institutional ethnography’ which focuses on empirical observation of text through which technologies of social control become apparent (Smith 1999). All identifying information was then removed. Summarised narratives of each individual’s trajectories and institutional engagement were then compiled revealing the longitudinal pathways and multilevel interactions of these individuals as tracked through their contact with criminal justice, health and human services agencies across their lives. Short forms of these narratives for each individual are set out below.

## 6.4 FINDINGS – CASE STUDY NARRATIVES

### 6.4.1 Matthew

Matthew is an Indigenous man in his early twenties who was diagnosed with ‘behaviour defiance syndrome’ as a child, and subsequently diagnosed with a borderline intellectual disability with an overall IQ of 70 as well as substance use disorder. He attended school on and off until year eight but his school attendance was very poor and he effectively ceased to engage with school around year four.

Both Matthew’s parents came from highly disadvantaged backgrounds and used alcohol to excess, and Matthew was surrounded from birth with drugs and alcohol. Matthew lived between the streets and various relatives from a young age and was regularly recorded by police and community services as having ‘no fixed address’ and as being a child at risk.

At age seven Matthew had his first police event, 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 OOHC, however all his foster care arrangements broke down quickly due to his behaviour. Between the ages of seven and 11, Matthew had over 70 contacts with police as a person of interest, often for minor thefts of money and retail items (usually food) and some for more serious matters.

Matthew had hundreds of recorded police contacts for both offending and being a child at risk, and many juvenile justice orders before the age of 18. His first custodial episode was at age 10, and he went in and out of juvenile justice custody over 10 times for increasingly serious offences. He also committed offences whilst in custody, including assaults on young workers and escapes, and threatens self-harm. As an adult he has had hundreds more police events and many adult custody episodes.

Matthew 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 as his frontline ‘carers’. He receives no adequate interventions or services by relevant government agencies despite his vulnerability and homelessness from an early age. By the time he was 14 he was entrenched in this criminal justice system. He has not received disability support as a child or adult.





## 6.4.2 Hannah

Hannah is an Indigenous woman now aged in her thirties. She has a diagnosis of a depressive disorder, anxiety and psychosis, behavioural disorders, has hepatitis C and a history of alcohol and drug abuse. Hannah experienced abuse and neglect in her childhood although spent no time in OOHC. She has three children.

Hannah had many contacts with police in her youth as both a victim and offender. Hannah was frequently in contact with police for offences including motor vehicle theft, property damage, drug detection, theft and aggravated assault with associated factors of alcohol or drugs. Between the ages of 15 and 17 Hannah had numerous juvenile justice custody episodes for periods of up to six months as well as juvenile control orders, and probation with and without supervision. Hannah has had 96 police contacts recorded, 33 of which relate to domestic violence and has had hundreds of days in both juvenile and adult custody. Hannah has served numerous short remand and prison sentences as an adult.

After the birth of her first child she and her baby became homeless. She lost her public housing when she had a number of custodial episodes during which she also attempted suicide and had a number of self-harm reports. When out of prison Hannah continued to experience dozens of domestic violence episodes resulting in 17 AVOs being taken out by Hannah against her partner and her partner against Hannah. In the majority of these contacts the police note that alcohol was involved. On one occasion police were called to Hannah's place and found she had been seriously assaulted by her partner, and then arrested her for breaching community orders. On another occasion Hannah was evicted from a housing tenancy after her partner damaged the property, and soon after committed a serious offence and spent another year in custody. There were numerous reports by police to Community Services of a child at risk in the DV instances.

Hannah continues to move in and out of public housing, custody and homelessness. Hannah's regular contact with police for DV related matters began just after the birth of her first child, and intensified following the birth of each subsequent child. Police noted that Hannah is illiterate and this may assist in explaining some of her interactions with criminal justice and human service agencies; for example, her repeated offences relating to driving whilst unlicensed, and her lack of pursuing of AVOs on a number of occasions. There have been systemic failings to intervene and support her as a child and as an adult.



### 6.4.3 Roy

Roy is an Indigenous man in his thirties. He has a borderline intellectual disability with a reported IQ of 71 and has been diagnosed with a personality disorder. He has a long history of problematic drug use, including cocaine, marijuana, amphetamines and heroin, and it is this that frames the majority of his interactions with the police, corrective services and the health system. As a child, Roy lived primarily with his mother and brothers in public housing. He left school at the age of 13 after attending a special class. Roy had two periods in out-of-home care as a teenager and was often homeless.

Roy's early contact with the criminal justice system was mostly in regard to matters of petty theft and victimisation, and he was often recorded as co-offending with his brothers and a friend. As a teenager Roy was given orders that required he not go out without a responsible adult, but as he had no adult to be with him he frequently breached his orders resulting in juvenile justice custody.

Roy has had a high level of interaction with police with over 200 incidents and 46 police custody days over his life to do with family altercation and violence, travelling without a ticket, drugs, theft, break and enters, malicious damage, and breaching orders. He has been regularly recorded as homeless as an adult. He has spent over 1400 days in adult custody to date. During these custody episodes his LSI risk assessments indicate high risk, specifically for 'accommodation', 'alcohol', 'attitude', 'crime', 'employment', 'family', 'finance', and 'leisure'. He is recorded as attempting suicide. He has numerous admissions to hospital (over 100 days) for drug related, mental health and self-harm matters and has had over 5,000 days of methadone treatment.

Roy's engagement with the criminal justice system at a relatively early age appears to be significantly related to the presence of his cognitive impairment, in his co-offending with his brothers and friend and their use of his identity as an alias. His adult offending is linked to his misuse of alcohol and drugs, which also precipitated his mental health disorders. He has had minimal housing support.





## 6.4.4 Ned

Ned is an Indigenous man now aged in his forties 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 behavioural disorders, schizophrenia and mental illness related to psychoactive substance use. He is from a regional town in NSW and moves regularly around that area of the state. He has at least six 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 for theft, malicious damage and assault, accumulating numerous incidents and custody events. His first child was born when he was 18. As an adult Ned has lived in caravans with and without his family and has sometimes been itinerate. He often has AVOs taken out against him by his partner and constantly breaches them. He has a serious 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, however doctors have regularly refused to schedule him. During a prison stay when he was 35, Ned participated in a methadone program and saw a drug and alcohol doctor and psychiatrist.

Upon release from custody, Ned lived with his mother in Sydney and underwent psychiatric treatment through the Aboriginal Medical Service. He completed the 'Walking Together' Program and a TAFE course. He started to apply for and receive more services and support, including the Newstart allowance. Participation on the methadone maintenance program and treatment for drug and alcohol and psychiatric problems through Justice Health marked the beginning of a change in behaviour. His subsequent psychiatric treatment through the Aboriginal Medical Service and continuation on the methadone program led to a period of desistance from offending behaviour.

### 6.4.5 Casey

Casey is a young Indigenous woman aged in her early twenties 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 with an IQ of 64. She has a long history of self-harm, physical abuse and trauma. She has used alcohol and other drugs from a young age. After the age of 13 she barely attended school.

Casey began to be recorded by police as disturbed, suicidal and homeless in her early teens in the remote NSW town in which she grew up. 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 Community Services, the local mental health service and the local hospital recorded they could not support Casey.

Casey was a client of Community Services, ADHC, juvenile justice 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. Police noted that Casey needed medical and mental health treatment that she was not receiving. Although her mother was unable to support her, bail conditions continued to require that she live with her mother, so she constantly breached bail. The only time Casey was not recorded as being regularly picked up by police or held in detention or in hospital was during a respite placement for six months. When this arrangement came to an end, Casey resumed her frequent police contact. After this Casey was again imprisoned in juvenile justice detention and was repeatedly admitted to psychiatric facilities under the *Mental Health Act* where she was restrained and sedated.

Casey's intellectual disability and personality disorders together with her traumatic childhood appear to be the key factors precipitating her institutional contact. The pattern of frequent self-harm, assaulting carers, damaging property, absconding from the facility and resisting arrest continued until Casey accessed the Community Justice Program, a specialised intensive 24 hour supported accommodation program. This support reduces her police and other criminal justice contacts for the first time in her life, other than the six months she spent in kinship care.



## 6.4.6 Alex

Alex is an Indigenous man in his late twenties. He has an intellectual disability with a reported IQ of 69, and a long history of problematic drug use beginning at the age of six, which includes prescription drugs, amphetamines, alcohol, cannabis, heroin, methadone and buprenorphine. Much of his contact with police is related to his drug use and break and enter and robbery offences, and he is often violent. He regularly attempted self-harm from a young age. As a child, Alex attended a special class but did not continue schooling after age 12. Members of his family are known for their problematic use of drugs and alcohol. Alex had frequent short periods in out-of-home care (over 1000 days) as a child. He was regularly noted as homeless.

Alex 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 juvenile justice custody, and reports being raped during one custodial episode though there is no further record of follow up on this matter.

When he wasn't in custody Alex was mainly homeless though was on occasion provided with disability supported accommodation. He was often restrained and sedated when he attended the local hospital emergency department, usually for self harm or attempted suicide, due to his aggressive behaviour. He was often scheduled under the Mental Health Act but rarely spent more than a few days in a psychiatric

unit. After one self-harm incident, police noted that Alex stated he was being supported in a unit by a government agency that would not move him to his hometown to be near his family and this was making him depressed.

From a young age, Alex was portrayed as 'uncontrollable' and 'attention seeking' rather than as a young person in need of care and protection. Corrective Services case notes detail his illiteracy and abuse experienced in his early years that were not responded to earlier in his life. Despite extensive diagnoses, he received little effective intervention as a young person or as an adult.



### 6.4.7 Kevin

Kevin is an Indigenous man in his late thirties who lives in northern NSW. At some point in his life he was diagnosed as having an IQ of 63, placing him in the intellectual disability range. There is no data on contact with government agencies in his childhood or youth until an application to live in public housing at the age of 25. As an adult Kevin is known to police as a user of heroin, cannabis and amphetamines and for being affected by drugs and alcohol in public places, however the bulk of Kevin's interactions with police relate to his treatment of his partner.

Kevin's first encounter with police was at the age of 26, where Kevin was charged with malicious damage and trespassing in relation to his partner's property and given a fine. The following year he was convicted of theft and released with a bond. Kevin had contact with police in subsequent years as a result of altercations with his partner and allegations of him sexually and physically assaulting her. He contravened a number of domestic violence orders and was imprisoned as a result. Kevin was also involved in ongoing disputes with his partner over the custody of their children. Kevin was imprisoned for theft on one other occasion, which is recorded as relating to his drug use.

Kevin appears to have no contact with the criminal justice system as a child or young person, his offending only beginning in his mid-20s in connection with his drug use and violence towards his partner. There is no record of him receiving disability support or services as an adult.





## 6.4.8 Michael

Michael is an Indigenous man in his mid-20s. He was diagnosed as a child as having an intellectual disability with a total IQ of 54 (verbal IQ of 52 and non-verbal IQ of 65). He has a long history of substance abuse. Police records note that he began abusing substances at the age of five and throughout his life he is noted as using alcohol, cannabis, amphetamines, heroin, cocaine, petrol and glue. Michael's childhood was characterised by instability and due to domestic violence in the home he was a state ward from the age of five, living in a number of different OOHC placements. Michael is unable to read or write. He was placed in a special class at school until suspended for criminal behaviour in year five.

At the age of 11, Michael was the victim of a sexual assault by a neighbour of extended family members with whom Michael was living. After the sexual assault Michael was taken into care though he immediately absconded, and police then discovered him in a semi-conscious state in a park. Due to concerns for his welfare and because he was in breach of current bail conditions he was taken first to the police station then subsequently to the hospital as police believed he had inhaled aerosol. Michael absconded from hospital and was subsequently arrested by police and placed in the care of Community Services before running away again.

Police contact in Michael's youth primarily relates to petty theft offences and bail breaches, escalating to motor vehicle theft and break and enters. He frequently absconded from his carers or foster parents and during these periods he repeatedly offended. Upon being apprehended by police, he generally admitted his guilt freely, rarely lying in order to attempt to extricate himself from a situation. Whilst in police custody, police record a number of instances of self-harm. He also had numerous escape attempts, and frequently assaulted police whilst in custody. Michael had 163 episodes of police custody as a young person, and 25 juvenile justice custody episodes.

Michael's contact with the criminal justice system began early in his life in a context of great vulnerability and violence, and increased in association with his drug use and an escalation in the seriousness of the offences for which he was arrested. He experienced little positive intervention by child protection or disability services.



## 6.4.9 Winston

Winston is a 30 year old Indigenous man diagnosed as a child with a mild intellectual disability with a total IQ of 67 (verbal IQ of 67 and non-verbal IQ of 74). He attended a special school until the end of year 12. Winston has an extended family that features frequently in his police contacts. In Winston's early encounters with police he was almost always in the company of his brothers who both have extensive criminal histories. Throughout his contact with police he was always recorded as living with his parents. He has a history of drug and alcohol misuse.

Winston has had 121 police contacts and 16 police custody episodes, the first when he was caught shoplifting, to which he freely admitted once confronted by police. Winston's contact with police ranges from events relating to theft, with stealing motor vehicles one of the highest contributors. He is frequently picked up on trains for not having a ticket, and is often stopped and searched on the street due to police knowing him and his criminal history. Frequently when Winston is stopped and searched implements are found that are commonly used to break into cars. On numerous occasions police note that Winston changes his mind regarding his story about the implements and offers no reasonable excuse for having them in his possession.

Winston has frequently come into contact with police for causing trouble in public areas whilst intoxicated, with alcohol playing a substantial part in most of his police contacts. In one instance Winston's mother called the police when she found a bag of marijuana in his room. Winston's contact with police whilst intoxicated has frequently resulted in him abusing, threatening and assaulting police. Winston has also come to the attention of police as a victim of assault. In most of the instances where Winston has been the victim and the police have been called, within the next few days police note that Winston has retracted any statements he has made about the incidents.

Winston has a relatively stable family environment residing in one regional town, and in numerous instances his bail conditions stipulated that he resides with his parents. Subsequent police checks confirm his adherence to this. Despite the apparent influence of his older brothers, Winston's offending never progressed to the level of serious offences and while being a juvenile justice client he was never in juvenile justice custody. Alcohol plays a substantial part in Winston's ongoing contact with police.







## 6.4.10 Robert

Robert is an Indigenous man in his late 30s. He is identified as having a mild intellectual disability with a total IQ of 67 (verbal IQ of 68 and non-verbal IQ of 72). Robert lacked parental involvement in his early life although he was not placed in OOHC. The police event narratives indicate that there was alcohol misuse by his parents and he spent some time in the care of his aunt and other extended family members. Robert attended three different schools before leaving in year eight. Police note Robert's drug use from the age of 14, beginning with cannabis and sniffing solvents and progressing to heroin and cocaine.

At the age of 11 Robert had his first contact with police when he was arrested for stealing, and his offences progressed from stealing in his youth to bag snatching, break and enters and drug offences in his teens. He had six juvenile justice custody episodes. Robert has had frequent contact with police in inner Sydney, primarily in connection with his drug misuse. He has had 143 police contacts, with 35 episodes of police custody. Police noted on one occasion that when Robert was arrested they recognised that he has a disability, and when legal representation could not be found for him, a charge of break and enter was not pursued. As Robert grew older his interactions with police began to be characterised by his becoming violent, and when he was 20 he seriously assaulted a police officer.

Records indicate that Robert is a client of ADHC including its Community Justice Program. Robert is reported as having limited communication skills, difficulty comprehending issues, difficulty in planning and being easily led by others. His drug use is a primary factor in his offending.



## 6.4.11 Sarah

Sarah is an Indigenous woman now in her late twenties. Over the course of her life she has been diagnosed with intellectual disability, foetal alcohol syndrome disorder, epilepsy, acquired brain injury and a range of mental health disorders including depression, schizophrenia and post traumatic stress disorder. She has a history of sexual abuse, self-harm, and drug and alcohol misuse. Between the ages of 16 and 24 years Sarah was admitted to hospital on 49 occasions. She had no contact with the juvenile justice system and did not receive disability related services.

Sarah was raised by her grandmother along with her two brothers. When she was 14 she alleged she was repeatedly sexually assaulted by a neighbour. When police investigated, they found that Sarah was an 'unreliable witness' due to inconsistencies in her recounting of the incident and no charges were laid. This response comes to characterise virtually all her subsequent reports of sexual assault and victimisation. From 15 years of age Sarah was under the care of the Community Services due to her 'vulnerability' and 'concern for her living circumstances'. She resided in youth refuges interspersed by instances when she absconded and returned to her grandmother's house for short periods. At the age of 18 she came under the Protective Services Commissioner for financial management.

From age 10 to 24 Sarah had 129 police contacts in which she was identified as a victim of crime, including sexual assaults, domestic violence and property related offences – including an incident in which she was robbed of her disability support payment as she exited the office of the Protective Commissioner. As an adult Sarah was charged with 12 criminal offences including property damage, driving without a license, non-aggravated assault and resisting arrest. She served three short sentences averaging 33 days each in adult correctional custody, with self-harm incidents noted on each occasion.

Sarah experienced violence in a series of relationships beginning in her late teens, including with a known drug dealer. Police were regularly called to domestic violence related incidents between Sarah and her partners, and were recorded as having discussed the use of AVOs with Sarah and the possibility of her pressing charges against these perpetrators. AVOs were rarely taken out as Sarah's partners were also her carers and she indicated she would be unable to manage without their 'care'. Sarah pressed charges only once, resulting in her partner being charged and appearing in court, at which point Sarah refused to give evidence against him, again stating that she 'needs him at home'. Despite extensive notations relating to her intellectual disability and mental health disorders in police records, there is only one instance in which a support person is called to the police station to assist her.



## 6.4.12 Jimmy

Jimmy is an Indigenous man now in his late twenties. He has been diagnosed with borderline intellectual disability, an acquired brain injury, a number of mental health disorders including schizophrenia and psychosis. Jimmy also has epilepsy and a history of non-compliance with medical treatments and self-harm. Jimmy came to the attention of Community Services at the age of five, with reports indicating that he had been sexually and physically assaulted by his mother's partners. As a young person it is recorded that Jimmy had abused his two younger brothers. Jimmy left school at the age of 16, though police indicate that he had little education.

As a young person Jimmy resided intermittently with his mother and aunties and numerous foster homes, and was frequently reported by police to be homeless. Jimmy's early contact with police was as a result frequent counts of theft, malicious damage, and threatening and assaulting his carers and other young people in care or in the special school he attended. He had four episodes in juvenile justice custody. Records indicate that Jimmy suffered multiple instances of physical and sexual assault whilst in juvenile detention.

By his late teens Jimmy's offending included frequent break and enters, stealing and motor vehicle theft, generally committed in company with other young men. At times Jimmy informed police that he was compelled to commit these break and enters or face being assaulted by the other men. There are numerous allegations made against Jimmy about him exposing himself and sexually assaulting younger boys in the group homes in which he was residing.

By the time Jimmy was 18 he was frequently referred to in police narratives as being homeless and the police often noted he was under the influence of marijuana or alcohol. At 18 Jimmy had an epileptic fit during which he sustained a brain injury. When Jimmy was aged 20, police use section 24 of the *Mental Health Act* to apprehend him after he attempted to hang himself. A number of days after this event, Jimmy's carer became concerned after he refused his medication for two days and he began making threats and self-harming. As a result he was taken to a psychiatric hospital where he was refused admission. Carers then took him to a police station where the police decide to again use section 24 of the *Mental Health Act* and took him back to the same psychiatric hospital for assessment and admission. He is not recorded as receiving any disability support or services.



### 6.4.13 Ryan

Ryan is an Indigenous man in his early thirties. Over his life has been diagnosed with borderline intellectual disability and a number of mental health disorders, some connected to long-term drug misuse. Ryan was a state ward from the age of five and spent the majority of his childhood in OOHC, involving 27 distinct foster care placements. Ryan did not complete schooling beyond year 5. Police describe him at 11 as 'very emotionally disturbed' and as having experienced 'physical and psychological abuse'.

Ryan's contact with police began at 9 as a missing person. He was recorded as a missing person 18 times prior to his first criminal charge aged 11. Ryan's police contacts then shifted from relating to absconding from his residence to offences of property damage and assault against care workers. At 11 he had his first custodial episode after police assessed bail as being 'inappropriate', with the reason for remand recorded by juvenile justice being 'lack of community ties'. Ryan subsequently had 185 charges recorded, resulting in 38 periods in juvenile justice custody and 7 in adult custody, both on remand and sentenced. From the age of 12, bail breaches began to become a dynamic in Ryan's criminal justice pathways, with Ryan's carers notifying police when he absconded from his residence, resulting in him being breached and spending longer periods on remand in juvenile justice custody. These longer periods spent on remand marked the beginning of Ryan's self-harm in custody.

By the age of 15, Ryan's care-related offending had ceased and he increasingly came into contact with police for theft, motor vehicle and driving offences. From this time Ryan cycled in and out of custody frequently, with the longest period he was out in the community being six months. Ryan's self-harm in custody was particularly frequent and severe during the weeks prior to his 18th birthday. On the eve of his birthday, Ryan reportedly tried to self-harm and offend so he could be transferred to an adult correctional facility, with police notes stating that he 'claimed that his grandfather and father had both killed themselves in Corrective Services and now it was his turn'.

There is no record of him receiving disability support services as a child or adult.





## 6.4.14 Wendy

Wendy is an Indigenous woman in her early forties. She has been diagnosed with moderate intellectual disability and recorded as having 'brain damage' and a range of mental health disorders, mostly in connection with her use of cannabinoids.

Wendy's first police contact was at 13 years of age for theft, and then at 14 as a missing person. Wendy's offending primarily related to property theft and damage, assault, and breach of bail. Wendy has had 330 recorded contacts with police as a person of interest and 240 charges against her over 25 years. She has had 39 periods of adult custody, primarily on remand. Her longest period of incarceration (13 months) was for breach of a parole order that required that she reside at a drug rehabilitation centre. Wendy has been charged with 127 offences in custody, primarily for intimidation, disobeying directions and abusive language, with only two of these being dismissed for lack of evidence. She was also recorded as being the victim of violence and self-harming in custody.

Much of Wendy's contact with police has been in public spaces, with her alleged offending occurring in train stations, churches, beaches and fast food restaurants. They mostly related to theft, although she also reportedly threatened or used violence against others in order to steal from them. In relation to a number of such incidents the police decided to take no further action, due to the wishes of victims and police recognition of her intellectual disability and mental ill health. Despite the absence of charges, the frequency of her contact with police contributed to a narrative about her criminality in police records.

Early in her adult life Wendy was recorded as having no fixed permanent address. At the age of 31 she began living in disability supported accommodation with case management and behaviour intervention and support following a period of involuntary confinement in prison and in a mental health facility. From that time on, she moved between prison and various supported disability accommodation settings and locations: group homes, hospital based large scale accommodation and specialist forensic community disability supported accommodation with 24 hour supervision. Wendy had regular police contact in relation to property damage and assault against disability support service staff. Wendy regularly breached orders that required her to reside at disability accommodation and/or follow the direction of her case manager and other staff, requiring police notification. Support staff have been recorded as active in encouraging police not to press charges around property damage. She received 17 section 32 orders as an adult. The most recent police contact recorded in the data related to her being a victim of domestic violence perpetrated by a co-resident at the disability supported accommodation where she was residing.



### 6.4.15 Michelle

Michelle is an Indigenous woman in her early thirties. She grew up in a coastal town in very disadvantaged circumstances. She was taken into kinship care when she was three. Michelle was expelled from school at 15. She has a borderline intellectual disability that was not diagnosed until she was 23 years old.

Michelle came into contact with police at nine as the victim of an assault, and then as a person of interest in relation to a theft the following year. She was arrested at 13 for theft, with her case dismissed with a caution. Aged 14 she was charged with a number of counts of theft, resulting in her being given bail conditional on her residing at home with her mother and not being out at night. Soon after she was found at night in a tent in a caravan park, and ended up in juvenile justice custody. Police began to be regularly called after instances of violence perpetrated by Michelle, resulting in an AVO in one case which referred to her being often affected by cannabis and alcohol. Soon after, while Michelle was subject to bail conditions requiring her to be in the presence of her father when not at home, Michelle was arrested for offensive language, and reportedly assaulted police when they restrained her. She was then charged with offensive language, assaulting police and breaching bail conditions and spent more time in juvenile justice custody. Her contact with the criminal justice system for theft, violence and breach of bail conditions increased throughout her teenage years.

Just after being expelled from school at 15, Michelle came into contact with police after a man paid her for sex and then for stealing a car with friends and driving to Sydney. She was held in remand in juvenile justice custody before escaping and then returning of her own accord a week later. Her cycling in and out of prison continued into her twenties. Whilst she was in custody aged 21 she alleged that when she was 16 or 17 she had been sexually assaulted by a man who had broken into her boyfriend's parents' house where she was staying. Police records stated that it appeared Michelle 'is suffering from either a mental illness or a reaction from a drug. Her letter does not make any sense and is extremely hard to understand' and no further action was taken. Michelle made a further identical allegation four months later which again was not followed up. Michelle continued to have contact with the police for theft, offensive language and violence-related offences as an adult, and received increasingly lengthy custodial sentences. There is no record of her receiving disability services.



## 6.5 CASE STUDIES DISCUSSION

Thematic and scholarly discussion of some of these case studies has been published in a number of peer reviewed journal articles and further publications are in train. These case studies provide individual narrative accounts of Aboriginal people with mental and cognitive disability who have had histories of contact with the criminal justice system, detailing particular conditions and experiences. They flesh out the events and incidents evident in the qualitative analyses. Together the case studies highlight the breadth and depth of social need and disadvantage experienced by Aboriginal people with mental and cognitive disability. They reveal the systemic arrangements positioning the individuals to have early and regular contact with criminal justice agencies and to experience systemic racism in particular. Significant disadvantage, vulnerability and risk factors are evident from childhood in all of these case studies, including poverty, the presence of drug and alcohol misuse and violence in the family context, episodes in kinship and OOHHC, early school disengagement, and early contact with police both as a victim (often of violence) and as an offender. These do not appear to trigger adequate responses from community-based services or any sustained support. The case of Matthew in particular exemplifies how a child can be identified by police and community services as at risk because he is moving between various relatives and institutional care, and living on the street, but where there is no evidence of early intervention by any service. The case studies highlight the lack of available and appropriate intervention or support for Aboriginal children and adults with multiple and complex support needs, precipitating their common experience of enmeshment in the criminal justice system.



## 7. NESTED STUDIES

A number of nested studies have been undertaken during this project by affiliated researchers drawing on the MHDCD Dataset. The results of those studies are summarised here.

### 7.1 ABORIGINAL WOMEN WITH MENTAL HEALTH DISORDERS AND COGNITIVE DISABILITY IN THE CRIMINAL JUSTICE SYSTEM

Elizabeth McEntyre is an Aboriginal woman from the Worimi and Wonnarua peoples of the eastern coast and Hunter Valley of NSW and a mental health social worker. Elizabeth was the Australian Postgraduate Award Industry recipient for the IAMHDCD project, studying under the supervision of Professor Eileen Baldry. The MHDCD Dataset revealed that Australian Aboriginal and Torres Strait Islander women with mental health and wellbeing issues and/or cognitive impairment (including intellectual disability and acquired brain injury) had contact with the criminal justice system, including the police, courts and prison, at much higher rates than other groups. Elizabeth's PhD research, nested within the IAMHDCD project, concentrates on the lived experiences of these Australian Indigenous women in both the NSW and NT criminal justice systems.





## 7.2 MHDCD GEOGRAPHIC DISTRIBUTION STUDY

As part of the IAMHDCD Project, a study was undertaken to investigate concentrations of disadvantage by examining the geographic distribution of members of the MHDCD Dataset cohort, providing comparison on the basis of Indigenous status and gender (Baldry, McCausland & Xu 2013). All 2731 individuals in the MHDCD Dataset were included in the study. Areas of concentration of the cohort by suburb/town as well as postcode were identified from the data gathered by government agencies on residential addresses. The study investigated whether there were different patterns of distribution and concentration for women and men, Indigenous and non-Indigenous people, and Indigenous women and men. Broader literature in the field was drawn on to give context for these findings, providing analysis of what the findings contribute to the understanding of the experiences and needs of vulnerable people in the criminal justice system.

The unit of analysis used to measure geographic distribution in this study was the unique combination of individual and suburb/town. The study measured each unique count of individual and suburb/town recorded in the MHDCD Dataset over each individual's lifecourse until 2009. Multiple addresses recorded for an individual in one suburb/town were only counted once. Addresses used in the count were gathered from a variety of data sources, primarily records of NSW Police, Corrective Services and Housing NSW. Every unique combination of individual and suburb/town found in the data was calculated, from individuals' earliest contact with a criminal justice agency or public housing. Addresses relating to correctional centres were removed.<sup>11</sup> Records of individuals having no fixed place of abode (NFPA) were also removed from calculations. While such records reflect the common experience of homelessness for people in this cohort, the acronym is not recorded consistently or rigorously enough by various agencies to draw robust research conclusions. Analysis was undertaken at both the postcode and the suburb/town level. The finest granularity available for analysis was used where possible, which in most cases was at the suburb/town level. However, for certain purposes postcode level analysis was used where that was the finest granularity available. Utilising suburbs and postcodes, the locations in which all individuals in the cohort have resided over their lifetimes was plotted, providing information about the locational distribution of the cohort and sub-cohorts in particular geographic areas. The most important findings relate to suburb/town level.

There are several limitations associated with the data utilised in this study which should be noted. Due to restrictions associated with the varying quality and method with which different agencies record data and challenges associated with data linkage projects such as the MHDCD Dataset, this study could not at this time provide evidence of the movements of the cohort and sub-cohorts over time to and from certain places. The compilation of individual case studies allows for the tracking of such pathways, and this is an area for future research. In addition, the level of granularity allowed for in this study – at the suburb level where possible – while more detailed than much previous research, is still not fine enough to highlight the different experiences that can occur within these spatial locations, which, particularly in inner city Sydney, can be marked.

<sup>11</sup> This was done so that correctional centres were not counted as residences, however it is important to note that the appearance of correctional centre addresses can indicate insecure housing or homelessness.

## 7.2.1 Geographic Distribution Study Findings

This study presents a preliminary picture of the geographic distribution and concentration of a specific group of vulnerable people in NSW, all of whom have been in prison and a significant number of whom have been diagnosed with one or more mental health disorders and/or cognitive impairment. Concentrations of people who have been in the criminal justice system have been identified in particular suburbs and areas, with significant variance on the basis of gender and Indigenous status. The study finds that Indigenous people in the cohort, and Indigenous women in particular, have lived in significantly higher numbers of different but concentrated number of suburbs and towns over their lifetimes. This confirms and adds significant evidence to Baldry et al's (2006) findings that Indigenous women post-release had the highest rate of moving often.

This study differs from earlier research that sought to highlight concentrations of socio-economic disadvantage in Australia in that it is not a population-wide sample; it draws on a purposive sample of people who have been in prison in NSW. It is also the first to analyse this geographical distribution by the number of different places people have lived as well as by suburb and town, not just postcode. It contributes to the body of research on distribution of disadvantage, and demonstrates that there are concentrations of people in particular geographic locations, who experience multiple and compounding difficulties and often become enmeshed in the criminal justice system. It highlights suburbs and towns that are under great strain to support some of NSW's most vulnerable people. This study provides insight into such concentrations, and gives specific detail on the towns and suburbs needing policy and program attention.



The key findings of this study are:

### **Concentrations in key areas**

There are clear concentrations of individuals in the MHDCD Cohort in the inner city suburbs of Sydney, in some key regional towns, and in suburbs in the west and south west of Sydney. This supports and enhances earlier research that highlighted postcode disadvantage by various measures of socio-economic inequities, and reveals the depth of geographic concentration of those in contact with the criminal justice system. What is interesting and unique about this study is the evidence of concentration in specific suburbs and variances in concentration between members of the cohort on the basis of gender and Indigenous status.

Drawing on our research on the MHDCD cohort, we can surmise that there could be various contributing factors to these patterns of distribution and concentration:

- The suburbs and towns identified from which most of the people in the MHDCD Cohort come and return to are areas containing clusters of public and community housing that are often lacking support and services to respond appropriately to the compounded disadvantage experienced by many of those living there;
- People in the MHDCD Cohort may be moving to certain suburbs (such as those in the inner city that feature heavily) or towns (such as the key regional centres identified) to access specialised services (such as homeless, medical and disability), support and transitional housing;
- There may be over-policing of people in the MHDCD Cohort in those suburbs or towns, and of Indigenous people in particular;
- There may be movement to/away from a small number of particular suburbs or towns to be with or away from family and community, including in association with Apprehended Violence Order conditions and parole restrictions.

## Significance of movement

This study demonstrates that a majority of people in the MHDCD Cohort have lived in a relatively small number of suburbs/towns although they may move often within a particular suburb or town. There is also a smaller number of highly mobile individuals who have been observed in a large number of suburbs/towns although still in the circumscribed places featuring in the top 50 places in this analysis. Earlier research on the cohort showed that individuals in the MHDCD Cohort have high rates of moving often characterised by moving in and out of prison and between primary, secondary and tertiary homelessness (Baldry et al, 2012). Though this particular address based study was unable to explore rates of homelessness, it is important to note the high rate of recording of NFPA, correctional centres, transitional or crisis accommodation providers as the address given by individuals in the cohort during their contact with Police and Corrective Services NSW.

## Influence of gender and Indigenous status

Analysis conducted in this study demonstrates that gender and Indigenous status are both important influencing factors on the number of unique suburbs/towns ever lived in by people in the MHDCD Cohort. The study finds that being Indigenous has a more pronounced effect on having lived in more places for females than males. Gender and Indigenous status are both strongly associated in a statistically significant way in the distribution of addresses on the suburb level. Suburb and gender are strongly associated in a statistically significant way in the distribution of addresses at the suburb level for the Indigenous sub-cohort. This indicates that Indigenous people and Indigenous women in particular are more mobile across suburbs than others in the MHDCD Cohort.

Indigenous people in the MHDCD Cohort have lived on average in 1.2 times more suburbs/towns than non-Indigenous people. The concentration of Indigenous people in certain suburbs/towns is markedly different from the concentration of non-Indigenous people, with clusters of Indigenous people in the cohort in inner city suburbs and key regional centres/towns. Thirty five per cent of Indigenous people have lived in one or more of just 3 suburbs and towns.

## Indigenous women

On average Indigenous women have lived in more postcodes than Indigenous men. The difference in average number of postcodes ever lived is statistically significant. On average, Indigenous women have lived in 1.4 times more postcodes than Indigenous men and 40.9% have lived in one or more of just 3 adjacent suburbs, indicating extreme concentration. The difference within the Indigenous group in relation to gender is more significant than that for the full cohort.

Past research has highlighted the particular invisibility and vulnerability of Indigenous women in the criminal justice system (Baldry and McCausland, 2009). One of the major contributing factors is the lack of data highlighting the specific needs and experiences of Indigenous women. This study provides evidence of the distinct geographic concentration of Indigenous women, and confirms Indigenous women as the most highly mobile and disadvantaged group.

## Policy implications

This study makes a unique and valuable contribution to understanding the specific location and concentration of people in the MHDCCD Cohort. It provides sufficient detail for government agencies and NGOs providing services and support to people such as those in the cohort to reflect on and respond to possible mismatches between service availability and need, and also other under-examined aspects such as differences on the basis of gender and Indigenous status.

The findings have particular relevance for the emerging understanding of vulnerable people in the criminal justice system and in the community. It adds important understanding to the work research bodies such as the Urban Institute in the USA have done that revealed over the past decade that certain communities were overwhelmed by returning ex-prisoners who needed employment, mental and other health services, housing and community support (Travis 2005). This current study provides evidence of the concentrations of Indigenous women and men in particular experiencing multiple vulnerabilities relating to drug and alcohol abuse, mental health and cognitive disabilities, histories of trauma and abuse who cycle in and out of prison with little support or specialised services.

## 7.3 THE SPRINT PROJECT – PRIMARY HEALTH CARE BETTER MEETING THE NEEDS OF ABORIGINAL AUSTRALIANS RELEASED FROM PRISON

Dr Jane Lloyd is an NHMRC Postdoctoral Research Fellow at the UNSW Centre for Primary Health Care and Equity who drew on the MHDCD Dataset to investigate the primary health care needs of Indigenous Australians transitioning from prison back to the community. The aim of the SPRINT Project was to develop culturally specific understandings of how primary health care services can better meet the health care and social support coordination needs of Aboriginal Australians after release from custody to the community, with a view to reducing ill-health and re-imprisonment and improving quality of life and wellbeing. The study found that there was inadequate continuity of comprehensive health care in the context of Aboriginal inmates' complex needs and significant emotional distress and anxiety. While the health and social support needs of Aboriginal inmates released from custody are high, post release support is not universally or immediately available to all former inmates and no one agency is responsible for post release care. In terms of health, the study found that Aboriginal people are not accessing timely and appropriate primary health care in the community and often delay seeking treatment until hospitalisation is required and that more needs to be done to support Aboriginal people released from custody to access primary health care immediately and over a longer period post-release.

During transition from custody to the community, Aboriginal former inmates were found to experience high vulnerability, trauma and emotional distress, have high medical and mental health and wellbeing needs, high risk of illness and injury, and increased risk of relapse to substance misuse and risky behaviours post release. They also have a strong need to reconnect with family, community and culture. While access to post-release care for Aboriginal Australians was found to be especially important, so too what happens in the five years post release and the extent to which institutions such as hospitals and mainstream primary health care services meet the specific needs of Aboriginal Australians was identified. Transitional support after release from prison was found to be critically important to Aboriginal people's adjustment to community life and therefore requires specific attention. The lack of transitional support was found to leave Aboriginal peoples and family members unsupported, prevent access to timely and appropriate primary health care and increase the risk of reincarceration. All of this contributes to the higher risk of injury and illness experienced by Aboriginal peoples post-release, and to the institutionalisation of Aboriginal peoples within and outside the criminal justice system. The report outlined that transitional support must be: coordinated and intensive; immediate; of longer duration; comprehensive and multi-faceted; systematically available to all; and culturally informed and appropriate, involving family, Aboriginal Elders and community members.



## 7.4 THE IMPACT OF COMPLEX NEEDS ON POLICE CONTACT AND CUSTODY FOR INDIGENOUS MEN

An honours thesis submitted in 2012 by Julian Trofimovs under the supervision of Assoc Prof Leanne Dowse – “Indigenous Males with Intellectual Disability and Police Contact and Police Custody: At the Intersections” - drew on the MHDCD Dataset to investigate the impact of complex needs on police contact and custody for the Indigenous men. The intention of the thesis was to provide greater insight into the significant over-representation of Aboriginal men with complex support needs in police arrests to indicate ways in which this practice might be reduced significantly. Through an analysis of aggregate data concerning a cohort of Indigenous males with intellectual disability, this study identified four significant factors that alone or in combination appear to impact on the frequency with which these men experience police custody. These include: young age at first police contact, instability in early life, the problematic use of alcohol and drugs, and mobility across geographic areas. These factors were contextualised and exemplified in the lives of several individuals presented in the case studies in order to create a real life context for the study and its findings. Early recognition of disability was found to be imperative in addressing the rates of police contact and custody for this group. At a practical level the study concluded that recognition is best addressed at three levels: the school, the local community, and in police practice.

## 7.5 THE USE OF SECTION 32 AS DIVERSION FOR PEOPLE WITH COMPLEX NEEDS IN THE NSW LEGAL SYSTEM

A project addressing the use of Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) for individuals in the MHDCD Dataset was undertaken by Ms Linda Steele, Assoc Prof Leanne Dowse and Mr Julian Trofimovs. The resulting report ‘Section 32: A Report on the Human Service and Criminal Justice Pathways of People Diagnosed with Mental Health Disorder and Cognitive Disability in the Criminal Justice System Who Have Received Orders Pursuant to Section 32 of the Mental Health (Forensic Provisions) Act 1990 (NSW)’<sup>12</sup> explored the patterns of the use of orders made pursuant to s 32 for individuals diagnosed with mental health disorder and cognitive disability who come before the Children’s and Local Courts in NSW as a result of an offence, and their demographic characteristics and longitudinal human service and criminal justice pathways. The study found relatively low numbers of section 32 orders as a proportion of convictions for those in the cohort overall, with slightly higher usage for Indigenous males. Indigenous Australians who have been the subject of section 32 orders were shown to have more complex diagnoses, higher prevalence of ABI, higher levels of criminalisation and marginalisation and to have limited access to disability services when compared to non-Indigenous Australians in the section 32 cohort. Significantly, the study identified that receiving a s 32 order may not mean an end to criminalisation or incarceration of an individual over the life course, suggesting its limited utility in addressing long term and multilayered criminalisation and early and ongoing social marginalisation. This highlights the need for ongoing attention to non-criminal legal and systemic approaches to safeguarding this group from lifelong enmeshment in the CJS.

A PhD thesis submitted in 2014 by Linda Steele under the supervision of Assoc Professor Leanne Dowse and Assoc Prof Arlie Loughnan (University of Sydney) “Disability at the Margins: Diversion, Cognitive Impairment and the Criminal Law” expanded the analysis of the use of s 32. Combining empirical analysis of the MHDCD Dataset with other empirical data and case studies, the thesis is an interdisciplinary theoretical and empirical analysis of this diversionary mechanism whose central argument is that section 32 enables the criminal legal regulation of individuals with cognitive impairment who are otherwise beyond such regulation because they exceed the limits of trial, conviction and sentence. The thesis identifies a number of effects of this regulation: that it furthers the criminalisation of individuals with cognitive impairment in the criminal justice system, marginalises the social, political, historical, material and institutional dimensions of the identities, circumstances and criminal justice pathways of individuals with cognitive impairment, promotes associations between cognitive impairment and deviance, risk and the need for management, and contributes to the ordering of the criminal law jurisdiction. The thesis’s analysis suggests that while diversion and cognitive impairment currently sit at the margins of critical legal scholarship, the issue should be located at the core of critical and political engagements with the criminal law.

<sup>12</sup> [https://www.mhdcd.unsw.edu.au/sites/www.mhdcd.unsw.edu.au/files/u18/Steele%2C%20Dowse%20and%20Trofimovs%20\\_MHDCD%20Section%2032%20Report.pdf](https://www.mhdcd.unsw.edu.au/sites/www.mhdcd.unsw.edu.au/files/u18/Steele%2C%20Dowse%20and%20Trofimovs%20_MHDCD%20Section%2032%20Report.pdf)





## 7.6 A COMPARATIVE ANALYSIS OF CRIMINOGENIC PROFILES OF OFFENDERS WITH COMPLEX NEEDS

A masters thesis submitted in 2012 by Intan Bailey under the supervision of Assoc Prof Leanne Dowse and Prof Alex Blaszczyński (University of Sydney) “On the borderline:

A comparative analysis of the criminogenic profiles of offenders functioning in either the intellectual disability or borderline intellectual disability range, and those with ‘complex needs’”. The thesis utilised analysis of the MHDCD Dataset, in particular the Level of Service Risk Inventory-Revised profiles of a selected sub-group of those with ID and BID in the cohort to determine whether the current practice of disability services within NSW of distinguishing offenders with intellectual disability from offenders with borderline intellectual disability, in order to determine post-release service allocation, is empirically justified. A further aim was to ascertain the extent to which the criminogenic profiles of offenders with ID and offenders with BID may vary depending on the presence of mental health disorders and/or substance abuse problems. The study found that offenders with ID and BID share the same medium-high risk of re-offending with those with BID having significantly more order breaches. The two most important influences on recidivism for both study groups were found to be education/employment and alcohol and/or other drug use. The findings of the study suggest that the current categorisation of offenders functioning in the ID or BID ranges as two separate groups for the purposes of service allocation are not empirically justified and that offenders with BID, a group largely characterised by complex support needs remain under-recognised, vulnerable and marginalised.

## 7.7 COMPLEX NEEDS AT THE INTERFACE OF HUMAN AND JUSTICE SERVICES

A PhD thesis to be submitted in 2016 by Alexander Sewell under the supervision of Assoc Prof Leanne Dowse and Dr Tony Eardley, this work sits at the intersection of social policy, criminology, public policy and implementation studies and considers the policy significance of people who are have ‘complex needs’, who experience a range of intersecting social issues that are both within and outside of the remit of responding agencies. Utilising the MHDCD Dataset, this study developed a range of detailed life course case studies for individuals who are both Indigenous and non-Indigenous, and includes individuals with and without intellectual disabilities. The study explores patterns of interactions between people with complex needs, social services and the criminal justice system, and develops a theoretically robust conceptualisation of complex needs as relational, as the product of interactions between multiply disadvantaged individuals and the agencies enacting policy and locates the problem of complex needs not only in the individual experiencing multiple forms of disadvantage but also in the policy and service responses that the person experiences. The findings of the thesis will inform social and other policy responses to people with complex needs in the human and justice service systems.

## 7.8 CRIME VICTIMISATION OF PEOPLE WITH COMPLEX NEEDS WHO ARE THE VICTIMS OF CRIME: BUILDING EVIDENCE FOR RESPONSIVE SUPPORT

This project, funded by NSW Department of Police and Justice and conducted by Assoc Prof Leanne Dowse, Assoc Prof Kimberlie Dean, Julian Trofimovs and Dr Stacy Tzoumakis utilised the MHDCD Dataset to provide a detailed description of the nature and experience of crime victimisation for an identified group of people with complex needs in NSW, including those who have intellectual disability and mental health disorders and other co-occurring experiences of social disadvantage and who have been in the criminal justice system as offenders. Through interview and consultation with key organisations delivering services or representing the interests of this group, the project has also explored the current context of service delivery in NSW, identified key current challenges in providing responsive, appropriate and adequate support to this group and identified current gaps and innovative or best practice where it currently exists. Findings suggest that victimisation is very common in the lives of people with complex needs who offend and that violent victimisation occurs at a higher rate for women, Aboriginal Australians, those with a history of homelessness and those who had experienced custody as a juvenile. Aboriginal Australians on average experience their first victimisation at a younger age than non-Aboriginal people. Findings also suggest that it is not simply the presence of a disability that increases vulnerability to victimisation, but rather the interaction of multiple and compounding disability and social disadvantage operates to increase vulnerability to violence. Interviews with representative and service provider organisations identified barriers to the provision of responsive and appropriate services for this group. These barriers include a general lack of capacity of mainstream support services to cater to the needs of this group, poor communication and awareness of services that are available, low levels of identification and engagement of people with complex needs in services generally, restricted availability and accessibility of services and the reluctance of people with complex needs to engage who generally have had poor experiences with services in the past. Enablers for better responses were identified as service flexibility and accessibility, proactive and outreach service models, which require workers skilled in the recognition, identification and assessment of victimisation and its impacts on those with complex needs.

## 7.9 REPORT FOR NSW ADHC ON PEOPLE WITH INTELLECTUAL AND OTHER COGNITIVE DISABILITY IN THE CRIMINAL JUSTICE SYSTEM

This study, funded by NSW Ageing, Disability and Home Care (ADHC), outlined the key findings derived from the MHDCD Dataset in relation to the members of the cohort with intellectual and other cognitive disability. It found that Indigenous Australians have higher rates of intellectual disability at 65% when compared to 54% of the whole cohort. 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 were also found to 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. Indigenous persons with a CD were found to be 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. The study found 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. The cognitive and complex needs groups in the study were found to 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.

[https://www.adhc.nsw.gov.au/\\_\\_data/assets/file/0003/264054/Intellectual\\_and\\_cognitive\\_disability\\_in\\_criminal\\_justice\\_system.pdf](https://www.adhc.nsw.gov.au/__data/assets/file/0003/264054/Intellectual_and_cognitive_disability_in_criminal_justice_system.pdf)

## 7.10 REPORT FOR HOUSING NSW ON PEOPLE WITH MENTAL HEALTH DISORDERS AND COGNITIVE DISABILITIES IN THE CRIMINAL JUSTICE SYSTEM – IMPACT OF HOUSING NSW INTERVENTIONS AND CONTACTS WITH SOCIAL HOUSING SYSTEM

This study, funded by Housing NSW, is a profile and description of the MHDCD cohort with analysis of the presence of Housing NSW clients amongst members of the cohort followed by a range of case studies on individuals in the Dataset. The study found that older persons, females, Indigenous Australians, people without a school certificate, those people who were a tenant as a child, people who have been homeless, ADHC clients, and persons with mental health disorders (i.e. those who have ever been subject to the Mental Health Act) are all more likely to be a housing tenant than those without these characteristics in this cohort. Those in the MHDCD cohort who have also been clients of Housing NSW are more likely to have complex support needs, to have had earlier contact with police, to have been in OOH, to have been clients of Juvenile Justice, and to have more ongoing contact with the criminal justice system than those who have not been clients of Housing NSW. Those with complex needs, in particular those with a combination of mental and cognitive disability, were far more likely to have ever been a housing tenant than those with only one or no disability or disorder. Those with complex needs including an AOD use problem were more likely to have ever been evicted. Those who have ever had a housing tenancy were found to be likely to spend less time in prison than those who have never been a Housing tenant.



# 8. QUALITATIVE STUDY

## 8.1 METHOD

The theoretical framework set out in section 3 of this report has infused and guided the project's research process. In particular, it provides a touchstone for the protocols and practices used in the qualitative phase, and its objectives of developing an Indigenous-informed perspective on the nature and meaning of 'disability' and 'offending' and on the identification, assessment, diagnosis and treatment of mental health disorders and support and resources for people with cognitive disability. This gives rise to a conceptual model and framework for research across criminal justice and human service systems to address duty of care and community safety issues, and the human rights of Indigenous persons with MHDCD.

The IAMHDCD Project has been committed to practising inclusion of and respect for Indigenous peoples and privileging Indigenous voices and knowledge in conducting this study. This involves respecting Indigenous knowledge systems and processes; recognising the diversity and uniqueness of people as individuals; respecting and preserving the intellectual and cultural physical and knowledge property rights of Indigenous peoples and communities; and involving Indigenous researchers, individuals, organisations and communities in research as primary collaborators. The lived experiences of Indigenous peoples are the explicit focus of this strand of the Project and therefore engagement with Indigenous individuals, organisations and communities has been the utmost priority throughout the qualitative study.

## 8.2 PROCEDURE

The approach undertaken in the qualitative study involved five phases:

1. Consulting key stakeholders in Indigenous-informed research
2. Establishing Indigenous Community research partnerships
3. Data collection in communities
4. Analysis, verification and validation of findings with communities
5. Development and presentation of education and advocacy resources to communities

Considerations and procedures used in each of these five phases are set out below.

## 8.2.1 Consulting key stakeholders in Indigenous informed research

The first phase of the qualitative work involved pre-fieldwork visits to Aboriginal communities for identifying and consulting with key stakeholders in the development of the Indigenous-informed methodology. This consultation was achieved by taking advice from the project's Indigenous Advisory Group, the Aboriginal Health and Medical Research Council (AHMRC) NSW and the Aboriginal Medical Services Alliance Northern Territory (AMSANT).

### Project Advisory Group

A Project Advisory Group was established to provide guidance on the protocols and procedures of approaching and working in partnership with the communities that were identified as appropriate for the study. The project advisory group comprised representatives from UNSW (Professor Juanita Sherwood, Associate Professor Susan Green), the Aboriginal Disability Justice Campaign (Patrick McGee), Aboriginal Health and Medical Research Council (Glenn Williams), and the Mental Health Coordinating Council (Corinne Henderson).

### Ethics Approval

Ethical approval was sought and granted from the UNSW HREC from the NSW AH&MRC Ethics Committee to conduct the project in NSW. In granting its approval, the AH&MRC commended the project, stating that it 'sets out an excellent model for respectfully working with Aboriginal communities in a culturally appropriate way in order to produce research which will be of benefit to them and which involves them intellectually in the production and control of the results.'<sup>13</sup> The Ethics Committee for Justice Health & Forensic Mental Health Network also supported the research. In particular, a close engagement with the AHMRC of NSW was achieved by Elizabeth McEntyre, a senior Aboriginal woman known within the NSW correctional health system and the project's APAI holder, and Professor Baldry, meeting regularly with executive members of the AHMRC of NSW to report on progress and seek guidance on particular matters. Discussion with the AHMRC of NSW resulted in guidance on appropriate links with Aboriginal Community Controlled Health Organisations in research sites as well as a sounding board on difficult matters. For the Northern Territory (NT), ethics was sought and granted from the Central Australian Human Research Ethics Committee (CAHREC) after establishing a relationship and partnership with the Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU) based in Alice Springs. Ethics was also sought and granted from NT Correctional Services for the fieldwork undertaken in Alice Springs Correctional Centre. Additional ethics was sought and granted from Corrective Services NSW for fieldwork to be undertaken in Silverwater Women's Correctional Centre and Miruma Diversionary Program for the nested project related to Indigenous women.

<sup>13</sup> Email from NSW AH&MRC Ethics Committee: '858/12 – Indigenous Australians with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System (IAMHDCD Project)', 16 May 2012.



## 8.2.2 Establishing Indigenous Community research partnerships

The second phase of the approach involved identifying Indigenous communities interested in becoming partners in the research and developing an agreed partnership protocol. The rationale for this approach was a commitment to moving beyond some previous research in Indigenous communities, which have simply used community knowledge as research data without respectful reciprocity (Sherwood 2010; Laycock et al 2011). Our intention was to heed critical Indigenous research scholars who call for a process whereby cultural safety is paramount and where Indigenous communities that agree to participate control and own the knowledge and information that emerge (Sherwood 2010; Rowe, Baldry & Earles 2015). In the case of the project here, this ensured that communities were able to communicate on their own terms the issues for community members who have MHDCD, as well as for their families and services.

The Aboriginal researchers made initial contact with an identified Aboriginal Community Controlled Organisation (most commonly the Aboriginal Medical Service (AMS) in each community) as the key agency in that site that would be able to engage with community members and seek consensus as to whether to participate.

Engagement with communities continued at length throughout the project whereby Elizabeth McEntyre, Peta MacGillivray and Eileen Baldry followed up with multiple visits, telephone calls, teleconferences, written briefs and presentations to the potential sites in NSW and NT, and Chief Executive Officers, Board Directors, Aboriginal community members and representatives and Aboriginal workers in both Government and Non-Government organisations were consulted to acquire support for and endorsement of the Project. Once an Aboriginal Community Controlled Organisation in each community had decided that it was in the interests of the organisation and the community to participate and collaborate, a letter of support was provided as a requirement of ethics and a research agreement was negotiated between the IAMHDCD project and the organisation.

### 8.2.3 Data collection in communities

The study aimed to capture the experiences of Indigenous people with MHDCD who have been enmeshed in the criminal justice system to gather information about their experiences of the criminal justice system as persons with an intellectual disability, cognitive disability and/or mental health disorder, and what the experiences meant for them while in the criminal justice system and in their Community.

A further aim was to capture the experiences of family members, and their perception of program interventions, as well as Community understandings of MHDCD, the impact of the CJS with respect to MHDCD, and their views on services for people with MHDCD. In addition data was sought on how Indigenous persons understand and identify mental health disorders and cognitive disabilities in their community, and especially in regard to MHDCD in the CJS. The views of those who provide services to persons with MHDCD who have been in the CJS were also sought.

A number of steps were undertaken to ensure a comprehensive culturally and disability informed approach was used. These steps involved: careful preparation prior to entering the communities; identification of stakeholders who would take part in the interviews; development of rigorous protocols for recruitment and informed consent; and the development of research instruments that were comprehensive while at the same time sensitive to the needs of participants.

#### **Preparation of Site Summaries**

Once the relevant Aboriginal Community Controlled Organisation in each community provided formal written support after consideration by their Board or senior management, Project personnel prepared a summary for each research site to ensure that Researchers were well informed about the context of each unique community. Site summaries included:

- Context – demographic, geographic, historic
- Service detail
- Interviewees
- Stakeholder group
- Types of service providers
- Aboriginality of service provider interviewees
- Sectoral spread of service providers Recruitment





## Recruitment

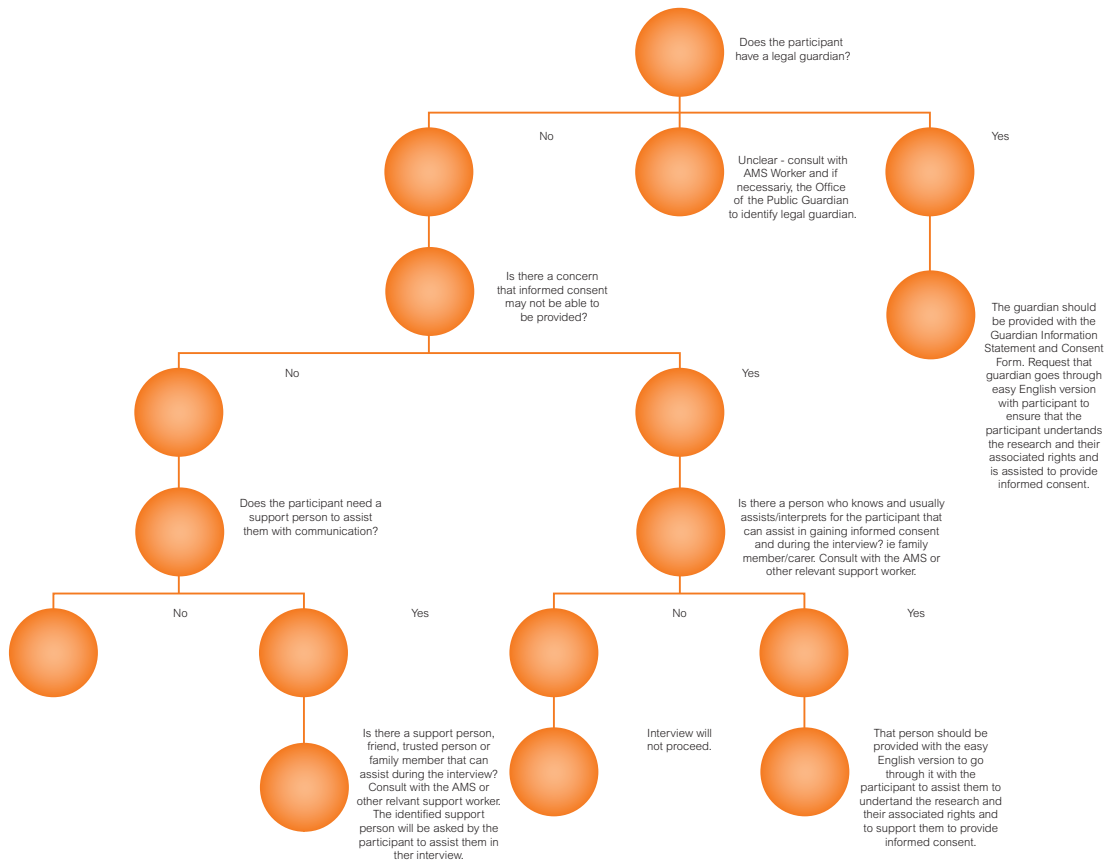
Recruitment of participants into the study involved a collaborative approach with Aboriginal Community Controlled Organisations to engage potential participants. Recruitment of participants was undertaken through the workers based in the supporting AMS or other community-based organisation and via an IAMHDCD study poster developed to promote the research and attract participants. Community-based frontline workers identified people in the community with MHDCD who have experienced the CJS through their work in the community and connections. People who learned about the study through the recruitment poster were invited to leave their details with the supporting community-based worker. Acting as a liaison, the worker then explained the aims of the study to the potential participant and provided them with the details of how to contact the research team, as well as a time and place where the research team would be available to talk with potential participants (drop-in). These locations were selected in consultation with the relevant community-based organisation as a space that is safe and culturally appropriate. The worker was not required to disclose potential or interested participants' names or contact details to the research team.

Participants with cognitive impairment were encouraged to identify and bring along a support person of their choice to provide assistance in understanding and communicating their views in the interview. In this way the recruitment process ensured cultural safety was established by connecting with potential participants via a trusted organisation and with a trusted supporter as needed.

## Informed Consent

A key issue for this aspect of the study was that of ascertaining and gaining informed consent from interview participants. Given the history of research with vulnerable groups, the project’s objectives and theoretical perspective, informed consent was not conceived of as a point in time sign off, but rather as an ongoing process of consultation, consideration and discussion with potential participants with MHDCD. A protocol was developed for use in the field which set out detailed procedures for obtaining informed consent with a particular emphasis on establishing whether an individual was able to provide informed consent themselves and where this was not the case how consent to participate should be obtained. Easy Read versions of the PIS and Consent Form were developed for use with participants with cognitive impairment and/or limited literacy. In addition, an Information and Consent Form was developed for Guardians. The Guardian was able to use the Easy Read version to discuss participation in the study with the person under guardianship. Once the Guardian was confident that the information contained in the Easy Read version was understood by the person, including why questions were being asked of the person and what would happen to the information provided to the researchers, the Guardian was required to give consent for the person to be interviewed. These forms ensured that all reasonable attempts had been made to ensure informed consent had been given. To assist this process, the research team developed a ‘decision-making tree’ set out in Figure 2:

**Figure 2: Decision tree: Consent type and interview support**



This aide incorporates the many issues that had to be considered when gaining informed consent from participants, particularly from those who didn't have a legal guardian, and whom researchers were concerned may not understand what was being asked of them.

As can be seen from Figure 2 the decision tree process provided checks and balances ensuring many points at which the person themselves, their guardian and/or support person were fully informed and involved in deciding whether to participate and to be well informed of the intention of the interview.

## Interviews

In order to collect the views of the range of participants in each site and to capture information and observations about the site in which the interview took place three data collection instruments were developed, including two different schedules for semi-structured interviews designed for different participants and a template through which researchers were able to capture the unique character and issues emerging in each site.

### Data Collection Instruments

Data was collected via individual and group interviews and through the compilation of field notes which captured general observations and issues in the research sites.

#### *i) Interview Preamble*

Each interview instrument was prefaced with general instructions for the interviewer to ensure a standard approach to interviewing. All interviews were conducted by two Indigenous researchers (a Lawyer and Mental Health Social Worker), one asking the questions and the other scribing. There was one exception to this, when one Indigenous researcher and one non-Indigenous researcher conducted the interview. The interview preamble included information on obtaining informed consent and permission to record, and a brief script to inform the participant/s of what to expect in the interview, the role of each of the researchers present, rules of disclosure and confidentiality for group interviews and expectations of supporters who attended to assist individuals with cognitive impairment or any participants who wished to have a support present. Finally a statement about what would happen after the interview was included to remind participants that feedback would be made available to the community about the research and that it would be used to inform government policy and practice.

#### *ii) Interview Schedule 1: Indigenous People who have MHDCD and have been in the criminal justice system*

This schedule was designed according to the principles of easy English and contained 3 parts to delineate specific areas of questioning: CJS experiences and associated support needs, which captured experiences in the CJS, assistance received and not received and the impact of these; lifecourse experience and associated support needs, which captured experiences in childhood/adolescence and adulthood; and a concluding section for any other questions and closing the interview. Each section contained a topic statement to introduce the area of questioning, question formats and suggested follow-up and prompt questions.

**iii) Interview Schedule 2: Family members, community members and service providers**

This schedule contained 3 parts: reflections on experiences and perceptions of family and community people with MHDCD and their interactions with the CJS; support and interventions and their availability and effectiveness; and a concluding section for any other questions and closing the interview. Variations in each of the questions were provided for different stakeholders including family members and carers, community members and service providers.

In addition for each interview an Interview Log was designed to capture key demographic details, any researcher reflections on the interview and issues for follow up. All individual and group interviews were digitally recorded and transcribed verbatim.

**iv) Field Note Template**

While much of the formal data collection for the fieldwork took the form of interviews with individuals and groups, a field note template was developed to provide for the systematic capture of other relevant observations or experiences during time in the field. The aim of this was to capture a richer sense of the everyday physical or social context of the field locations, the key agencies and individuals and their inter-relationships in each site and if possible a sense of the meanings that people in the sites attributed to these occurrences and relationships. This form of data contributed to the development of a more dynamic understanding of the context of the site in which the more formal interviews take place.

## 8.2.4 Analysis, verification and validation of results with communities

### Data Analysis

Transcriptions of all interviews, site summaries and field notes were entered into NVivo 9. As the project examines pathways into the CJS and individuals' interactions with human services and justice agencies across eight locations, two units of analysis were utilised: individuals and sites. These data sources were organised under case nodes in NVivo, with a case node acting as a folder containing all sources of data for each unit of analysis. To enable comparison each case was assigned attributes including their stakeholder classification and location.

A coding frame was developed in order to capture substantive structural and thematic issues emerging from the data. This frame included two levels of coding - organisational and conceptual. Organisational coding captured descriptive categories which represented the structural and locational data relating to for instance sectors within the service system such as education, health, criminal justice system and so on. Conceptual codes were created to represent themes and concepts which captured experiences and perceptions shared by participants. This approach allowed for analysis at multiple levels. For example, an interviewee's reference to the local court in one site could be coded under the site name or 'local courts – role of'. This would enable a query on, for example, what Indigenous participants say about the role of local courts, or whether issues to do with local courts are significant for persons with MHDCD living in that site. Having both a descriptive coding frame and a conceptual coding frame enabled an investigation of what was said e.g. about service providers in the site and who said what.

*Verification of analysis – 'Our First Go at Listening Up': Interim Community Report.* Following the completion of the full analysis of the data emerging from interviews from all research sites, a report was prepared for each site detailing a summary of the people and service providers interviewed, the results of the interviews and what would happen next. An Indigenous researcher who had undertaken the interviews then returned to the communities with an interim community report of the qualitative findings for presentation, discussion and verification. Positive feedback was received from all sites and the research team was commended for the timely reporting back to communities and the accuracy of content contained in the interim community reports.

## 8.2.5 Development and presentation of Education and Advocacy Resources (draft) to communities and final documents developed

The interim community reports were transformed into site specific Education and Advocacy Resources and presented to each community as draft documents. Discussions were held with participants as to how the resources could be best used to support those members of the Aboriginal Community with MHDCD who are or at risk of contact with the CJS. A final draft of these resources was then developed and presented to the Communities.

## 8.3 SAMPLE

### 8.3.1 Site Sample

A list of 10 potential town/suburb sites in NSW and NT was developed for possible participation according to the following criteria for inclusion in the sample.

- A high proportion of the population being Aboriginal people
- A mix of urban, regional and remote sites in NSW, and one regional centre in the NT
- An Aboriginal Community Controlled Organisation that could become a formal partner in the research

After initial contact and discussions with the Project Advisory Group, four community sites were chosen for potential recruitment of participants for the study. These were:<sup>14</sup>

- NSW
  - Regional Centre 1
  - Regional Town
  - Remote Town
- NT
  - Regional Centre 2

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<sup>14</sup> The place names of the research sites have been anonymised in order to avoid stigma or negative ramifications for those interviewed and for the communities.

## 8.3.2 Participant Sample

In each research site a range of Indigenous stakeholders were identified in order to capture the range of views outlined above, four groups were identified for inclusion in the interviews. These were:

- Indigenous people who have MHDCD and who have been or are enmeshed in the CJS
- Family members and carers of Indigenous people with MHDCD
- Aboriginal Community members
- Service providers across Disability, Primary and Community Health, Mental Health, Legal, Community/Human services. This category was further broken down into the following categories:
  - Aboriginal Community Controlled Organisations – Aboriginal and non-Aboriginal staff
  - Government service providers - Aboriginal and non-Aboriginal staff
  - Non-government service providers - Aboriginal and non-Aboriginal staff

Where possible, interviews were conducted with a number of individuals from each of these groups in each community. Interviews were conducted either individually or in groups, and for people with cognitive impairment, a supporter was present as requested. Diversity in terms of the gender and age of people who have MHDCD and who have been in the criminal justice system was also sought. The final sample for the project is outlined in figure 2 below, with a detailed breakdown of each site available in the Contexts section following.

**Table 2: Final Project Sample**

STAKEHOLDER GROUP	Regional Centre 1	Regional Town	Remote Town	Regional Centre 2	TOTAL
Indigenous people with MHDCD	6	1	2	13	22
Family members and Carers of people with MHDCD	1	1	0	0	2
Community members	0	4	18	2	24
Service Providers - Aboriginal community controlled organisation; Aboriginal staff	2	1	2	4	9
Service Providers - Aboriginal community controlled organisation; Non-Aboriginal staff	2	1	0	5	8
Service Providers - Government; Aboriginal staff	12	4	6	0	22
Service Providers - Government; Non-Aboriginal staff	6	3	1	10	20
Service Providers - Non-Government; Aboriginal Staff	2	2	1	0	5
Service Providers - Non-Government; Non-Aboriginal Staff	2	6	1	2	11
<b>TOTAL</b>	<b>33</b>	<b>23</b>	<b>31</b>	<b>36</b>	<b>123</b>

A summary of each research site including general demographic information and the profile of study participants is set out below.

### 8.3.3 Research Site and Participant Profiles

#### NSW

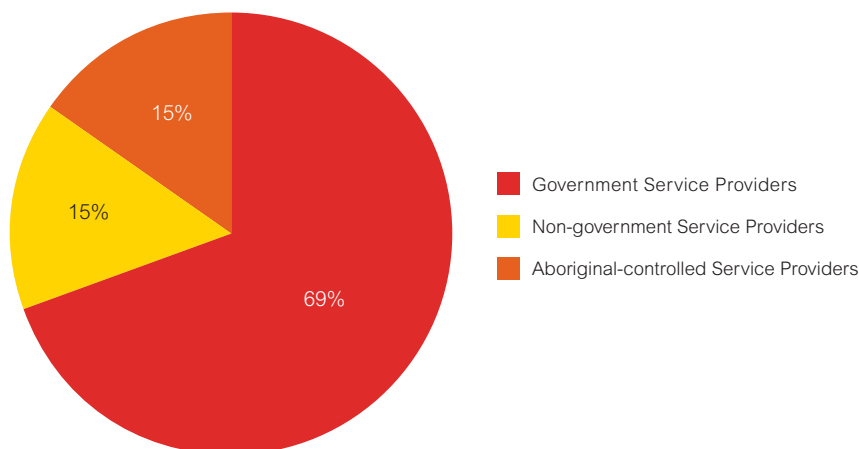
##### Regional Centre 1

Regional Centre 1 has a population of approximately 40,000, about 5,000 of whom identified as Indigenous. The median age of Indigenous people is 19. Regional Centre 1 is a town where more than 100 different language and clan groups were forcibly relocated on multiple occasions during the 19<sup>th</sup> and 20<sup>th</sup> centuries. The legacy of past paternalistic, assimilationist government policy is described by Aboriginal people in the town as evident in the lack of coordinated and appropriate service provision and complex community dynamics.

Twenty-three interviews were conducted in Regional Centre 1 with a total of 33 participants. There was near equal representation between genders, with fifteen female participants and eighteen male participants. Over three quarters of the interviewees (n=26) were involved in direct service provision, six were identified as persons with a mental health disorder or cognitive disability, and one was a family member/carer for a person with MHDCD. This interviewee also worked in a service role at a local school providing Aboriginal student support. Similarly, a Police Aboriginal Community Liaison Officer (ACLO) interviewed as a service worker was also engaged in informal care work looking after family members with an intellectual disability. Participants who reported acting in both a service worker and family/carer capacity had in-depth and nuanced understandings of the issues relevant to this project. Interviews with these participants in particular were sources of rich data.

Of the twenty six interviewees involved in direct service provision, eighteen worked in a government service, four worked for a non-government service provider, and four worked in an Aboriginal community controlled organisation, as shown in Figure 2 below.

**Figure 3: Types of Service Providers**





The majority (n=16) of service provider interviewees were Aboriginal. Of the ten non-Aboriginal interviewees, six worked in a government service, two worked in a non-government service, and two worked in an Aboriginal community controlled organisation.

The sample captures service providers operating in the human services and the criminal justice sectors. Of the ten participants engaged in the human services sector, three provided disability services, three provided mental health services, one provided family and youth services and one provided primary health care services. One participant also worked in the area of Aboriginal community development and one in housing. Of the sixteen interviewees working in the criminal justice sector, six provided legal aid services, six provided court support services, two worked in juvenile justice, one worked in corrective services, and one was engaged in policing as an ACLO.

Table 2 sets out the cross-sector distribution of interviewees working within Aboriginal community controlled, government and non-government organisations. It shows that while the majority of participants operating in the criminal justice sphere worked for government services, participants engaged in the human services sector were from a range of government, non-government and Aboriginal community controlled community organisations.

**Table 3: Service providers across service sectors**

Sector	Service Type	Aboriginal Community Controlled Community Organisations	Government Services	Non-government Services
Human Services	Disability Services	0	1	2
	Mental Health	0	2	1
	Family & Youth services	0	1	0
	Primary health care	0	0	1
	Community Development	1	0	0
	Housing	0	1	0
Criminal Justice	Legal Aid	3	3	0
	Court Support	0	6	0
	Juvenile Justice	0	2	0
	Corrective Services	0	1	0
	Policing	0	1	0

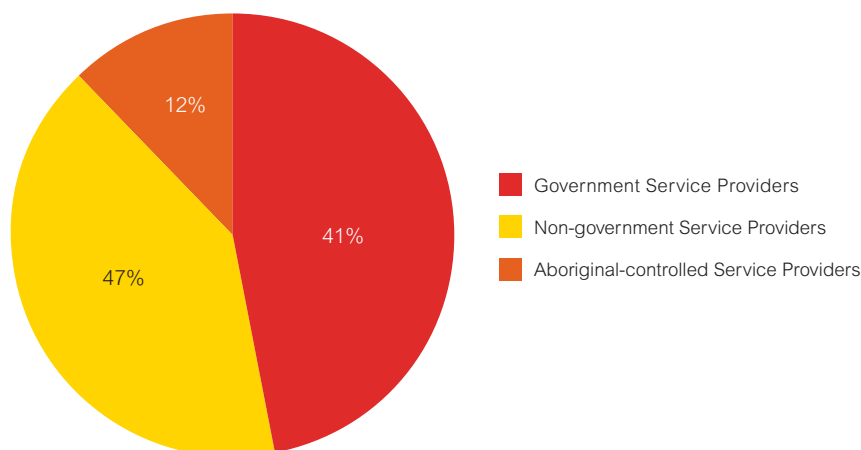
## Regional Town

The Regional Town research site has a population of approximately 14,000, about 3,000 of whom identified as Aboriginal and Torres Strait Islander. The median age of Aboriginal people in the town is 23. Regional Town 1 is located in a shire known for its rich and productive agricultural sector. There is significant economic and social division in the town, with great wealth existing alongside areas of great disadvantage, in particular in the area that was formerly the site of the Aboriginal mission in town and where many Aboriginal people live. There are more than 60 services operating in the town, although many of them were described as inaccessible by Indigenous people with multiple and complex support needs.

Sixteen interviews were conducted in Regional Town 1 with a total of 23 participants. There was near equal representation between genders, with twelve female participants and eleven male participants. The large majority (n=17) of interviewees were involved in direct service provision, while four were members of the local community. One interviewee was identified as a person with MHDCD and one was a family member/carer of a person with MHDCD.

Of the seventeen interviewees involved in direct service provision, eight worked in a non-government service, seven worked in a government service, and two worked in an Aboriginal community controlled organisation, as shown in Figure 3 below.

**Figure 4: Types of Service Providers**



The majority (n=10) of service provider interviewees were non-Aboriginal. Of the seven Aboriginal interviewees, four worked in a government service, two worked in a non-government service, and one worked in Aboriginal community controlled organisation.

Of the twelve participants engaged in the human services sector, five worked in mental health, three provided primary health care services, one provided disability services, and one provided information and referral services. One participant provided people with disabilities with individual advocacy services, and one provided employment services. Of the five interviewees engaged in the criminal justice sector, four worked in legal aid and one worked in corrective services.

Table 3 sets out the cross-sector distribution of interviewees working within Aboriginal community controlled, government and non-government organisations. It shows that unlike other sites, the majority of participants engaged in the criminal justice sphere worked in non-government and Aboriginal community controlled organisations, whereas the participants engaged in the human services sector worked for either government or non-government service providers.

**Table 4: Service providers across service sectors**

Sector		Aboriginal Community Controlled Community Organisations	Government Services	Non-government Services
Human Services	Disability Services	0	1	0
	Primary health care	0	3	0
	Information & referral services	0	1	0
	Individual Advocacy	0	0	1
	Mental Health	0	0	5
	Employment Services	0	0	1
Criminal Justice	Legal Aid	2	0	2
	Corrective Services	0	1	0

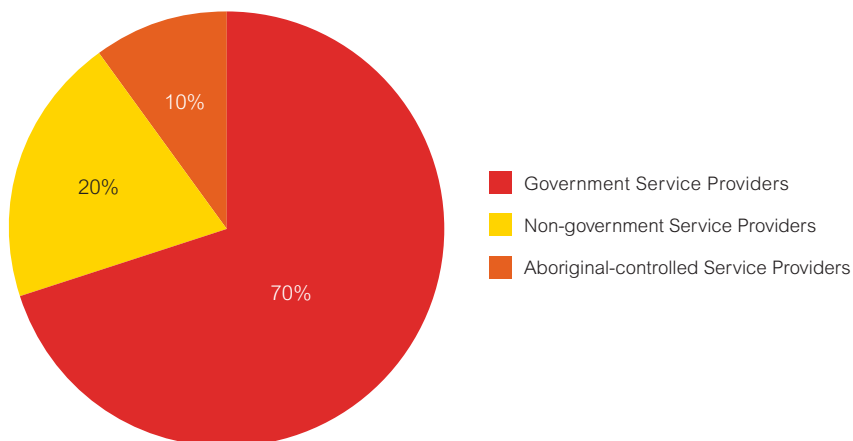
## Remote Town

The Remote Town research site has a population of approximately 2,300, about 1000 of whom identified as Indigenous at the last Census. The median age of Aboriginal people in the town is 23. Remote Town 1 is located at a river junction, and was formerly an important regional hub for agricultural industries. A number of notorious massacres of Aboriginal people took place in the area in the 19th century, and Aboriginal people in Remote Town 1 have been subjected to ongoing segregation and marginalisation. There is a strong tradition of Aboriginal political activism and community controlled organisations in the town.

Fifteen interviews, including several group interviews, were conducted in Remote Town 1. A total of 31 people participated in these interviews. There was near equal representation across genders, with sixteen male participants and fifteen female participants. Almost two thirds (n=18) of the interviewees were community members and/or leaders, just over a third (n=11) were involved in direct service provision, and two were identified as persons with a mental health disorder or cognitive disability. No family members or carers of persons with MHDCD were interviewed at this site.

Of the eleven interviewees involved in direct service provision, seven worked in a government service, two worked for a non-government service provider, and one worked in an Aboriginal community controlled organisation, as shown in Figure 4 below.

**Figure 5: Types of Service Providers**



The large majority (n=9) of service provider interviewees were Aboriginal. Only two were non-Aboriginal, one of whom worked in a government service, and one of whom worked in a non-government organisation.

The sample captures service providers operating in the human services and the criminal justice sectors. Of the six participants engaged in the human services sector, two worked in mental health, two in primary health, one in disability services, and one in Aboriginal community development in government/project management capacity. Of the five interviewees from the criminal justice sector, two were active in providing court support services, one was engaged in policing as an ACLO, one provided legal aid services, and one was a magistrate in the local court. Table 4 sets out the cross-sector distribution of interviewees working within Aboriginal community controlled, government and non-government organisations. It shows that while all the participants operating in the criminal justice sphere worked for government services, participants engaged in the human services sector worked in a range of government, non-government and Aboriginal community controlled organisations.

**Table 5: Service providers across service sectors**

Sector		Aboriginal Community Controlled Community Organisations	Government Services	Non-government Services
Human Services	Mental Health	1	0	1
	Primary health	1	1	0
	Disability Services	0	1	0
	Community Development	0	1	0
Criminal Justice	Legal Aid	0	1	0
	Court Support	0	2	0
	Local Court/Magistrate	0	1	0
	Policing	0	1	0

Four group interviews were conducted with eighteen Aboriginal community members from Remote Town 1. Six female community members took part in the first group interview, and seven male community members took part in the second. A further three male Elders participated in a third group interview, and a fourth interview was held with two female community members.

## NT

### Regional Centre 2

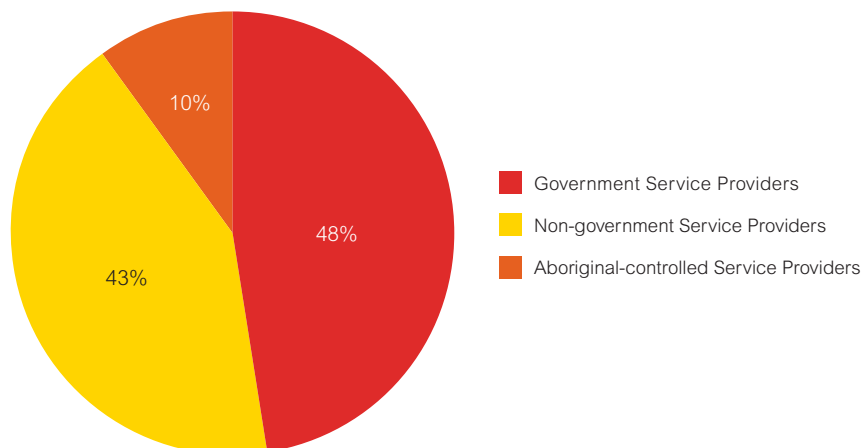
Regional Centre 2 is one of the largest towns in the Northern Territory. Regional Centre 2 has a population of approximately 25,000, about 5,000 of whom identified as Indigenous in the last Census. The median age of Aboriginal people in town is 24. Regional Centre 2 is deeply segregated, with high levels of disadvantage and homelessness experienced by Aboriginal people in town. Town camps provide temporary housing for people from remote communities who come into town to access services or after being released from prison. Many in the town camps come and go from smaller remote communities and the numbers in the census of Aboriginal people may be an undercounting.

A total of 36 people were interviewed in Regional Centre 2. There was equal representation across genders, with eighteen male participants and eighteen female participants. Over half (n=21) of the interviewees were involved in direct service provision, and just under half (n=13) were identified as persons with a mental health disorder or cognitive disability, and two were members of the local community. No family members or carers of persons with MHDCD were interviewed at this site.

### Service Providers

Of the 21 interviewees involved in direct service provision, ten worked in a government service, nine worked for Aboriginal community controlled organisations, and two worked for a non-government service provider, as shown in Figure 5 below.

**Figure 6: Types of Service Providers**



Over three quarters (n=17) of service provider interviewees were non-Aboriginal and four were Aboriginal. All Aboriginal service provider interviewees worked for an Aboriginal community controlled organisation, and all government and non-government interviewees were non-Aboriginal.

Of the thirteen participants engaged in the human services sector, five worked in mental health, and two worked for organisations that work specifically with persons with disabilities. A further three interviewees worked in primary health care and two provided family and youth services. One interviewee was engaged in a community safety program, one worked in the area of housing and homelessness, and one in the area of drug and alcohol, including residential rehabilitation. Of the eight interviewees from the criminal justice sector, four worked in corrective services, three provided legal aid, and one was a magistrate in the local court. Table 5 sets out the cross-sector distribution of interviewees working within Aboriginal community controlled, government and non-government organisations. It shows that while most participants operating in the criminal justice sphere worked for government services, almost half of those engaged in the human services sector worked in Aboriginal community controlled organisations.

**Table 6: Service providers across service sectors**

Sector		Aboriginal Community Controlled Organisations	Government Services	Non-government Services
Human Services	Mental Health	3	3	2
	Primary health	0	0	0
	Family & Youth Services	0	2	0
	Community services/safety	1	0	0
	Housing & Homelessness	0	1	0
	Drug & Alcohol/ Rehabilitation	1	0	0
Criminal Justice	Legal Aid	1	2	0
	Local Court	0	1	0
	Corrective Services	0	4	0

## 8.4 FINDINGS

This section sets out the findings of the qualitative interviews conducted during 2012 and 2013 with Aboriginal people with MHDCD,<sup>15</sup> their families and carers, and relevant Aboriginal Community Controlled Organisations and other service providers in New South Wales and the Northern Territory. The data is compiled into five overarching themes that emerged from the process of detailed and comprehensive analysis of the data, illustrated by key quotes from interviewees. These five overarching themes represent experiences found to be common amongst Indigenous people with MHDCD who have come into contact with the criminal justice system, across all the communities that were part of this study. The findings are elaborated in terms of their varying implications for Indigenous people with MHDCD, community members, carers, organisations and service providers, with many interviewees identifying with two or more of these categories. The voices and experiences of Aboriginal women and men with MHDCD in the criminal justice system are a primary focus and Aboriginal community-based solutions are highlighted, in keeping with our research methodology. Communities and individual quotes are anonymised, with a general descriptor used, in order to avoid singling out or stigmatising particular individuals or communities.

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<sup>15</sup> At the outset of this study, our research team used 'MHDCD' (mental health disorders and cognitive disability) to describe the diagnoses and experiences of a particular group of people in the criminal justice system. Whilst working on this study, the terms 'complex needs', 'complex support needs', 'mental and cognitive impairment' and 'mental and cognitive disability' have also emerged as having currency or relevance in different contexts. In this section, these terms are used mostly interchangeably, dependent on interviewees' terminology and context and our emerging analysis of the qualitative data. This chapter also refers to 'Aboriginal' rather than 'Indigenous', as this was how interviewees in NSW and the NT identified themselves and their communities.







## 8.4.1 Identity, Definition And Stigma

*It's a double stigma – because not only have they got the label and all of the positive and negative connotations of having an intellectual disability, but they have the 'dangerous' and 'violent' 'forensic criminal' label as well. People then change their perception of that individual dramatically. So people may assume that this person is more risky/at risk than they actually are, so they may foreclose on the range of therapeutic possibilities, so they may not pay the right amount of attention to the context in which that person may have offended, or alleged to have been involved in criminal behaviour.*

Institutional racism, stigma and discrimination were described as common, marginalising and destructive for Aboriginal people with MHDCD. Interviewees reported discrimination and stigma experienced on the basis of their Aboriginal status, their disabilities, and in regard to the criminalisation of their behaviour. There were countless examples reported of individuals with MHDCD experiencing stigma and discrimination that had a direct impact on their rights and wellbeing, with reports of individuals regularly struggling to access education, employment, housing and just legal outcomes. Paternalistic assumptions about Aboriginal people with MHDCD and their families and communities were reported by Aboriginal individuals with MHDCD, their carers and those working in service delivery in this area. An assimilationist approach was perceived as still pervasive in many of those working within criminal justice and human service agencies, with little recognition of the ongoing impact of colonisation, intergenerational trauma, grief and loss for Aboriginal peoples. Misinterpretation of Aboriginal family structures and the nature of protection processes in Aboriginal communities were viewed as underpinning the early and predominantly negative intervention by the state in the lives of many Aboriginal people with MHDCD. A lack of understanding of cognitive impairment amongst Aboriginal communities was also reported. Aboriginal people with MHDCD and their families who do seek help and support are reportedly responded to by a system that imposes its own agenda on their needs and priorities which, however well-intentioned, rarely serves the interests of Aboriginal people with MHDCD. The lack of recognition around cognitive impairment was perceived as a key problem exacerbating contact of Aboriginal people with MHDCD with the criminal justice system.

## Institutional Racism

Institutional racism was experienced as pervasive for Aboriginal people with MHDCD in their contact with criminal justice and human service agencies. It was described in terms of a lack of understanding of the intergenerational impact of colonisation, trauma, grief and loss, and the lack of funding and support for culturally appropriate services and support in Aboriginal communities. Aboriginal people with MHDCD described a particular lack of respect from many police officers when they are the persons of interest or their family member is a person of interest, and as being regularly subjected to police searches or raids. Community service providers identified a lack of contextual knowledge of Aboriginal communities as meaning that many police officers do not work positively with Aboriginal people, or attempt to understand why the relationship is poor. Police are reportedly often poorly informed of the history and experience of racism that Aboriginal peoples have experienced.

*I don't think they really want to try and understand – they've got their perception and they want to stick by it. [And what is that?] Well, that 'these young people don't care about anything and have no respect'. But they don't understand why the kids are like that, their stories, they don't understand the extent of the generational problems we've had since colonisation I suppose, that's where it all started and that's why its still like that today.*

For Aboriginal people with MHDCD, the negative effects of these legacies were described as particularly acute. Actions that should be understood in the context of an individual Aboriginal person's cognitive impairment or mental illness are regularly perceived by police as attention seeking or bad behaviour requiring punitive intervention and often custody. Many interviewees in regional towns reported witnessing police targeting Aboriginal people with MHDCD, particularly once they have a history of contact with the criminal justice system.

*A young bloke came out on the first day to report, he walked from our parole service to the main street which was 30 to 40 metres, he got picked up by the police and searched, stripped searched on the street, because they knew who he was. To me it seems like he was an easy target. The police evidence is that he was staggering and they knew he was on parole so searched him. I've been subpoenaed to court and my evidence is that he reported doing the right thing. Also I'm not allowed to interview clients if I think they have been drinking - police are using that as an excuse and saying they pulled him over because he was staggering and 'we believe he was drunk'. So the boy was doing the right thing by reporting, doing his bit, and then gets searched.*

Aboriginal interviewees universally identified police targeting and harassment as a result of racism. Aboriginal community workers reported trying to support Aboriginal people with MHDCD to avoid negative police contact, however this was described as difficult.

*... it's so constant they just get sick of it, and then it's 'why don't you just f off and leave me alone', and then the cops say 'gotcha'. And that's how it is. So I say to them 'just give them your name, say where you are living, that you're just going to the shop, and am I under arrest'. But it becomes constant and you can imagine if you've got cognitive behaviour what would happen.*

Many community members felt that Aboriginal victims of crime, especially those with disability, did not receive adequate support and assistance from police, again as a result of racism. Community members spoke about the inadequacy of the response to calls for help, that the police response was often too late for real help to be provided or incidents avoided.

*How many police in this place and they still take forever to get to you.... By then you could already have your throat slashed, raped or murdered. And they are still coming, 'Oh we were on a job', they won't come until it's over. Truly.*

A legal officer reported a police officer intimidating a client with MHDCD who was a victim of violence to pressure her into implicating her partner.

*I've got a client that is a mum to two children, she was just stabbed recently by someone. And her man keeps going to gaol for [breaches of] AVOs. And I was with her when she was saying to the police that he wasn't the one that had thrown some eggs at someone's car, that she had done it. And the police said 'well he's going to go to gaol anyway, and if you did this you are too – so who's going to look after your kids?' So she said he did it. So cops bluffed her. Scared her.*

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Aboriginal community members stressed how important it was that police understand community dynamics, culture and politics for community policing, but reflected on how difficult this is to facilitate because of poor relationships with police in many communities that is inter-generational and entrenched. Where attempts are made to improve relationships between police and Aboriginal communities, it was reported that incidents involving individual police officers derail attempts to promote positive collaboration and changes in practice. Aboriginal staff identified particular challenges in working with police officers to respond appropriately to Aboriginal people with MHDCD, including a lack of respect for the knowledge and experience of Aboriginal workers.

*If we are saying something, asking the police for help, we just need them to listen to what we have to say. We're not doctors, but we do know the community. So just hear our points, our views, and we might have better outcomes. Just listen to what we are saying, if Joe is down there off his rocker, what can we do together? ... That's what the coppers are arrogant about, they do a two-day mental health course - we do it every day! I've had a bloke at the station say 'well I've had mental health training, what's your training?'*

A number of instances of institutional racism in workplaces experienced by Aboriginal service workers were also detailed.

*I spoke to the CEO about taking on Aboriginal trainees as a very successful way to build your business, and the response was "Well I've had two Aboriginal staff members and they were hard work". So, that was that.*

The ongoing institutional racism experienced by Aboriginal workers and clients was perceived as a direct consequence of colonisation.

*I still think that society is still trying to knit Aboriginal people onto a colonial framework that we know doesn't work for us. And if we were to change the framework – which Aboriginal Affairs is supposed to have done – what would it look like? But it hasn't.*

A lack of genuine commitment to changing the culture of many criminal justice and human service agencies to better respond to and respect the experiences of Aboriginal people was reported by many interviewees. A lack of cultural attunement was described as particularly evident in many organisations working in remote communities, with destructive effects.

*So I find that very often the kind of projects and organisations that come into remote communities import that non-Aboriginal model and understanding of family and responsibility with them, without considering that they are not the dominant culture – and that would probably be one of the places where we are ineffective.*

Ongoing cultural awareness and cultural competency education was seen as crucial by many Aboriginal workers to enable organisations to work effectively with Aboriginal people.

*I think every workplace or service needs lots of Aboriginal awareness programs. This is how a lot of it gets blown out of proportion. Because they don't understand the Aboriginal perspective – how we think, how we see it – and it's completely different to non-Aboriginal people.*

Some other interviewees were of the view that until there is greater leadership and commitment across government agencies and service organisations to challenge institutional racism, it will remain pervasive, as will the over-representation of Aboriginal people in the criminal justice system, particularly for those with MHDCD.

## Poor Identification of Cognitive Impairment

Interviewees reported a lack of understanding and identification of cognitive impairment amongst teachers, police, lawyers, magistrates, health professionals, service providers, as well as amongst Aboriginal families and communities. The lack of recognition of and appropriate services and support for people with cognitive impairment was perceived by many interviewees as exacerbating the over-representation of Aboriginal people in the criminal justice system. Formal diagnoses of intellectual disability were described as less common for Aboriginal young people, manifesting in a lack of early intervention and appropriate support in school and by ADHC more generally. Interviewees said it was common for Aboriginal young people to disengage from or be expelled from school, being regularly characterised as badly behaved or in terms of ‘this person just never learns’. Stigma and discrimination experienced by Aboriginal people with cognitive impairment was described as also manifesting in a lack of appropriate and targeted support in the community, contributing to their pathways to and enmeshment in the criminal justice system. Once caught up in a cycle of charges, court appearances and incarceration, a lack of access to diversionary and rehabilitation options was described as a significant matter of discrimination for people with cognitive impairment.

Many community members and service providers in one rural community spoke about the mistreatment by the police of an elderly Aboriginal man with intellectual disability who was well known in the community. This case demonstrates how a lack of culturally sensitive knowledge and training regarding MHDCD can impact on individuals and the community as a whole:

*I had a 55 year old Aboriginal man (with cognitive impairment), and his issues first started was when he was carrying a can of fuel for his lawnmower across along the footpath. The police pulled up to ask questions and their attitude was over the top, and they assumed he was intoxicated. Because of his disability he gets the shivers and his face quivers from his medication and stuff like that. Anyway he ended up throwing stones and running away, they chased him and got into him with their batons. He actually did a couple of weeks in gaol that time. And then he got a hatred for the police after that, the uniform would set him off.*

Service providers reported that the police and the community make false assumptions about the ability of people with impairment to seek help, often because there is a poor understanding of disability and how it impacts on people’s lives. It was also reported that the police and community have no context for the kinds of social issues people with impairment might face, for example social isolation, and that police regularly consider people with disability as ‘bad people’.

*People in the community and the police say “they [people with impairment] should know better, they should make a change” – but how can they when they don’t have any family, (or) the families are frustrated and don’t know how to help?*

Service providers identified a number of reasons why families may not identify an individual's cognitive impairment, either currently or in the past. In terms of a child or young person with intellectual disability, the transience of families, non-attendance at school, and the family adapting and coping with behaviours or expressions of their disability in everyday life are identified as factors. Schools were perceived by families and service providers as rarely enabling a diagnosis of cognitive impairment for Aboriginal children and young people, but rather characterising them as children with problematic behaviour. This was often addressed by involving the police.

*Young people with cognitive impairment are noticed at school from their behaviour. Sometimes the school doesn't take this into consideration, which means the police get involved... [We have a client with] an intellectual disability. Anger issues, which we are aware of and mum is aware of, but unfortunately the school just sort of didn't take that into account. So if he's shouting then it becomes a police issue. Whereas if that was dealt with differently, or someone else [other than the police] was contacted at the time, then it probably wouldn't have come to their attention.*

Service providers also reported that an individual's disability was often 'masked' or hidden from view, with the family experiencing other challenges such as chronic financial hardship, intergenerational trauma, long term unemployment, parental mental health and drug and alcohol issues, domestic and family violence and high levels of contact with police. These complex support needs were seen as not being addressed holistically or effectively by services in the community. Service providers reported that the lack of identification of the need for disability support for adults was due to a focus on the primary behaviours of a person coming into service contact. For example if the person is coming via the criminal justice system, offending behaviour is often the primary focus; if in health, it is their mental illness.

A number of Aboriginal service workers reported that they brought an understanding of cognitive impairment and its impacts to their work through personal experience of being an advocate for their own family members.

*[Did you have any training with ID?] No, not training, but I have a lot of personal experience. I have a sister and a brother with intellectual disability, and I've just always been that advocate for them. Yeah they were diagnosed when they were younger. My sister is a client of ADHC, so I've had to do a lot of that advocacy for them.*

Interviewees reported that prison was regularly the first place that many Aboriginal people with cognitive impairment received a formal diagnosis.

*He has an intellectual disability, only just been identified in gaol, vision problems, hearing, on top of his ID. And that ID has never been identified, because it's just always behaviour, behaviour, behaviour. They aren't bad kids - what they are doing might be bad, so look at why they are doing it.*

Other interviewees problematised diagnoses received in prison.

*How do you assess something like a cognitive impairment in a confined space like in a gaol? Because the assessment has to generally be done in the lifestyle arrangement you have. How do you assess in a gaol? We'd argue that they are bullshit assessments. Because they are making a determination that a person is not only mentally capable, but also that the thought processes around undertaking a routine are there. And if they can't undertake that gaol routine, what's stopping them?*

People assessed as having a borderline intellectual disability and therefore not being eligible for services and support was also raised as an issue.

*My friend's daughter is 11 and she has only just been properly assessed and is borderline. She is autistic and has an intellectual disability, but it's borderline, it's just under by a little bit – and she can't get help. So how many of us don't meet that high-end need and falling just below the line? And I think if people paid more attention to the young people at the JJ centre they would actually find there are underlying disabilities.*

The devastating impact of incarceration on individual Aboriginal people with MHDCD was illustrated by interviewees through countless examples. Some high profile cases of Aboriginal people with MHDCD detained indefinitely without being sentenced were raised.

*I had a young man who hung himself three times in two days. He had been using a lot of cannabis. We had him evacuated and he was admitted to [a hospital], but the family felt terrible about him being in there, so they went to the hospital and said "he's alright now" and he said he was okay and not a risk to himself, so the family took him home. And he couldn't be contained under the Act, didn't fit the criteria anymore. But he continued to actually deteriorate and behave in ways that placed himself and others at risk, while continuing to use cannabis and alcohol.*



Service providers described the negative impact that individuals with MHDCD especially people with multiple and complex support needs, can have on the family due to the full gamut of their needs, which present most often during a crisis and are a consequence of a lack of support for their issues. Disability service providers also identified the significance of understanding the needs of an individual in the context of the family, given the importance of family and community for Aboriginal people. Service providers explained that without support families may become unable or unwilling to care and support their family member with MHDCD, due to their needs and behaviours being understood as 'risky', or families becoming burnt out because of the emotional and physical stress.

*[With respite care I think we need a] whole family approach – we've got to stop looking at this by individual. Because that's what we do, we look at it the individual and not the family component of it all. It has huge effects on the family, and it goes on to the extended family. If I was a parent and I had one of those episodes and I had a small child, where would my child go? You know what? I [as the child] got to get the hell out of here, I'm at the gate and I'm at Nan's, or I'm at Pop's or I'm at Aunty's, or I'm at a friend's house crashing on their floor. That then leads to the other group of juveniles walking the streets of a nighttime, it opens them up to criminal activity, sexual assault, drugs and alcohol. It's a vicious cycle and until that circle is broken we ain't going to solve it.*

Some allowances within the criminal justice system for young Aboriginal people with diagnosed cognitive impairment were described, with magistrates seeking to keep them out of prison and refer them to support services. However, interviewees reported that once young people turn 18, accommodation of the experiences or needs of people with MHDCD in the criminal justice system disappears.

*Then he turns 18. Things start to change – the court's attitude is, okay well he's been under the care of the minister, under the intensive behaviour management program, he's moved onto guardianship, nothing is working and I have to protect the community from this kid. So he starts moving into mainstream gaol. So that just struck absolute fear into the hearts of all of us involved with him, because it just didn't seem like the right place. You have potentially got someone with a mental age of - God knows, a kid - going into adult prison.*

The lack of understanding of the experience and effects of cognitive impairment were described as leaving Aboriginal adults with MHDCD vulnerable to compounded discrimination and disadvantage and entrenchment in the criminal justice system.

### Section 32<sup>16</sup>

While section 32 of the *Mental Health (Forensic Provisions) Act 1990 (NSW)* allows for applications to be made for magistrates to take into consideration an individual's mental health or cognitive impairment, its use reportedly varies widely between courts. The discretionary aspect of section 32 was highlighted by interviewees as potentially discriminatory in implementation, as were the complexities associated with ensuring court supervision and associated treatment plans are adequate and meeting the broader aims of the legislation.

*That's the problem that we have with the magistrate - he's likely to be sympathetic to people with these issues and want to deal with them according to law but he's reluctant to deal with them under section 32 for the reason that he doesn't think that the treatment plans are adequate. And if there's nothing in place at the time, he says 'How can you assure me that this is going to work, that it will stop them from offending?' And I think he's also concerned that the court can only supervise for 6 months. He wants to supervise them for longer... 6 months usually is the length of a section 32 and he prefers to have the court supervision over them for 2 years, but that's a difficult task for somebody who may just not be compliant with their medication at one point and get back into the criminal justice system and then also breach their section on bond. So I don't think it's appropriate to be dealing with people that way.*

Despite the apparent surfeit of services in some towns, a shortage of professionals with appropriate knowledge and training in regional and remote areas able to meet the requirements for reporting under the legislation was also raised as an issue. One interviewee told of having to send clients hundreds of kilometres to visit a psychiatrist for a Sec 32 assessment or for reporting.

*Well here there's a difficulty because there's no psychiatrists or psychologist which you can make referrals to... I had to refer [one client] to a psychiatrist in Newcastle, so he had to travel all the way to Newcastle [500kms away].*

The challenges facing disability service delivery workers who have the sometimes contradictory responsibility of supporting a person with a disability and also the power to report a breach to police and return them to prison were detailed by a number of interviewees.

<sup>16</sup> This section specifically relates to NSW legislation, however there are similar concerns about the lack of diversionary options in the NT.

## Stigma

The stigma of having a family member with MHDCD was described by many community members and service providers. A common example given was the stigma associated with children being diagnosed with an intellectual disability and being allocated to a special class. This was identified as leading to parents advocating for their child to be in a mainstream class, even if they were struggling.

*Parents aren't getting the support, and the kids aren't getting the support in the classrooms. The little ones, and the parents really, would like to see them in a mainstream class. And then others are forced into special ed classes.*

Service providers explained that parents are not getting the support they need to understand their children's needs, and children are not receiving the support they need in classrooms. Workers understand the stigma as being due to parents not having sufficient information to understand the causes, characteristics and behaviour associated with cognitive impairment. The importance of overcoming shame associated with stigma around MHDCD was raised by an Aboriginal service provider:

*Stigma. I'd say stigma would be one of the biggest ones. Shame. Shame that. And how I overcome that with people, I tell 'em I've been through the same thing. You know, it's not shame at all. It's a strong tool to try and help yourself or your family.*

Aboriginal people with complex needs were described by workers as behaving in problematic ways and making poor choices, and also as vulnerable to being manipulated by others. The stigma of a diagnosis of disability was described as greater than that associated with involvement in the criminal justice system.

*... and I know for some people, in this kind of zone, not being seen as disabled, but as gangster criminal, is preferable.*

The value of education and awareness raising around MHDCD was highlighted.

*I guess it's about education around mental health and it's something the community is learning about... I look back a couple of years when I was with housing and there was a fellow and when he did go off his meds he would just tap all night. And the lady downstairs was scared of him because he wore a jumper in the middle of summer, she just didn't understand him at all. It was only a matter of explaining 'oh well, if you notice he's doing that can you give us a quick ring because it means he hasn't taken his tablet'. And we never heard anything since, and she's not scared of him anymore, she talks to him, she knows there's a problem... so I think just community awareness around that to take away that stigma.*

Stigma and discrimination emerged as underpinning the normalisation of the criminal justice system as the means of 'managing' Aboriginal people with MHDCD.

## 8.4.2 Normalisation of the over-representation of Aboriginal People with mental and cognitive impairment in the criminal justice system

*They just think that screaming and yelling and going off the deep end down at court and swearing outside the court where the Magistrate is, they say, 'Oh that's just how people behave', and I say 'No – that's not how people behave when they don't have mental illness or some kind of impairment. That's not the behaviour of someone who doesn't have any issues'.*

The over-representation of Aboriginal people with MHDCD in the criminal justice system was described as normalised in every community and context we investigated. Disability emerged as part of the accepted overall presentation of Aboriginal people with multiple and complex support needs in the criminal justice system. The view that Aboriginal people with MHDCD should be managed by criminal justice agencies permeates all agencies' practices. What emerged strongly from the data was the systemic normalisation of disadvantage, disability and offending, with the conflation of these seen most clearly in people with multiple and complex support needs. The 'disablement' of Aboriginal people as a result of colonisation emerged as a contemporary negative political economy, evidenced in the over-representation of Aboriginal people with MHDCD in the criminal justice system. There are inter-generational issues underpinning this normalisation, including the poor relationship between Aboriginal people and the police.

## Systemic Normalisation of Disadvantage, Disability and Offending

Across all research sites, management of Aboriginal people with MHDCD through the criminal justice system was described as the standard and default approach. Interviewees detailed the way that Aboriginal people with MHDCD are targeted by police and end up in prison in the absence of more appropriate community-based care and support. There were reports of a small number of Aboriginal people with MHDCD who manage to stay out of the criminal justice system, but these are individuals with resourceful and significant family networks and are the exception. For the vast majority of Aboriginal people with MHDCD, coming from families and communities with few resources and inter-generational challenges around trauma, disability and incarceration, entry into the criminal justice system has become normalised. 'They'll end up in gaol' was described as a common comment made by teachers, service workers and police in relation to Aboriginal children and young people with MHDCD. As noted earlier, institutional racism was seen as an underpinning contributor to Aboriginal people's general over-representation in the criminal justice system, with disability compounding this but being less recognised. Common factors reported by interviewees included early contact with police, a lack of engagement at school, a disrupted or dysfunctional home environment, overcrowded or unstable housing, OOHC, and a general lack of positive early intervention or support. Community services was perceived as only becoming engaged in the lives of many Aboriginal children and young people with MHDCD in the context of child removal, and not in terms of ongoing case work or oversight or support for families. This means that young Aboriginal people with multiple and complex support needs become entrenched in the criminal justice system early in life, and their social needs become more complicated. Disconnection from family, homelessness, social isolation and being unknown to support services were all described as common experiences for Aboriginal people with MHDCD.

A lack of understanding, diagnosis and early intervention for Aboriginal people with MHDCD was raised by many interviewees as the reason for their over-representation in the criminal justice system. Participants across stakeholder groups described the experience of Aboriginal families who are socially and economically disadvantaged and who have suffered multiple traumas. They explained often that when a family has all these other stresses, everyone including those services that do exist, are overwhelmed. Therefore issues relating specifically to cognitive impairment are not prioritised or addressed. A failure of support and care networks and key agencies to recognise and mitigate risk factors was linked to the criminal justice system becoming the default for Aboriginal people with MHDCD.

*It could just be a care breakdown, the support system broken down, or the person has been teased by children and they've acted out because they have a lower frustration tolerance – whereas if those dynamic risk issues had been dealt with at the time appropriately then the trajectory of the charge, guilty verdict, may not have taken place. To a certain extent it all boils down to the fact that there is a restriction of options if the person doesn't have support and care networks around them or the community isn't switched on to intervene early on in crisis and does something proactive to reduce precipitating factors, like talking to the children at school. So if those suites of options aren't available, the default is safety, police, and criminal.*

The important role that schools can play in early intervention was identified across sites, including many situations where that had not been the case.

*You have some kids with hearing loss and they become part of the [criminal justice] system. The client being released in June: everything that should have been picked up going through school – primary and high – was never ever picked up, and now all this stuff is happening now. It's a lot harder and it's a bigger struggle for them the older they are to be able to find support and work with people because they are so used to doing what they've been doing [cycling in and out of the criminal justice system]. If they had been contacted at a younger age, working with the parents to work with the ID...*

A lack of understanding of the experiences and needs of Aboriginal people with MHDCD was reported as widespread and damaging.

*They don't know, everyone just thinks that [he]'s a drunk Abo, and that's how he will get treated. But he isn't. He may be under the influence of cannabis but he has a mental illness and an intellectual disability, he's certainly not drunk.*

For some Aboriginal people with mental and cognitive disability, prison became a place of relative security and predictability, where they receive a diagnosis for the first time and their drug and alcohol misuse is reduced. However, for most Aboriginal people with MHDCD, being incarcerated exacerbates their long-term experiences of disadvantage. Homelessness, drug and alcohol misuse, vulnerability to sexual and physical violence, and forcible disconnection from family and community were reported as common experiences. The particular vulnerability of Aboriginal people with MHDCD in prison was highlighted. One informant gave an example of a prison which reportedly had an officer who was focused on managing vulnerable Indigenous people with cognitive disability, and Aboriginal service providers described being able to communicate with him constructively around how best to support clients within prison, including who they were placed with. The impact of poor sensitivity to the needs of Indigenous people with cognitive impairment in prison was detailed in one distressing example:

*[A man with cognitive disability] ended up being put in [an NT] prison with two family members and ended up being seriously sexually assaulted. That went to trial, and he was torn apart by defence counsel, and those two were acquitted, but the client wasn't in a position to be able to give good evidence [because of his cognitive capacity].*

The normalisation of disadvantage, disability and offending was described as evident in the predominance of the risk management framework within corrections:

*There was another man who had a head injury and he was in [maximum security] because of his behaviour - he was in from the age of 19 to 28 - and apart from me going down and doing 6 sessions with him on how not to offend again, he got nothing really, he was just regarded as a behaviour management problem. So he was released and within 4 months he had reoffended. I tried to get him out, I tried to suggest to community corrections that he needed to be out on parole so that someone could be looking after him, and guiding him and looking after him, but they said his risk was too high. So he just finished his full term... and then there was no one taking responsibility for him at all and he reoffended in Darwin so he went back to gaol, so that was pretty sad.*

The assumptions upon which incarceration is premised were questioned by some interviewees in relation to Aboriginal people with MHDCD. The notion that an individual breaks the law and is incarcerated to 'be taught a lesson' and can then make a choice to live functionally in the community was considered to have no relevance to the reality of many Aboriginal people's lives.

*The idea is that this recidivist recalcitrant model where people come in and then they go back and they don't get it: if you do that you'll go back to gaol. So it's cyclical. And I was saying that what if you have no choice? You go back to your community, there's no employment, you know, what's going to change? So I'm kind of thinking that it's all very well to say 'No, don't do this, you'll get into trouble': once a person's been to gaol and that fear has gone, the thing that keeps a lot of people on the straight and narrow has no power. Yeah back in communities, what are the options? Live a good life, you can be successful. What? Have a job? What job?*

Many criminal justice processes were identified as inevitably leading to the incarceration and reincarceration of Aboriginal people with MHDCD. Stringent parole conditions were described as difficult for people with disability to understand and to meet; with breaching parole having significant consequences.

*It's their understanding of what they are obliged to do if they come out on parole... They think they are out, they've done their time and it's hard to explain that you are still on parole with these other obligations. That's where the problem is.*

Some interviewees detailed the nature of the post-release experience of Aboriginal people with MHDCD, describing the transition to the community for people who have experienced long periods of institutionalisation being particularly challenging. Workers detailed the need for the right balance between supervision, support and independence.

*You'd get someone [released from] a system where there's no rights, well, there's rights, token rights - to this system we're trying to do in CJP about empowerment and everything... and it was kind of like 'yeah, you know, we're here, we'll help you' and at a certain point it was like 'oh this is too much temptation', and we actually should have moved more slowly I believe.*

The lack of adequate or appropriate community-based services and support for Aboriginal people with MHDCD was seen as a major factor exacerbating their contact with the criminal justice system. For those Aboriginal people interviewed who live in a rural or remote location, this problem was even more stark. All stakeholders reported on the great variation in access to specialist assessment, support and services for Aboriginal people with MHDCD based on geographic location. The particular challenges facing people in small, remote communities were highlighted.

*For people in remote communities where there is so much service fragmentation and so many different services from government services and NGO services, it's very confusing for the individuals, for other services and for families in community to try and access the assessment and support.*



Community members and service providers described how the lack of appropriate disability and health care in the community for Aboriginal people with MHDCD means that service engagement usually comes when things have escalated to a crisis. The normalised response is police, emergency services and custody for Aboriginal people with MHDCD. Service providers identified the need for more targeted, appropriate early intervention for people suffering mental illness. They identified that crisis responses, such as hospitalisation and being sent away from the community, often involve forcible restraint and dislocation from home, family and community, all experiences which exacerbate Aboriginal people with MHDCD's distress. They argued that early recognition of and supportive action for a person with developing mental illness or behavioural concerns was imperative.

*If we can catch it while it is building up we can stop it then before you have to get the hospital involved, before they have to be sent away. It might be a bit of education on signs and symptoms*

However, community members explained that those working in services often wait until a crisis occurs before intervening to assist someone with MDHCD.

*The abuse and drugs and alcohol - y'know, sniffing petrol, no direction in life... We wait until it happens, until the crisis hits, rather than early intervention. We gotta wait until it happens until it justifies itself to do something about it.*

## Over-Policing

Service providers who work closely with Aboriginal clients with MHDCD reported how the practice of individual police officers, especially less experienced officers, negatively impacts on people with MHDCD, contributing to distrust and fear of the police and compounding their contact with the criminal justice system.

*We had two particular young coppers, straight out of the academy, full of their own importance and new-found power, who used to badger and stalk my client. And all he was doing - he had been to the pool, he was walking home which was about four blocks, they went slowly past him – he hates people in uniform by the way and he hates police cars or anything that looks like a police car – and they went slowly slowly past him, then sped around the block, then slowly slowly passed him, then sped around the block, five times. To the point that he got so frustrated he picked up a handful of rocks and threw it at them and told them to piss off. So they then pulled in to arrest him for throwing rocks, then they pushed him against the paddy-wagon that hard that they made the dint in the paddy-wagon, and were going to charge him with [malicious damage].*

Service providers reported that instances of the over-policing of Aboriginal people with MHDCD such as this damages entire families, creating tension around the person with MHDCD:

*Yes, you can see it impacting on families. Well it ends up being a hatred of the police, ‘Oh my God, they are here again, what do they want this time?!’ And sometimes the police are only there to push their buttons. And it causes conflict in the family, because they family will say “you’re always getting into trouble, and the police are always here looking for you and we’re sick of it”, so it causes conflict for the family.*

Service providers who work with Aboriginal people with MHDCD identified that it is almost inevitable that police will become involved due to the presenting behaviours of this group, triggering ongoing and escalating contact with the criminal justice system. Service providers also suggested that the police have certain understandings of what it means to ‘protect’ the community, which also impacts on police practice and discretion.

*The police way of providing a sense of security and safety is to charge the person, and so it starts that process [of management through the criminal justice system].*



The normalisation of the management of Aboriginal people with MHDCD via the criminal justice system was illustrated by Aboriginal community workers being dismissed when they raise concerns with the police:

*Because I remember one time a couple of years ago when we went to the police about a client, and [the Police ACLO] had been in this job for 15 years – and he begged the police to go get him help. They literally said to him “How do you know that he needs help?” And he said ‘Well, unusual behaviour, and his wife has told me’ and stuff like that. They said: ‘Unusual behaviour doesn’t mean he has a problem’.*

A lack of understanding of cognitive impairment and mental illness amongst police was described as a major factor compounding the negative over-policing of this group.

*They think severe depression and anxiety doesn’t mean anything, well it does make people do some stupid things. They don’t understand brain injury and how with frontal lobe damage people can lose control of their emotions. They think a person screaming and yelling and swearing is just ‘totally off his tree’ but no understanding, not enough training.*

Many service providers and community members reported that Aboriginal people with MHDCD are commonly and disproportionately targeted and harassed: their disability means that they come into contact with police earlier and more frequently. Their offending history then becomes the reason given for why police target them and why they don’t receive bail, leading to their subsequent overrepresentation in prison.

*Once you have a record, the slightest little thing: it’s on your record. Like a bloke recently got 9 months for pushing another bloke - that’s just a little harsh. [Because of his offending history?] Yep. And of course he had only been out of gaol a couple of weeks... I think the problem with people with mental health issues and cognitive impairment is, when they do start out in the gaol system and they get themselves a record, nothing is ever in the past. Nothing is ever in the past. So how can you get help, do the right thing, get your life on track when as soon as the police see them they start harassing them?*

Many community members reported on the suspect target management plans (STMP) apparently used by NSW police to monitor and surveil persons of interest. The STMP were described by lawyers as internal policy rather than legal regulations, but which the police use as a risk management tool within individual commands. Aboriginal people with MHDCD appear to be subject to STMP more regularly than others.

*She’s now on a police - what’s that list called? - STMP list, so they keep stopping and searching her. I think someone saw her in the street walking her dog and the police were around her searching her... When you get on that list the police target you more often and they don’t need to have reasonable suspicion when they search you, and so you’ve got someone with a cognitive impairment now on this list that’s being harassed all the time. ... As soon as you get to a certain number of convictions they just put you on this list and they start monitoring you more.*



## Intergenerational Issues

When talking about young people or young adults with MHDCD, service providers identified the impact of intergenerational incarceration and the complex support needs of many parents and grandparents. Service providers also identified the generational repetition of the pathways to prison due to lack of support for MHDCD needs, drug and alcohol issues, and contact with the police.

*A lot of our parents don't have the education or knowledge to keep up – to get help. This is what needs to happen, for a lot of our kids we've got to break the cycle. A lot of our issues are from a long way back and are deep generational problems, and they are the types of things we got to break down.*

The incarceration of Aboriginal people with MHDCD was described as systemic and intergenerational.

*[Aboriginal people with cognitive impairment,] usually they are homeless, sick, on the grog, We try to put people with family [in prison] but sometimes we put people elsewhere. When I started I was dealing with fathers, now I'm dealing with their grandsons and granddaughters – that's scary.*

Prison was described as becoming normalised in some Aboriginal families.

*... if you got a young generation coming up now with no social skills, and no living skills, just violent skills... so you know they're going to be imitating their uncle, their sisters and brothers. They're going to say 'Unc's in gaol, why can't I?'*

While Aboriginal people are over-represented in the criminal justice system generally, interviewees confirmed the earlier and more compounded levels of criminalisation of Aboriginal people with MHDCD as significant issues. These multiple and complex support needs encapsulate the failure of systems, policy and programs to take account of these support needs than individual diagnoses and became a unifying and central theme emerging from the study.





### 8.4.3 Multiple and Complex Support Needs

*We had a referral of a man with an intellectual disability and we didn't take him on [as an AOD client], and I asked why, but I think it was because it was too complex, because none of us have been properly trained to help people with intellectual disability. We have two clinical psychologists and we've had some training in that area, but the psychologists and social workers - this is all new for them, and then the AOD workers who are not trained at all.*

Many of the observations already reported refer to people with multiple and complex needs. Interviewees reported how prevalent it is for Aboriginal people in the criminal justice system to experience multiple and complex support needs that are not adequately met and in many cases, are created or exacerbated by their criminalisation. Many Aboriginal people who end up in the criminal justice system have early lives marked by poverty, instability and violence, without access to good primary health care or early childhood education. What emerged from the qualitative interviewees is the way that an Aboriginal child with an intellectual disability or Fetal Alcohol Spectrum Disorder (FASD) in participating communities rarely received early diagnosis or positive intervention, resulting in their disengagement or expulsion from school at a relatively young age. Drug and alcohol misuse by young people is often recorded as a common experience, along with emerging mental health issues. Frequent OOHC placements which break down and homelessness are often experienced. Increased police contact as a person of interest in relation to minor theft or public order offences is a common pathway, with the likelihood of a number of court appearances before a juvenile justice custodial period.



Moving into adulthood, drug and alcohol misuse and mental health-related illnesses tend to worsen, often accompanied by increased experience of violence and self-harm, more serious offending and longer periods in custody. Other than occasional crisis-related admissions into hospital, there is reportedly little positive interventions around health and wellbeing for this group. Drug and alcohol rehabilitation is often only available in a regional centre many hundreds of kilometres away, and even then, excludes people with a cognitive impairment. Mental health services are unable to accept people with drug or alcohol addiction. Diversionary programs that aim to assist people whose offending is connected to their drug and alcohol addiction will not accept those with a history of violence. Incarceration becomes the default option in the absence of available or appropriate community-based care, housing or support.

*So that is another key issue for people with dual disability. The respite funding for people with mental health is easy enough to access but [mental health services] won't provide respite services for people with intellectual disability because they say that disability services have their own respite funding.*

The multiple and complex support needs experienced by many Aboriginal people in the criminal justice system can then be understood as emerging from the siloed institutional responses to their circumstances; as in effect created from those responses. Negative, punitive criminal justice interventions rather than positive human or community based service interactions are the norm. Families and service providers reported with few exceptions that the model for care and support of Aboriginal people with MHDCD and their carers are disconnected from their actual support needs, care experiences and availability of services. What also emerges is that the nature of care and support needed for Aboriginal people with multiple and complex support needs is qualitatively different and more than the sum of their individual diagnoses and disabilities. Combined with the normalisation of the criminal justice system as the avenue through which Aboriginal dysfunction and disadvantage is managed, systems of control and containment predominate. This is also intergenerational.





## Siloed Service Provision

*And that's what I've been saying – you want me to work with a borderline personality, but I only just got this training 2 years after working with someone for 2 years. But in general the department doesn't offer mental health training and I think that's outrageous... if we're going to look at our safety and our patients' safety why don't we get more training on what is actually wrong with them and how to deal with them?*

A major gap in service delivery and support for Aboriginal people with multiple and complex support needs was described by interviewees as the result of the common arrangements around siloed service provision. Organisations, services and funding streams are usually connected to a particular policy area, such as physical or mental health or disability. Commonwealth, state and territory government agencies and non-government organisations may all be providing services in a community under a different policy area and funding arrangement. There is reportedly resistance by service providers to working with clients with multiple and complex support needs as it requires a level of coordination and cooperation and extra resourcing that is not possible or common practice. Certain professionals or community workers also tend to have expertise in a particular area such as intellectual disability or AOD rehabilitation but not across all issues facing Aboriginal people with multiple and complex support needs. They were often not provided services and support because they were 'in the too hard basket'. Understanding the distinction and interplay between mental health issues and cognitive disability was raised as important but lacking.

*There aren't services for people with brain injury. There's stuff for physical disability, but mental health and brain injury? The services and staff is difficult because there isn't anything.*

Many interviewees mentioned mental health training as being scant or non-existent; current training reportedly involves a day or two days training and is referred to as 'mental health first aid'. The importance of Aboriginal-specific training was raised. Specialised training regarding working with people with both mental illness and cognitive impairment was identified as lacking and an area of great need.

*So it was more along the sexual offence side, none of our CJP training is targeted at mental health, none of it. We've had behaviour training where they do talk about the ID side of things... there's always a reason for a behaviour it's not just someone being naughty.*

A key barrier that prevents early intervention of community-based services supporting Aboriginal people with multiple and complex support needs at the point of initial contact is the tendency for services to reject or refer people who are deemed the responsibility of other services, based on the diagnoses or issues they present with. This is often the case for people with both an intellectual disability and one or more mental health disorders.

*From our perspective we just see that there are six extra beds that are required for our own increase in activity for people with just plain mental health problems. So it's [accessing] going to be problematic [for] people with intellectual disability... This man has been case managed by disability services since he was a baby, that's regarded as a primary disability, so when I talked to frontier services they said 'No, we can't' because they are mental health respite.*



Many services are used to working unilaterally within their sector and appear resistant to new practices involving inter-agency and inter-sector collaboration. This is bound up with the reality that each sector tends to operate under a different philosophy of care and model of service as well as in siloed budgets. Lack of inter-agency collaboration was described as undermining good practices in referral, case management and information sharing. Even though in some smaller towns all the relevant workers are located in the same building and know each other personally, services reportedly rarely worked collaboratively even where it would greatly benefit the client to do so.

*[Community Services] aren't very good for referring out to other services. I've been in this position - even though we've sat in their office - I've been in this position for 13.5 years and the whole time I've only ever shared 2 clients with them.*

One key problem identified was the lack of clarity around which community-based agency was ultimately responsible for leadership around service provision for this group – family, community or disability services? Unlike police or corrections, there is a voluntary aspect to the provision of community-based care that means service providers can refuse to support Aboriginal people with MHDCD if they are considered too challenging or to not fit eligibility criteria.

The lack of protocols for communication between health professionals working in custody and in the community regarding medication for Aboriginal people with mental health diagnoses was raised as a particular challenge that can have significant negative implications.

*The biggest thing I find with the mental health ones coming out from gaol, Justice Health doesn't release them with a meds sheet: what they were on or what they were taking. So when parole says to them: 'Oh here, go to the AMS to get this and this,' and they come here saying 'I was on so and so medication in gaol, can I have it now?' Well we can't give it to them – it takes time, there's a process – and that's how we lose them. ... We say: 'Can't give you that til you see someone, could take a week or so,' and they are already back on the grog and the grass to substitute it'.*



Interviewees identified eligibility and suitability of AOD facilities as a major impediment for Aboriginal people with MHDCD seeking help for alcohol and drug addiction. People were regularly discharged from rehabilitation services due to what was considered problematic behaviour, often relating to their cognitive impairment or mental illness. Service providers identified the difficulty in getting clients who have histories of violent offending into mainstream rehab facilities, due to the facility not accepting them based on risk assessments.

Service providers also reported that mainstream rehab programs and therapy were not suitable for people with cognitive impairment, because they were not specifically developed for people with cognitive impairment.

*We've got some old ladies who used to drink a lot and have stopped now due to [an Aboriginal worker] taking them out on these bush trips and things, and some of them could have memory problems and stuff from drinking all of their lives. But they don't engage in therapy. Now, why? Well it could be because they don't understand what's going on.*

Service providers reported that court ordered rehab stays were useful in overcoming reluctance on the part of services to take certain clients on, although there was still a lack of understanding and accommodation of people with complex support needs.

*Yeah he went to rehab, a number of rehabs... [were they mainstream or special rehabs?] Oh man, the issues is trying to get a violent offender into some of the rehabs... it's a bit hard. We tried to get him in before parole but then the judge ordered rehab so that got him in a bit easier. But then... he got kicked out [due to behavioural issues].*

Participants with multiple and complex support needs described how their drug use was inherently connected to their offending, and how in some instances their offending was a direct result of their drug use. Service providers confirmed the presence of drugs in remote and rural towns as a significant issue for clients with multiple and complex support needs in becoming involved with the criminal justice system, and suggested that the situation was worsening. One interviewee identified that this had in fact precipitated greater holistic engagement by some services with Aboriginal clients with multiple and complex support needs.

*A number of things happen, due to the drugs in the communities, I think that's the main link to the justice system at the moment, and that's probably always been the case. It seems to be getting worse, particularly in the western towns. The drug issues just make all the other services have to come on board.*



Interviewees described the way that Aboriginal people with multiple and complex support needs are regularly described as 'not the right fit' for services, whereas in fact the situation should be understood as service models not matching or meeting their needs. Coordination of services around individuals was described as not the norm and many clients with complex support needs do not experience the benefits of coordinated case management.

*The problem is there is no flexibility of service delivery. They don't understand that you have to move and change the model to fit the area.*

The prevailing rationale is that the individual must actively engage with the service to receive any benefit rather than the services changing their approach to be what is now referred to as an assertive approach. For example one interviewee said: They told me they weren't going to go looking for him. He needs to engage with them, he needs to consent to the services they want to provide to him. Emphasis is placed on the willingness of the individual rather than the capacity of the service to facilitate engagement (such as, through outreach) or to understand the factors that might inhibit engagement in the first place.

*If they're too difficult then they refuse to work with them. So they don't go that extra step to continue and maintain that support, even when I guess the client has low periods, or things that become difficult in their life, at some point they refuse to continue to maintain that relationship and that support, which a person may need to get through that difficult time.*

Eligibility criteria were described as prohibitively narrow and/or difficult to meet for Aboriginal people with complex support needs who lack literacy and numeracy skills, formal documentation and diagnosis, knowledge of the system and competency in self-advocacy.

Where people do meet eligibility criteria, demand for services greatly exceeds current levels of availability.

*Sure the demand is really high... no one is getting the thorough treatment that they need, and the right follow through – because workers are jumping to this one to that one.*

Where demand for services was reported as low, it was apparent that services were not identifying, or were unable to measure, real levels of need.

*I don't think it's a great demand, or whether it's actually identified. The ones who we know have MH issues, and who have gone to a service will be utilising a program like HASI, without a doubt, and if they aren't then it's only because they don't want to.*





Aboriginal workers and service providers said that this sort of response (saying people didn't want to engage with the service) was a common response by mainstream services that didn't genuinely wish to engage with Aboriginal people with multiple and complex support needs.

Some workers attributed poor service responses to their inability to work flexibly within a centralised, bureaucratised and heavily regulated system of funding and governance. Aboriginal workers were seen as particularly disadvantaged by this system.

*All of a sudden the shires and the bureaucratic process got hold of this and this sort of naturally organic process of conflict resolution, distress management, was taken over by the system so that the people involved had to satisfy OHS requirements, credentialing issues, work hours, all of these hundreds of things - they had to write reports. So these older [Aboriginal] people, they were excluded because they didn't fulfil these white-based tick box bureaucratic exercise.*

A lack of professionals with specialised mental health and disability skills was identified as a key problem in the failure to meet the needs of Aboriginal people with multiple and complex support needs, particularly in smaller, more remote areas and in prison. Staff are reportedly under pressure to work across large areas with small budgets, often under centralised management structures that do not recognise the importance of collaboration and community engagement.

*What I argue to head office is that I need to be at x interagency and be really involved in their programs and their consultations because they need to know that [we] are interested in that town. We can't just go in and leave without doing anything because they won't want to deal with us. So you have to keep going back. It's been a great fight and still a fight every month [with the central office in Sydney] about why we still go to the same inter-agencies. They don't let you do it.*

A lack of support and services for Aboriginal women in particular was highlighted.

*There aren't enough people – qualified people – to look after people inside [prison], particularly the women. They get neglected, they get hardly anything – don't get rehab programs because they are in for very short periods of time. So it's a revolving door for the women. ... My major thing is that for the women there isn't enough rehabilitation in the prison.*

A lack of suitable and supported housing was a key issue identified by interviewees. Service providers raised the specific challenges faced by Aboriginal people with multiple and complex support needs in terms of housing accessibility.

*The three areas that will put your tenancy at risk will be property care, arrears and nuisance and annoyance. The people you are talking about will come across all these three areas as problems.*

Group homes were raised as a model that could be appropriate for some Aboriginal people with multiple and complex support needs, but they were not an option in many regional sites.

*There are some [clients] that might be suitable for a group home to socialise and go out and do activities, but there is just nothing.*

The prevalence of homelessness amongst Aboriginal people with complex support needs was raised across sites by a number of interviewees. Homelessness was described as leaving Aboriginal people with complex needs as particularly vulnerable to violence and reincarceration. The particular challenges around accessing emergency accommodation as well as longer-term housing was detailed.

*Now because of his behavioural disturbance it's impacted on his housing, so he's also effectively homeless. Because he's very disturbed he does things like rips the meter box of the wall, or burns all the white goods, or threatens other people.*

A lack of appropriate and targeted support in prison for Aboriginal women with multiple and complex needs was identified. Being in prison for short periods of time and having no access to rehabilitation programs as a result was described as a 'revolving door' for the women. They were identified as often having problems with communication. The vulnerability of Aboriginal women with complex support needs was a serious concern:

*A woman who probably has an intellectual disability - she was there when I first went out there [to the prison], and really nice and incredibly vulnerable. Gets into fights easily. When she's in the women's block gets into fights and often gets sent down to G block because she's seen as disruptive. The last time she was down there, not this time, she was put into a separate cell in the women's prison to keep her away from everyone else. But when she was released last time there was no release program for her at all except for Mission Australia and they don't do anything for the women. They do nothing. I don't know how much they do for the men but they do nothing for the women.*



## **Families' Multiple and Complex Support Needs**

Aboriginal families in the communities surveyed were described as coping with many family members with multiple and complex support needs, often across generations. The stress for families coping with minimal or no support was articulated:

*It's partly the extent of the problem – the range of factors that we have spoken about... If you look at the extent of FASD, behavioural stimulants, difficulties in managing effect – kids are volatile. You know if something happens, 'I don't get this, I don't get that', their ability to calm and soothe themselves is just diminished. It's partly the extent of this issue. Families just have so many responsibilities – it's overwhelming, ... there is only so much the family and the community can manage.*

Service providers detailed the presence of multiple family members with disability, describing how this could further marginalise and isolate the family from support and assistance. Service providers also explained that a disability might not be identified within the family if they are not divulging sufficient information to services and government agencies. This often results in not identifying all family members with disabilities unless services engage with clients in a culturally appropriate way.

*We had one application that didn't make sense and intake were very concerned about it, so I hopped on the phone with intake and we had a conversation with mum. She was only applying for one child, but out of that conversation I said 'I'm taking off my worker's hat and I'm talking to you as an Aboriginal mother too', and we discover she has three children under the age of 16 with disability, she's worked in disability services – and the disability field has let her down greatly. She now homeschools 3 children and looks after her aged mother who has dementia. So unless I had that yarn with her over the telephone, and actually could go through all of the information she was offloading through frustration to say 'so this is where you need help Aunt' - it was about taking what she needed and putting into context to meet the application guidelines.*

Carers who support multiple people with MHDCD in the family explained how the family unit adapts to and copes with the different kinds of needs of each family member. They described how understanding the disability and the mental health issues helped them to plan and strategise.

The challenges of parenting difficult children, including those children who have been affected by their mother's drug and alcohol misuse, were raised by a number of interviewees.

*[The children] would just scream, and they would remind me of children that have been born with the effects of drugs, because the baby used to bang his head on the floor. Bang it on the floor. And even the boys in my care now [other foster children] they used to do that too because their mum was on speed. And I know when he was two days old he started crawling - he would do it and it took a long time for him to stop doing that. And the little girls, they have lovely long hair, and they just pull it out. It's really, and for [their mother], she just gets really angry with the kids, she'll swear. Afterwards we talk about it but she doesn't understand what's going on.*

These complicated and difficult multiple interactions and problems work against the holistic, integrated service provision that interviewees working at a community level identified as what is needed for this group. Funding for culturally appropriate services was described as a particular need. Adequate resourcing for training skilled staff was considered as an acute need in small communities, although it emerged as a broader issue for Aboriginal people with multiple and complex support needs everywhere.

*There is a gap and it's all around that knowledge and training, and the dollars I guess. If you want someone that's more qualified you're going to have to pay... I guess that's just an all-round-the-state issue for people that need that extra help.*



## **Need for Culturally Appropriate, Holistic, Integrated Services and Responses**

Aboriginal interviewees reported on how crucial it is for services to understand and work with Aboriginal people with multiple and complex support needs in their cultural context and community. Culturally appropriate and coherent integrated services were consistently identified as key across all research sites.

*[Police, Corrections, Probation and Parole, Health, mental health, disability services – so who do you think should be working with the family?] It needs to be a bit of everything, you've got to look at the history of the person themselves and get to know them, have sort of relationship so you can understand them. You can't understand by reading a piece of paper or a file, you need to ask 'what do you want to get out of life, what do you want to do?'. You'll never be able to help a person if you don't understand them.*

One interviewee articulated the particular responsibility borne by Aboriginal service providers in small communities:

*It's more about person-centred holistic approach to servicing. We don't want to see clients back here in 6 months' time with the same problem. 'Cause if they are, we've let them down. They haven't done anything wrong, we've let them down. 'Cause we haven't put them on the right pathway for their personal needs. And when you're coming in small communities like this you've only got one option, one service.*

Lack of cultural awareness and competency was identified as deterring Aboriginal people from engaging with general population or mainstream services and receiving appropriate support.

*Therapy isn't an option. The professionals in this town don't have any experience. Not at all culturally appropriate and they don't think they need to be. They don't try to get family involved.*

Where there had been an emphasis on cultural awareness and competency in organisations, there were tensions reported in both mainstream and Aboriginal controlled services in terms of efficacy, who should provide services, and the status of cultural advisors.

*My experience of people coming through that have had cultural education sessions, is that it's really not adequate for working in communities. My belief is that for a non-Aboriginal person, to be working effectively in an Aboriginal community, you need to be employing someone to be your cultural mentor and supervisor.*

In regional and remote areas, cultural awareness or more importantly cultural competency training is reportedly often unavailable or inappropriate to the community, particularly if programs have been transplanted from other contexts. Consequently, many services are not provided in a culturally safe or appropriate way. The particular problems associated with professionals flying in for brief visits without sufficient understanding of the local culture or community were raised.

*Services are not provided in a culturally safe way. And in a totally meaningless way. I mean the idea you can visit a community in one day with an occupational therapist and develop something that is going to be meaningful for somebody...*

The value of Aboriginal people bringing a lived experience to a professional role working with people with multiple and complex support needs was also raised, as was the common lack of respect for Aboriginal workers' perspectives.

*We are still living it now – no qualifications can ever cover the life experience of what we see and do. You can do training all your life but if you've never lived it then you're hopeless compared to someone who has lived through it and survived it. So why not just listen? Simple.*



Some service providers spoke about correctional staff who are local community members with an understanding of cognitive impairment, and the level of appropriate care they were able to provide as a result:

*We've had three people in the last 12 months, we have a bloke with an ABI which he got at age 9, he's about 40 now – and he has a lot of issues, But the Corrective Services guys [parole] were so good with him, how they interacted with him. The other two were women, with ABIs and mental health all rolled together. They were great with them as well. So I sent an email to their boss and said your officers need to be commended – they treated these three people with so much respect and integrity, and I was so impressed. I don't think I've seen people treated in hospital as well. And it's because these corrections officers are local. They understand. That local knowledge, mate you can't beat it. I mean even the fellas that aren't from here you know their family, so I've never had any trouble – the local stuff works, it's huge. The fly in-fly out doesn't work.*

However, culturally competent case management is reportedly extremely rare. Interviewees noted that some Aboriginal people leaving prison don't receive any type of supportive supervision upon release, inevitably resulting in quick re-offending once back in the community. People with multiple and complex support needs leaving prison are reportedly often characterised as 'a lost cause' due to the difficulty for service providers in engaging meaningfully with this client group to provide support.

*He was left to his own devices when he got out. He reoffended within five days. He's a lost cause, people have tried to engage with him...*

Interviewees overwhelmingly reported that the experience of Aboriginal people with multiple and complex support needs at all stages of contact with the criminal justice system are failed by the service model and its delivery across all sites investigated.

## 8.4.4 Trauma and Violence

Trauma and violence emerged as common and pervasive experiences for Aboriginal people with MHDCD in the criminal justice system. Aboriginal people with MHDCD were described as particularly at risk of physical and sexual violence from a young age, Aboriginal women in particular. Violence reportedly remains a common experience for Aboriginal people with MHDCD throughout adulthood, including at the hands of police and in custody. Many Aboriginal interviewees working in service provision discussed the impact of child removal in terms of intergenerational trauma. Contact with the criminal justice system was perceived as the result of childhood experiences of trauma and grief, and in turn compounding that trauma.

### Complex Trauma

*When I was younger, when I was in foster homes, I didn't like it. It broke me, being that young and not understanding – being ripped away from your mother. It hurt. It breaks you mentally and physically... Being in JJ brought back memories of being snatched away from my family.*

*How do you identify people with impairment? They will have been a victim of violence as children. The young ones don't have any sense of their culture at all.... Post traumatic stress disorder – they all suffer from it, it often contributes to their behaviour and probably offending.*

Mortality rates were very high for Aboriginal people in the communities visited, with death occurring due to accidents, chronic health conditions, and most significantly suicide. Of the Aboriginal people interviewed with MHDCD who had been in the criminal justice system, attempted suicide was common, and knowing someone who had attempted suicide or had committed suicide was universal. The impact of this was reported as related to spikes in drug and alcohol related incidents and violence in the community. Grief and loss were specifically identified as something impacting negatively on Aboriginal people with MHDCD, on par with drugs and alcohol.

Service providers characterised the impact of loss and grief on clients with MHDCD as 'spiralling', which was described as the experience of using drugs and alcohol as a means of dealing with grief, and often resulting in contact with the police. Aboriginal people with MHDCD who had been in the criminal justice system described how being separated from their family and placed into OOHC contributed to feelings of loss and grief. People described how being incarcerated brought back those feelings of loss and exacerbated trauma.

*When she first went in she was pretty unhappy because she was away from her country, she's from WA and didn't know anybody in prison. I've seen her once every 3 weeks, she's got quite attached to me and doesn't mind sitting with me, but over time she has just regressed. The last time I saw her was last Thursday and just sat next to me and didn't say a word. And her mental disorders – anxiety, depression – she tried to hang herself in 2008 after a domestic violence episode. She's covered in cuts up her arms and neck, legs from self-harm and also from her partner harming her as well. In the first session she kept saying "I want to go to Kalgoorlie prison, I've got family there, I want to go to Kalgoorlie, I want to go to Kalgoorlie". So I wrote to her lawyers to ask is it possible for her to be transferred, and we found out she can't be transferred until after her trial which is in April. So she is locked up, and [Aboriginal psychologist] Tracey Westerman talks about an illness that Aboriginal people can have which is called 'crying' or 'sick for country', and that's what I see her going through.*

Being in a state of grief due to deaths in the family and the community was described as the norm for many Aboriginal people with MHDCD, with deaths occurring so often.

*There can be constant states of grief – I'm in my 50s and have only been to 4 or 5 funerals. For one my clients I've had since 2002 I've been to 14 funerals. There is just a constant state of grief... a client of mine that has been out for 6 months and already 3 deaths.*

Service providers reported that there were no culturally appropriate services available for Aboriginal people in Western NSW dealing with grief and loss.

*A lot of suicide in the communities, so a lot of grief and loss around that. More support for grief and loss would be great, particularly out west, because the services aren't there.*

Aboriginal people with MHDCD identified that seeking help from people to deal with loss and grief can be challenging because they don't feel comfortable talking about what they are dealing with, or would prefer to talk to people who have also experienced what they are going through.

*My problem is I just don't talk to anyone. I'd rather talk to someone that's been through it, not just read it out of a textbook. They might have just read it... You just have to connect with the right person and just talk.*

## Violence as Pervasive

The experience of violence was pervasive amongst Aboriginal people with multiple and complex support needs who are managed by the criminal justice system. Participants described the presence of violence in the family as a factor that drives children and young people with MDHCD into vulnerable situations, or into contact with the criminal justice system. From a young age, many Aboriginal people with MHDCD experience violent interactions with police.

*She was off her medication at that time too, pregnant, and she was confronted by the police and she became irrational in that situation. I don't think the police over here have learnt how to deal with people with mental illness appropriately. So she became irate, they then dragged her into the police station and took her down in the foyer because, well, their excuse was the way she was acting.*

Aboriginal people with MHDCD described how police violence impacted on their attitudes towards police, and confirmed the inter-generational mistrust of the police.

*"It's when I'm drinkin'. They pick on me. And they tip my grog out. Then I do something silly, swear at the coppers, threatenin' them, then sometimes they chuck me around on the street. [Who is they?] The police".*

The particular vulnerability of Aboriginal people to sexual and physical violence whilst incarcerated was raised by a number of interviewees.

*It makes them very angry – they come out angry. My son was assaulted in gaol. People with brain injuries shouldn't be put into gaol because they can't keep their mouth shut. They can't control their emotions – and once they start: 'rah rah rah', they just carry on. And those blokes in gaol aren't going to tolerate that, so they just go and job them. And someone with a brain injury shouldn't be getting another belt to the head.*

*We need a facility – not a secure one but one that is more supportive and safe. These guys are not safe, they are targeted.*

Service providers and carers identified the issue of negative family influence when family members take advantage of people with mental health or cognitive impairment. For example, people with MHDCD were described as vulnerable to having disability pensions or compensation payments taken.



## Violence Against Women

Domestic and family violence was the most significant issue identified that specifically faces Aboriginal women with MHDCD, often in connection with alcohol misuse. This was identified as an intergenerational issue. The cause of cognitive impairment was attributed to acts of violence in some cases. Women experiencing long-term domestic and family violence were identified as commonly experiencing severe depression and anxiety.

*It was even hard for my mum because my mum has cognitive problems herself, horrific DV history growing up, so sometimes there are times when she couldn't take the kids to appointments.*

Challenges associated with taking out AVOs were identified, including police not taking women's complaints of domestic violence seriously enough; violent partners taking out counter AVOs against women as retaliation; and the problem of unrealistic conditions leading to breaching of AVOs and escalation of contact with the criminal justice system. Service providers working in the area of domestic and family violence reported that the police use their discretion to decide whether or not to issue AVOs to Aboriginal women who are victims of violence. This can be based on the police officers' own impressions about how AVOs are used, rather than the evidence of people who can confirm the existence of danger or violence.

*One thing we do is if they don't have any success dealing with the police in getting AVOs in place, we can lobby the police or assist them in making private applications, which is very uncommon... I did speak with the police, they just weren't of the opinion that there was a real and genuine risk to her of her safety, so they didn't think there was a threat that warranted putting an AVO in place. The applicant said she felt very strongly otherwise... Historically I suppose there's been a lot of AVO tit-for-tat type stuff - you know, you get an AVO against me I'll get an AVO against you.*

Services working with Aboriginal women who are victims of violence reported the failure of the police to provide an adequate response to complaints as commonplace. This includes not correctly recording the incidents, and not providing the appropriate support when Aboriginal women seek the assistance of police.

*We had a woman with schizophrenia and as I say, she was scheduled several times. Word around the community was that there was no doubt she was being abused, she used to sell herself, but if she went to the police, they didn't even make a record of these incidences. One of our support workers... she's known this person from high school, all her life, and she can say that: 'Look I'm aware that all these things happen' and she even accompanied her to the police station one day to make a complaint. And then when we obtained the police records for her victim's compensation matter for DV there were just no records in existence.*



It was reported that complaints are only taken seriously, or followed up, when services get involved and advocates of the women push the police to respond.

Aboriginal women are reportedly unlikely to participate in mainstream women's domestic violence programs. Some are also reluctant to involve the police in domestic violence situations that might lead to their partner being imprisoned and unavailable to parent their children or contribute financially to their care.

*In the domestic violence side of things we don't have a high rate of Aboriginal women in that program. My own opinion is that you don't do in your partner to the police, of all people, and you don't run him down or you'll get called names by the daily. Also a lot of the times women think, well, I'm seeing the women say 'terrible partner, but he's good to the kids, he's a good dad', and they say they need his help with the kids.*

Reporting domestic violence was also identified as increasing the risk that women would have their children removed from their custody, which for many Aboriginal women worked against seeking police intervention for protection against violence.

*So I've had instances... where there's been a DV situation evolve, the police have been called to the premises, not by the people themselves - they've turned up, the children are safe but they're within that environment, the police have addressed the situation of DV, and then DOCS have been referred to look in, and that's the first time that family's ever come under the scope of DOCS. And that woman's response to that situation was she doesn't give a fuck if he beats her black and blue, she will never ever call out for help ever again. And so where does that leave us as trying to encourage our people to step forward and stand up when there doesn't seem to be the accountability on the other side? It's sort of like all of us fighting against the system.*





Women reported a lack of institutional support for retaining or regaining custody of their children. A lack of timely and accurate legal advice was identified as a particular challenge for Aboriginal women with MHDCD, especially where they had experienced domestic or family violence.

*Well they never gave us an option, they didn't say: 'We can help you, we can take you to domestic violence counselling'. They didn't do any of that, they just took the kids, they said it was me – if I left [my partner] then I could keep the kids. But when I got to the DoCS office the kids were already gone.*

A number of women identified experiencing violence at the hands of their partner with MHDCD, often leading to their partner's imprisonment.

*It's torn me family apart. Their father is - all my kids have the same father - who is in gaol now, he was ADHD and his parents used to beat the crap out of him and each other. It's the cycle, you know, he does the same to me as well which is why he keeps going to gaol. Assault me and anyone he didn't like the look of. I think he seen his mum and dad beat each other up, plus drugs.*

Financial stress was identified by a number of interviewees as the reason for women staying with violent partners. Insufficient financial support for carers of people with MHDCD or the children of people with MHDCD was also identified as limiting women's options for leaving situations of family and domestic violence.



## 8.4.5 Capacity for Support

*There's no support there [for the person leaving prison or their families] and that's the problem. ... You can understand the frustration of carers or family members who then, you know, eventually have to get on with their lives and their children; also for people with cognitive impairment and mental health, they just suffer. They just fade way, forgotten about. Because you sit here in this job and think 'oh, if I could just do more', but it comes down to 'well, I don't have capacity, I'm not a case worker to be able to do all that'. It's just a big vicious cycle that swallows them up.*

The issue of capacity was a consistent theme emerging from the qualitative data in relation to families, communities and the service system. This included discussion of the capacity of Aboriginal communities to 'take care of our own' as both an aspirational narrative and a response to negative government intervention. Some Aboriginal interviewees gave examples of families having strong and culturally derived care networks in place which meant that vulnerable Aboriginal people with multiple and complex support needs were able to be supported to live in the community. Many Aboriginal carers were described as taking on responsibility for the care of family members, often a number of them with complex support needs, to ensure that they did not end up in prison, given the lack of community-based alternatives. However those carers are reportedly frequently overwhelmed, often ageing and in ill health themselves, and such care arrangements often break down to the great distress of all involved.

*Two of his aunties have stepped forward. So the family have talked and they are both quite young, early twenties, and have young children. So he can live with them.... The treating psych has talked to his aunties, and they are saying: 'We know he has difficulties, we know it's going to be hard, but we want to look after him, we feel sorry for him, he's been stuck in hospital for a long time and his mum can't care for him and we want to try'.*

Community capacity to cope with people with multiple and complex support needs was described as both eroded by the scale and depth of the challenges involved, and not sufficiently tapped in some cases. The starkly evident lack of capacity of government agencies to adequately or appropriately support Aboriginal people with MHDCC and their carers in the community was widely discussed in all research sites. As noted earlier, disability, child protection, health and criminal justice systems and services emerge as often working against the provision of the kind of holistic, coherent, integrated, culturally appropriate model of care needed to support Aboriginal people with multiple and complex support needs.







### **‘We take care of our own’**

Interviewees in every site highlighted the significance of family and community for Aboriginal people with multiple and complex support needs, both in the context of being reliant on family for primary care and support as well as the impact of being disconnected and isolated from family. The presence or lack of supportive family networks was described as having a demonstrable impact upon an individual’s experience of marginalisation and contact with the criminal justice system. Aboriginal carers and service providers talked about the importance of Aboriginal communities taking care of their own people with complex support needs. Service providers specifically identified support and care by family as a protective factor in keeping Aboriginal people with MHDCD out of prison and contact with police.

*Their families. That’s it in a nutshell. If they’ve got that family who want to love and protect them, and keep them, keep them safe, include them in everything, so that they aren’t excluded and the family are around them – they are at the centre of the wheel, not on the outside. That’s what keeps them out of the system.*

Service providers working in some communities described how Aboriginal people with MHDCD would live and go about things independently of anyone taking a particular interest in them. However, when an incident occurs whereby that person’s welfare is threatened or they are mistreated, the community steps in to see it stopped. While many challenges for those in remote communities were described, interviewees also reported on the strength of cultural and family networks of support for Aboriginal people with MHDCD in remote communities.

Service providers explained that those families and communities that do manage the needs of Aboriginal people with MHDCD effectively often do so without any service contact or support.



*A more mature family or community will look at managing this in cultural parameters – that they look after anyone that is distressed or behaviourally activated by pressure or stress. We never hear about this formally, we hear about it afterwards by talking to family or community members – you know: ‘this person was sort of acting out, and this is what we did to manage that’ within the family, within the community, without the requirement of the clinic or the police or formal protective services to be involved.*

Carers reported being able to provide more consistent and intense support and care for their family members with MHDCD where they had long-term stable housing. The cost and availability of stable and appropriate housing was identified as an issue.

Rejection or marginalisation of Aboriginal people with MHDCD was raised by a number of interviewees. In most cases this appeared to be because of a lack of understanding of the needs of people with MHDCD and a lack of resources and support for people with MHDCD in community settings.

*When I’m out I feel like I’m not wanted. People keep their distance – they think you’re mad. I keep my distance from them too. And I will pick stuff up and throw stuff. They are scared about you being in gaol.*

*There is a petition from Aboriginal people and non-Aboriginal people from his community that he never be allowed back, because the arrangement was that he just be dropped on to this little community and told there would be a worker, but there never was.*



## Lack of Support for Aboriginal Community Capacity

Service providers observed that family members, as the primary providers of support, often do not receive the right kinds of assistance needed to sustain that care and support. Aboriginal families that have capacity to care for people with MHDCD are often responsible for the care and support of many people, including children, grandchildren and extended family. This results in experiences of financial hardship, without the capacity to purchase often the most basic items to meet family needs. Service providers who give support in the way of packages of material resources and respite described the kinds of assistance needed by Aboriginal families, and how this can differ to non-Aboriginal families. Aboriginal carers in particular described the need for material resources that assist them in the care of others.

*What we find is that our Aboriginal clients more need furniture and stuff to make them comfortable whereas the generic people need flashy things like respite, and massages and exercise equipment, but the poor blackfellas just need stuff that's going to make life easier. We did an intake in [one regional town with a large Aboriginal community] where the family were still sleeping on beds the hospital gave them 20 years ago.*

Service providers described the deterioration of family and primary carer capacity to sustain the intensive support of family members with MHDCD in the face of compounding factors. Interviewees described capacity issues for carers who are elderly or have their own health issues and disabilities, and how this can negatively impact upon Aboriginal people with MHDCD.

*My biggest concern in the disability sector at the moment is if we don't start collecting this data and start proactive planning for future generations – if Aunt or Unc here dies who's going to look after these children? That's a really big concern for me for multiple number of siblings coming forward with disabilities.*

Service providers identified particular concerns for Aboriginal people with MHDCD who are living with older carers, and the absence of any alternative stable accommodation and support after their carers have passed away.

*For me its future planning, because we don't have a lot of group homes, and we don't have any Aboriginal specific group homes, and we deal with carers that are 75 or 80 who are worried sick about what's going to happen to their kids but unless they have something lined up, where are they going to go?*

One consequence of deteriorating carer capacity is the increasing incidence of people with MHDCD experiencing crisis. Interviewees reported that such crises often result in the individual being arrested and taken into police custody or hospitalised.

*The range of options for communities when a person in crisis... If the family is unable to manage, the clinic won't be able to manage, because there will be an expectation that once the clinic is involved the family will have to agree to a conservative management plan - that is, we manage this in the community, perhaps some sedating medication, but there is no other possibility except evacuation. So [the management plan] either works or it doesn't, so then it's evacuation. There is nowhere in between. When I talk about family I'm talking about extended family as well - perhaps the person can stay somewhere else for a day or two. There is not usually any other places to go.*

Interviewees described the dire lack of support for families who take on care roles for someone with MHDCD being transitioned into a community or family after being incarcerated or hospitalised.

*Quite often people will come into high cost and very supportive placements, and then be taken back to family and not transitioned back with the types of support they need. And things have been done lately where if family were provided two hundred dollars per week and a motorcar repair, would have managed quite well with a client. But that's not what government did.*

Mental Health service providers in the Northern Territory site identified an increasing number of people with MHDCD moving into town from remote communities, which they attributed to the decreasing capacity of families to take care of people on country. A lack of support for families of people with MHDCD in remote communities was described as common, and worsening. This was seen as having a devastating impact on Aboriginal people with disability who might otherwise be able to live with support and dignity at home, and on their carers. This also creates extra responsibilities for extended families and services in regional centres.



*When and if the families aren't adequately supported there is a great sense of let-down, and from my experience it's often anger. If they aren't supported, their ability and willingness to continue [to be the carers] is reduced so people travel to be with relatives in town. There seems to be an increase of the numbers of people moving into town, which is linked to the capacities of families out bush to take care of people, which is steadily receding little bit by little bit.*

Access to respite was described as critical for families and carers in terms of their capacity to support family members with multiple and complex support needs. Yet funding for respite is very limited, and reportedly requires services to target their respite packages through strict eligibility criteria, which families of Aboriginal people with mental and cognitive disability may not meet.

*They just needed someone to say we are going to look after him for two weeks so the parents can have a bit of a breather, but my understanding is that the discussion was – is this primarily a mental health issue, in which our service would provide the respite?*

*For the respite program you do have to meet the definition under the Disability Services Act. They can be self-referral but I need documentation to back up that the person has a disability.*

Access to appropriate support was reported by service providers as something they anticipated becoming even more complex for Aboriginal people with multiple and complex support needs with the introduction of the National Disability Insurance Scheme (NDIS).

## Lack of Capacity in Services and Systems

A lack of capacity within service systems and workers to meet the needs of Aboriginal people with multiple and complex support needs was identified in all sites. More appropriate and specialised services and support at all stages of contact with the criminal justice system was highlighted as key to reducing over-representation. Access to services was reported to be largely subject to workforce capacity. It appears that even where services are ostensibly available, there may be no staff or in particular no appropriately trained or skilled staff to deliver the service.

*It's a constant struggle getting appropriately qualified experts to assess people and assist in treatment plans and that goes for all the locations that we service.*

*I as a psychologist would love to be able to do more assessments to work out who has ID, learning problems, etc. and I have done a few. There are a few that are culturally appropriate, but because there aren't enough staff I don't get a chance to do those sorts of things.*

There is an increasingly high level of unmet need for forensic mental health services, partly due to the lack of appropriately qualified clinicians in regional and small towns and in prisons.

*More mental health experts in the prison. At the moment they have the forensic mental health team which is a nurse, a visiting psychologist and a visiting psychiatrist. The psychologist comes once a month and the psychiatrist once a fortnight. You've got 650 people in the prison!*

The need for targeted, specialised training was raised as particularly important for staff in human services working with Aboriginal people with MHD/CD.

*Inconsistencies and confusion. Not everyone is on the same level of understanding or the same degree of care. And so the client then has to work with different personalities, which is hard in the human service industry. But then when you have people that don't really understand what's going on, and then they're inconsistent, they will feed that borderline personality.*



Such problems are exacerbated in times of crisis in the lives of Aboriginal people with multiple and complex support needs. This occurs when the required service does not exist locally as well as when services do not operate during the time of day at which issues tend to escalate into crisis. Although the need for 24/7 crisis services has been recognised, crisis services are often only accessible remotely by phone and are rarely culturally or community appropriate.

*We wait until it happens, until the crisis hits, rather than early intervention. We gotta wait until it happens until it justifies itself to do something about it.*

*We try to say to the families 'the only thing you can do is ring the ambulance or police because our hands are tied', we don't have any power.*

All participant groups stressed that despite high levels of demand, there is a widespread and chronic lack of services in regional and remote communities. In many cases the need for a service is recognised and acted upon but is not met because the required service is permanently or temporarily unavailable. Perversely prison may be the only place an Indigenous Australian with disability can get disability support.

*To get that they've got to travel or be sent to gaol, that's the only help that they can get.*

A dearth of appropriate post-release support and services was described as chronic.

*The support when they're coming out, that's really lacking, the post-release support. I haven't had a lot of experience with it... I have heard of people getting out of gaol on a Friday night and there's no services from Wellington to go anywhere, so they sleep on the street in Wellington. So they're off to a bad start from the get-go.*

A pertinent example was given by a disability worker regarding the challenges and implications of severely under-resourced or non-existent post-release services.

*I've had one particular gentleman... he's actually from [a small community in regional NSW] and he has a moderate intellectual disability and he resides when he's not in gaol with his mother and father at [home]... about an hour and ten minutes [away]. So both of his parents have been ill: dad's triple by-pass and mum's got arthritis and also heart problems now. This gentleman has been a repeat offender and he's very easily led by others but when he was released from his last stint in gaol he was handed his money, no medication, and told to make his own way home.*



The importance of having Aboriginal staff in front line positions as well as management roles was emphasised by a number of interviewees, as was the fact that this is often not the case.

*Yes, I do [think it makes a difference having Aboriginal staff]. Considering 80% of our clients are Aboriginal, very much so. I see my role to support my co-workers to have effective communication with our clients, to be treated fairly and compassionately. Otherwise they [the clients] are going to get their back up and I don't blame them. Clients need to feel comfortable to voice their concern, and come into this office and talk about any issue they have, not 'Nah, I'm not going near there'.*

Aboriginal workers identified pressure and high expectations from their community as a challenge, especially when this wasn't sufficiently recognised by mainstream organisations.

*The expectation in the community for us to provide services is very high. We are Aboriginal health workers. It's not a mainstream service that people go to when things are going wrong, it's us. What we want is for organisations to listen to what we have to say because we know the community here, and as I say things don't go wrong until night time.*

Barriers to professional training for Aboriginal staff working with people with MHDCD were identified.

*I'd love to do a bit more around counselling, and accidental counselling, but like I say, it's just so hard to try and get into personal development yourself when you're in charge of three staff and you've got high demand from clients. And those clients that you're dealing with are all complex, high complex, highly disadvantaged and marginalised clients, so it's those people that don't need the help come and access the service to help themselves.*







One Aboriginal interviewee described some non-Aboriginal staff as feeling threatened by larger numbers of Aboriginal staff in a workplace, stemming from concern at fewer employment opportunities for them. Animosity towards Aboriginal workers by non-Aboriginal workers was mentioned by some interviewees, in particular in connection with a lack of understanding of the cultural and community responsibilities of Aboriginal workers.

*I had a lot of trouble with worker jealousy and management – it's like the canal analogy – the ship doesn't get through without the guy who sits on the bridge reading his novel all day – and if you can get him to lift the levers you can get the whole juggernaut through.*

One non-Aboriginal interviewee articulated his concerns about increasing numbers of Aboriginal workers, revealing elements of the institutional racism highlighted earlier.

*You've got more of a chance getting a job in these [geographical] areas if you are Aboriginal, there is just more funding. I know in [our non-government organisation] we are very top heavy with Aboriginal workers. I don't give a damn provided they do their bloody job and don't have the lazy bones, part of their nature sometimes – we've had problems here.... I don't give a damn... I know nearly all of the HASI workers are Aboriginal now, which is not a problem, I mean I don't care, I work with Aboriginal clients... You always see Aboriginal identified positions, which pisses me off because you can't say white designated position. (WG\_3)*

Non-Aboriginal staff who work in remote Aboriginal communities identified issues with non-Aboriginal service and support staff not having adequate training and cultural supervision when working with Aboriginal people and families.

*My experience of people coming through that have had cultural education sessions, is that it's really not adequate for working in communities. My belief is that for a non-Aboriginal person to be working effectively in an Aboriginal community, you need to be employing someone to be your cultural mentor and supervisor. And without that's it very difficult to even understand what is going on, to even know who the right person to talk to about something, or to be effective.*

## 8.5 CONCLUSION

Institutional racism, stigma and discrimination are common, marginalising and destructive experiences for Aboriginal people with mental and cognitive disabilities. Interviewees reported discrimination and stigma experienced on the basis of their Aboriginality, their disabilities, and in regard to the criminalisation of their behaviour, affecting their access to education, employment, housing and just legal outcomes. An assimilationist approach was perceived as still pervasive amongst many of those working within criminal justice and human service agencies, with little recognition of the ongoing impact of colonisation, intergenerational trauma, grief and loss for Aboriginal peoples. Misinterpretation of Aboriginal family structures and the nature of protection processes in Aboriginal communities were viewed as underpinning the early and predominantly negative intervention by the state in the lives of many Aboriginal people with mental and cognitive disabilities. The lack of understanding and recognition around cognitive impairment was perceived as a key problem exacerbating contact with the criminal justice system. The over-representation of Aboriginal people with mental and cognitive disabilities in the criminal justice system was described as normalised in every community and context we investigated. Disability emerged as part of the accepted overall presentation of Aboriginal people with multiple and complex support needs in the criminal justice system. The notion that Aboriginal people with disability should be managed by criminal justice agencies and that this is 'just how it is', permeates all agencies' practice. What emerged strongly from the data was the systemic normalisation of disadvantage, disability and offending, with the conflation of these seen most clearly in people with multiple and complex support needs.

Many Aboriginal people who end up in the criminal justice system have early lives marked by poverty, instability and violence, without access to good primary health care or early childhood education. What emerged from the qualitative interviewees is the way that an Aboriginal child with an intellectual disability or Fetal Alcohol Spectrum Disorder (FASD) rarely receives early diagnosis or positive intervention, resulting in their disengagement or expulsion from school at a relatively young age. Drug and alcohol misuse by young people is a common experience, along with emerging mental health issues. Frequent out of home care placements which break down and homelessness are often experienced. Aboriginal people with mental and cognitive disabilities were described as particularly at risk of physical and sexual violence from a young age, Aboriginal girls and women in particular. Increased police contact as a person of interest in relation to minor theft or public order offences is a common pathway, with the likelihood of a number of court appearances before a juvenile justice custodial period. Moving into adulthood, drug and alcohol misuse and mental health-related illnesses tend to worsen, often accompanied by increased experience of violence and self-harm, more serious offending and longer periods in custody. Trauma and violence emerged as common and pervasive experiences for Aboriginal people with MHDCD in the criminal justice system. Many Aboriginal interviewees working in service provision discussed the impact of child removal in terms of intergenerational trauma. Contact with the criminal justice system was perceived as the result of childhood experiences of trauma and grief, and in turn compounding that trauma.



Other than occasional crisis-related admissions into hospital, there are reportedly little positive interventions around health and wellbeing for this group. Drug and alcohol rehabilitation is often only available in a regional centre many hundreds of kilometres away, and even then, excludes people with a cognitive impairment. Mental health services are unable to accept people with drug or alcohol addiction. Diversionary programs that aim to assist people whose offending is connected to their drug and alcohol addiction will not accept those with a history of violence. Incarceration becomes the default option in the absence of available or appropriate community-based care, housing or support. The multiple and complex support needs experienced by many Aboriginal people in the criminal justice system can then be understood as emerging from the siloed institutional responses to their circumstances; as in effect created from those responses. Negative, punitive criminal justice interventions rather than positive human or community based service interactions are the norm. The nature of care and support needed for Aboriginal people with multiple and complex support needs is qualitatively different and more than the sum of their individual diagnoses and disabilities. Combined with the normalisation of the criminal justice system as the avenue through which Aboriginal dysfunction and disadvantage is managed, systems of control and containment predominate. This is also intergenerational. Aboriginal people articulated a holistic, integrated, culturally responsive model of care with rigorous client and community accountability that is needed to support Aboriginal people with multiple and complex support needs to reduce contact with the criminal justice system.



## 9. DISCUSSION

The findings of this project strongly demonstrate that pathways into and around the criminal justice system for many Indigenous people with mental and cognitive disability in NSW and the NT are embedded and entrenched by the absence of coherent frameworks for holistic disability, education and human services support. Indigenous Australians with mental and cognitive disabilities are forced into the criminal justice system early in life in the absence of alternative pathways. Although this also applies to non-Indigenous people with mental and cognitive disabilities who are highly disadvantaged, the impact on Indigenous Australians is significantly greater across all the measures and experiences gathered in the studies across the project. Interrogation of the MHDCD Dataset and information gathering through interviews was purposive and selective rather than representative, yet the synchronicity between the overall findings emerging from the quantitative study, case studies and qualitative data analyses points to a commonality of experience for Indigenous people with mental and cognitive disabilities in the two criminal justice jurisdictions involved in the study. Together these findings indicate that thousands of Indigenous people with mental and cognitive impairment are being ‘managed’ by criminal justice systems in lieu of support in the community. Systems of control rather than support, care or protection are being invoked for this group, often from a very young age. The quantitative study highlights the ways that Indigenous people with mental and cognitive disabilities experience multiple, interlocking and compounding disadvantageous circumstances. The data reveals extraordinarily high and early rates of contact with police for Indigenous children and young people with mental and cognitive impairment, as both victims and offenders. The case studies and qualitative data further highlight that those with disability who are most likely to be incarcerated are Indigenous people from highly disadvantaged families and geographic locations. This confirms and extends the body of research interrogating the relationship between Indigenous status and disability, disadvantage, place and over-representation in the criminal justice system in Australia.

The serious implications of poor diagnosis and unclear definitions of mental and cognitive disability are starkly highlighted in this research. The findings demonstrate that there is a severe and widespread lack of appropriate early diagnosis and positive culturally responsive support for Indigenous children and young people with cognitive impairment. This is connected to schools and police viewing certain kinds of behaviour through a prism of institutional racism rather than disability, as well as Indigenous community reluctance to have children assessed using particular criteria that are perceived as stigmatising and leading to negative intervention in Indigenous families. For adults in the criminal justice system, cognitive impairment is either not recognised at all, or if recognised, poorly understood. For many Indigenous people, diagnosis of their cognitive impairment comes with assessment on entry to prison. However such a diagnosis rarely leads to appropriate services or support; analysis of the data reveals that subsequent interventions tend to continue to foreground offending behaviour rather than complex social disadvantage or disability, mental health or AOD support needs. Services often only support an individual around a single diagnosis, that is, of mental illness or intellectual disability or alcohol or drug addiction – rather than responding to their multiple and complex support needs. This leads to a failure of community-based options as they currently operate because they are not appropriately integrated or inclusive and do not have the capacity and approach needed. Diversionary and therapeutic approaches do not address the underlying causes of behaviour by people with mental and cognitive impairment that is considered problematic and regularly criminalised. The disabling effects of social, cultural and systemic factors for Indigenous Australians with impairment are evident at all stages of contact with the criminal justice system.



Our findings illuminate the particular challenges and vulnerabilities facing Indigenous women with mental and cognitive disabilities. Aboriginal and Torres Strait Islander women are the most disadvantaged group in our cohort in terms of their multiple and complex support needs – they are more likely to have multiple disabilities and health problems than non-Indigenous women or Indigenous and non-Indigenous men. They were 3.7 times more likely to have been in out-of-home-care than non-Indigenous women. They have earlier and more regular contact with police and significantly higher numbers of police convictions. Indigenous women in the cohort were 2.4 times more likely than non-Indigenous women to have been in custody as juveniles, and had significantly more remand and custody episodes as adults. Histories of violence and abuse and ongoing trauma are common experiences for Indigenous women with mental and cognitive disabilities. Indigenous women in our cohort were recorded by police as victims of crime an average of 23 times in their lives, while for non-Indigenous women, the number of reports as victims of crime was 16. Indigenous women were 2.2 times more likely than non-Indigenous women to be homeless at some point in their life. They were likely to have moved more often than their non-Aboriginal peers but lived in a smaller number of towns and suburbs. The negative impact of a lack of specialist, culturally-responsive, therapeutic community-based support for all Indigenous people with mental and cognitive disabilities is compounded for Indigenous women. There are distinct issues facing women such as the lack of police responsiveness to domestic violence, access to Aboriginal Legal Services, and gender-specific diversionary programs and post-release support. Elizabeth McEntyre's forthcoming PhD research will elaborate on the lived experiences of Australian Indigenous women with mental health and wellbeing issues and/or cognitive impairment (including intellectual disability and acquired brain injury) in both the NSW and NT criminal justice systems.

During the course of the project, our research influenced and was in turn informed by the work of the Aboriginal Disability Justice Campaign and reports by the Australian Human Rights Commission and NSW and Victorian Law Reform Commissions (Baldry 2014). There is a growing awareness of the devastating impacts of current legislation, policies and practices on Indigenous people with mental and cognitive impairment and a need for an evidence-informed response by political leaders, policy makers, people working in criminal justice systems (police, magistrates, correctional officers) and service providers. This next section will consider the implications of our research in the context of legal issues, policy and service capacity relating to Indigenous Australians with mental and cognitive impairment in the criminal justice system.

## 9.1 LEGAL ISSUES

The complex and multi-faceted needs of Indigenous people with mental and cognitive impairment create particular legal issues which often manifest in high levels of contact with police, courts and prisons (MacGillivray & Baldry 2013, 23). The law is a blunt and often punitive instrument by which to address the issues facing Indigenous people with mental and cognitive disability (Baldry 2014), and yet as evidenced in the qualitative data gathered for this project, has become the default framework by which to manage those who are perceived as too 'complex' or 'difficult' to be supported in the community. The key legal issues that emerge for this group in their interactions with police and courts are the result of cumulative problems with service system design and function, and a legacy of colonisation and entrenched disadvantage and discrimination. The 'offending' of the majority of Indigenous people with multiple and complex needs who come before the court would not be considered within the gamut of the criminal justice system if they had been properly supported in the community. This should be the blueprint for reform in this area (ADJC 2013; Baldry, Dowse, McCausland & Clarence 2012). For those who still end up in the criminal justice system, energetic and focused court diversion with robust case management support should be available. These strategies would be economically as well as socially beneficial (McCausland et al 2013).

### 9.1.1 Police


As the quantitative findings detailed in this report show, Indigenous people in the cohort have a significantly lower age of first police contact than their non-Indigenous counterparts (14.9 vs 18.3 years). Indigenous young people also have a significantly higher number of police contacts than their non-Indigenous counterparts as both persons of interest and victims. The data shows that Indigenous young people with complex needs will come into contact with police more than two years earlier than their non-Indigenous counterparts (14.6 vs 17 years). Aboriginal people in regional and rural NSW report that the police are often the first respondents to a crisis involving Aboriginal people with MHDCD, followed by ambulance services. Often the presence of a cognitive impairment will not be recognised or acknowledged by police, being 'hidden' or misidentified as another kind of impairment such as a drug-induced mental health episode or being affected by drugs and/or alcohol. Other issues identified in the community were that Aboriginal people with mental and cognitive impairment have long histories of offending (around behavior usually associated with their disability), and that this is used as a justification for police 'hyper-surveillance' of them in the community. This brings these individuals into contact with the police more often for non-offending reasons, and this contact does not result in positive outcomes (MacGillivray & Baldry 2013, 24). Even as victims, police are reported to view Aboriginal people with mental and cognitive impairment through a prism of offending behaviour. As highlighted in the qualitative data, the over-policing of Aboriginal people with complex needs is experienced as institutional racism by Aboriginal communities. The stark contrast between high funding for police stations and officers in regional and remote areas and poor funding of Aboriginal community-based mental health and disability services was described as evidence of inappropriate government priorities regarding Aboriginal communities.



## 9.1.2 Courts

There has been government commitment to diversion for people whose co-occurring impairments influence offending behavior, as noted earlier in this report, particularly in relation to Section 32 and Section 33 of the Mental Health (Forensics Provisions) Act 1990 (NSW) (NSW Law Reform Commission 2012) and similar legislation in most Australian jurisdictions. However, evidence from the MHDCD Dataset indicates very low rates of use of such legislation, with only 142 out of 2731 people in our cohort being granted a Section 32. Aboriginal people are far less likely than non-Aboriginal people to receive a Section 32 (Steele, Dowse & Trofimovs 2013). The qualitative data gathered for this project reveals that Aboriginal community members and services recognise this extreme under-use and believe it to be at least in part due to the extremely high volumes of matters that magistrates, Aboriginal Legal Service (ALS) solicitors and NSW Legal Aid lawyers deal with in local courts.

The data analysis reveals two main reasons high numbers of Indigenous people who appear in local courts either have their impairments unrecognised by the court, or if they are identified, are left unassisted. The first is the impact of the drive for efficiency in summary courts, as well as the application of the 'crime-control' model in court processes. The second is the capacity of solicitors to represent their clients under the high-volume conditions and lack of viable options in the community (MacGillivray & Baldry 2013, 24). This project found that in relation to the first reason, the expansion of 'technocratic justice' is obvious in regional and remote courts in NSW, as exemplified by circuit court arrangements in the far-western parts of the state. The high numbers of matters heard back-to-back in a circuit court, together with the high caseload for prosecuting police and defence solicitors, appear to compel all court personnel to process matters quickly. This has routinised the handling of matters, including those involving people with mental and cognitive impairment, with little scope for individuality or flexibility. Furthermore, conformity to a crime-control model is most obvious in the heavy reliance on the offending histories of those appearing. This is the primary source of information used to deliberate on the sentencing of the individual. This static assessment appears to disproportionately impact Aboriginal people with impairments, as they have much longer offending histories (Baldry, Dowse & Clarence 2012, 11-13).



In relation to the second reason, a major factor influencing whether someone's impairment will be recognised is whether a solicitor has had sufficient time to speak with their client to establish their background and any indication of mental illness or impairment. Analysis of the MHDCD Dataset conducted for this study reveals that Indigenous people in the cohort have significantly more remand episodes compared to their non-Indigenous counterparts (6.7 vs. 5.2), and Indigenous people with complex needs in the cohort have significantly more remand episodes compared to their non-Indigenous counterparts (7.2 vs 6.0). Changes to bail laws over the past 15 years have been described as having a disproportionately negative impact on Indigenous people with mental and cognitive disability (Cunneen et al 2013), and this was evident in interviewees' reports of court processes. Feedback from solicitors in the field was that they rarely see their client outside of custody before their court appearance, and receiving enough information from a client in the court environment to establish the presence of a cognitive or mental health impairment is a great challenge. Nevertheless, if a client's impairment is recognised, then the responsibility for making a diversion application or any non-custodial sentencing option generally falls upon the solicitor representing the client, unless the client has a disability service case manager - a very rare situation for Aboriginal people. Interviewees consistently indicated that this was very difficult given that there is little time or capacity to make these support and diversion arrangements in or out of court, or guarantee that these supports and services are available in the community. For instance, the objective evidence relied upon for a Section 32 application must be accepted by the deciding magistrate. Evidence such as thorough and up-to-date medical reports and assessments are preferred, and if these are unavailable (as is often the case in regional and remote areas), they are disregarded as realistic options. In their absence Section 32 applications are repeatedly futile (MacGillivray & Baldry 2013, 25). There is evidence that in some cases Indigenous people are being sent to prison for a psychiatrist assessment only to return to court a few months later without a medical report having been completed.

Legal service providers regularly identified extra-legal issues such as alcohol and drug issues as being closely related to offending, and felt that to have a positive impact any service or support being provided to clients needed to include capacity to address AOD issues. The availability of appropriate services and support to address the underlying reasons for offending was noted as a particular challenge for Indigenous people with co-occurring disorders, in particular those in regional and remote areas.





## 9.2 POLICY

This project reveals distinct policy failures associated with the lack of inclusion of people with cognitive disability in health, mental health, education and social policy in general and in particular the exclusion of disadvantaged and poor Indigenous Australians in these policy arenas. These have led to the over-representation of Indigenous people with MHDCD in the criminal justice system. Rather than ‘falling through the cracks’ of early intervention and care and protection safety nets, our findings highlight the default and systematic channeling of thousands of Indigenous people with mental and cognitive impairment into management by police, courts and corrections from an early age. This emerges as an almost inevitable outcome of the institutional racism, disadvantage, stigma, discrimination and neglect experienced by this vulnerable group in Australian society, creating their multiple and complex support needs. This project has brought a critical Indigenous lens to the over-representation of Indigenous people with mental and cognitive impairment in prison, highlighting the legacy of colonisation in the ongoing control, containment and institutionalisation of Indigenous people. Analysis of the quantitative and qualitative data indicate that without an explicit holistic coordinated policy approach to supporting Indigenous people with mental and cognitive disability in the community, the inevitability of their management by the criminal justice system will only be compounded. Given this, concerns about the approach taken to date by the NDIS are explored in this section.

### 9.2.1 Systems of Control Rather Than Care and Support

The case studies compiled from the Dataset reveal the way Indigenous children and young people were characterised from a young age as ‘a risk’ rather than ‘at risk’, many of them whilst in OOHC. Management by police and then in juvenile justice and adult custodial settings is detailed in both the qualitative and quantitative data, accompanied by narratives around the need for Indigenous people with mental and cognitive disability to be controlled and contained ‘for their own good’ but in particular for reasons of community safety. The increasingly pervasive notion of risk as a guiding framework for police and corrections policy (Cunneen et al 2013) emerges as working against the interests of Indigenous people with mental and cognitive impairment. Community and disability services being replaced by criminal justice interventions for Indigenous people with mental and cognitive impairment clearly becomes the default. Surveillance and targeting of Indigenous people with mental and cognitive impairment and their families and communities was described as commonplace. The qualitative findings reveal that the lack of culturally appropriate support services for Indigenous people with cognitive impairment has particularly devastating long-term effects, leading to multiple and complex – and invariably unmet – support needs.

One dimension to the subjection of Indigenous people with mental and cognitive disability to systems of control rather than care and support is that the response is invariably crisis-focused: without appropriate community-based early intervention, police or other emergency services become involved at a point of crisis or harm. The disempowerment, violence and distress often associated with crisis intervention for people with mental and cognitive disability and their families and communities was seen to exacerbate their entrenchment in the criminal justice system.



## 9.2.2 National Disability Insurance Scheme

While the project did not have a direct opportunity to explore issues for Indigenous people with mental health and cognitive disabilities in the National Disability Insurance Scheme (NDIS) as the research was conducted prior to the establishment of NDIS trial sites, learnings now emerging from the trial sites raise a number of issues of concern for this group. These relate to engagement and preparation for the scheme, issues of eligibility for those with complex support needs in which multiple low level disability and mental health issues are present, the impact of individualisation and marketisation on services and communities and the lack of capacity to service those with complex needs in the market economy. This is compounded by the cessation in some jurisdictions, of state based supports for those with complex needs, and the closure of state based behavioural support services. This is likely to impact negatively on the ability of the service sector to respond to those with complex needs, and to reduce the capacity of the system to begin to address the types of problems this report highlights.

Observations emerging from the Hunter trial site to date identify specific challenges for Indigenous people with complex support needs who are in contact with the criminal justice system in relation to undertaking even the first step of access checking for eligibility for the scheme. This requires computer literacy as well as self-advocacy and interpersonal skills or advocacy support to approach the NDIS, which many are unwilling or unlikely to be able to undertake in the first instance (Clift 2014, 26). For those who are able to move to the point of applying, eligibility for the scheme may be a key concern. The NDIS's eligibility criteria redraw the boundaries of who and who is not eligible for disability support, with eligibility premised on a strong diagnostic framework to establish the existence and degree of impairment and an evaluative impact assessment of its interactional effects on an individual functioning (Soldatic, Van Toorn, Dowse & Muir 2014, 9). This raises significant concerns for those who lack access to appropriate diagnostic processes, which will enable them to establish their claim for eligibility. This is a major concern for Indigenous people with MHDCD caught in the criminal justice system, as made evident by this project. A further concern is that the presence of mild or borderline cognitive impairment may not meet NDIS eligibility criteria for 'substantial and ongoing disability needs' despite these commonly co-occurring with mental illness, substance use and entrenched social disadvantage precipitating their contact with the CJS. Finally, as Indigenous people with MHDCD in contact with the criminal justice system may be unable or unwilling to identify with a disability label for cognitive, social or cultural reasons, requirements to claim this label for the purpose of NDIS eligibility may limit their participation.





For those who are able to access and become participants in the NDIS there are further concerns about the mismatch between the individualised nature of support which is at the cornerstone of the NDIS approach and Indigenous individual, community and cultural holistic approaches to support. The adequacy of the types of supports made available for people with complex support needs are a further concern for two reasons. Firstly, the scheme will fund only 'disability' related needs, with those deemed not related to 'disability' are pushed back to mainstream services. This project and other research has shown that services not tailored to the specific needs of Indigenous people with cognitive impairment in particular will not serve their interests. A second concern relates to the capacity of a marketised service system to provide services to those with multiple and complex support needs in the criminal justice system. This concern is intensified for regional, rural and remote settings, which as this project has found, already have extremely poor levels of appropriate service capacity resulting in 'thin' or non-existent markets. It is therefore likely that contracting arrangements enshrined in the NDIS model will perpetuate the dynamic of services not engaging with the most complex clients, a particular problem for Indigenous people with mental and cognitive disability who have been in the criminal justice system. This lack of an appropriate framework for service provision for Indigenous people, which has been identified in this project as needing to be whole-of-government, cohesive and requiring high level coordination and integration, will be negatively compounded by the exit of government agencies from the specialist disability sector, potentially removing a key entity with the role of negotiating and implementing cross sector agreements. Where will leadership to address policy, services and training in this area, come from?



### 9.2.3 Explicit Co-ordinated Policy Approach Needed for Indigenous People with Mental and Cognitive Disability

This project demonstrates that a whole-of-government, inter-agency, early childhood and family focused, flexible, person and community-centred model is needed for all people with multiple and complex support needs, but recognising that particular Indigenous specific and community based and focused approaches are required for Indigenous people with multiple and complex support needs. There are human, social, community and economic reasons for such an approach. There are enormous costs to government of the current approach of managing Indigenous people with mental and cognitive disability via the criminal justice system, and the toll on Indigenous people is catastrophic. While programs such as the NSW CJP offer support options that can make a significant difference to the lives of many Indigenous people with intellectual disability cycling in and out of the criminal justice system, there are still major barriers to appropriate support and services for the vast majority of Indigenous people with cognitive impairment across Australia. There is a stark need for greater flexibility and resource allocation on the part of criminal justice and human services agencies in order to develop and implement an explicit coordinated policy approach for Indigenous people with mental and cognitive disability that contributes to reducing contact with criminal justice systems and imprisonment, particularly in regional and remote areas. Importantly, the loss of state specific government disability agencies who would have a key role in enabling and implementing this approach is a significant concern as Australia moves to a new model of marketised service delivery under the NDIS.

### 9.2.4 Fetal Alcohol Spectrum Disorder (FASD)

It is important to note that a diagnosis or discussion of FASD rarely appears in the institutional data contained in the MHD CD Dataset, and yet the qualitative data gathered for this study and other national and international research in the field suggest that it may well be affecting a large number of Aboriginal people in the criminal justice system. FASD is emerging as a major concern in North America and other parts of Australia where assessment processes are in place (Fitzpatrick et al 2015; Ospina 2011). There is a dearth of attention to the diagnosis and treatment of FASD in NSW and the NT. Corrections and Juvenile Justice do not routinely assess people in custody for FASD. Yet the evidence strongly suggests that early recognition and support for individuals with FASD is crucial to prevent adverse secondary outcomes (Elliot 2015) such as enmeshment in the criminal justice system. There is an urgent need for greater resources and support for the assessment, diagnosis and treatment of and education around FASD across criminal justice and human services agencies and Aboriginal communities.





## 9.3 SERVICE CAPACITY

The culmination of structural system deficiencies, institutional racism, policy experiments and service 'silos', in both budgetary and service terms, has not served the interests of Indigenous people in child, disability and education service areas (MacGillivray & Baldry 2013, 25). Non-criminal justice services and agencies have the most potential for preventative and support capacity for Indigenous people with mental and cognitive disability, yet their siloed nature counteracts attempts at coherent holistic and integrated support for adults and children with complex needs. Aboriginal adults and children who have these multiple and complex support needs cross the boundaries of many services and yet often fall outside of the remit of any one service, raising questions about the role and responsibilities of government and non-government agencies (Baldry, Dowse, McCausland & Clarence 2012, 77).

The key challenge emerging is service implementation and delivery for those with complex needs, as this is difficult for one individual service provider or service type to deliver. Attempts at co-location and an 'all under one roof' approach have not adequately provided full service integration. Aboriginal people with mild or borderline intellectual disabilities who also have drug and alcohol issues or lengthy offending histories are the most at risk of being excluded from all service support, propelling them back into offending pathways and homelessness (Baldry, Dowse, McCausland & Clarence 2012, 79). As a consequence, diversion from prison is difficult as services in the community lack the required information and expertise to appropriately and effectively support Aboriginal people with multiple and complex support needs. This is particularly the case in regional and remote areas, in addition to the social and economic pressures experienced daily by many Aboriginal communities. Presently, even minimal service integration for the wider community is a challenging endeavor for government agencies.



### 9.3.1 Failure of Service Co-operation and Coordination

The lack of communication and cooperation between government services has significant negative impacts on Indigenous people with MHDCD. Interviewees described adversarial relationships between staff at different agencies, particularly in regard to delineation of responsibilities in a post-release context. Appropriate and accessible post-release services and support for Indigenous people with MHDCD across NSW are severely lacking. There is a clear need for improved referral pathways and greater case coordination, especially upon release from prison between corrections to community-based health providers. The period after release from prison is a particularly vulnerable and difficult time for Indigenous people with MHDCD, and there is a clear need for immediate and intensive support, particularly with regard to accommodation, case management and medication.

Referral pathways are often negatively cyclical for people with multiple and complex support needs and histories of violent offending who cannot access services, are refused services, or are disengaged from services. The barrier to initial contact can be result of a lack of language, literacy and numeracy skills necessary to meet the service requirements for intake and assessment. Identification of disability and appropriate referral often depends on self-disclosure, which often only occurs when a person is in crisis or displays changes in their servicing patterns.

Good practice in service collaboration was found to occur in only small pockets and tended to be driven by local coordinators on the ground rather than middle to upper management. Such collaboration needs to be strategic, and shaped by sensible policy and programing, as well as transdisciplinary and cross-sector models and responses. Where flexibility and person-centred care was evident it was described as occurring in spite of funding and organisational systems, rather than because of them. The particular role played by many Aboriginal woman in support and service roles was noted on numerous occasions, and in particular those who took on the care and support of numerous family and community members, often with little support for themselves.





### 9.3.2 Reputation, Trust Building and Reliability in Services

This project has identified significant levels of distrust of government services in communities. For some people, residual distrust is bound up with past experiences of institutional racism and family trauma, and histories of the stolen generations. Yet trust, reliability and reciprocity were identified as key requisites for strong and enduring client engagement. Several services reported positive outcomes of sustained inter-agency coordination for Indigenous people with multiple and complex support needs - some were involved in case conferences for individuals with complex needs who were or needed to be in contact with services from different sectors. Sustained, supportive and trusting relationships between service staff and clients are key to maintaining engagement of people in services. There is a clear preference by most Indigenous people for Indigenous community-controlled services. However there were some concerns expressed by Indigenous people with mental and cognitive impairment about privacy in small towns, or accessing services seen as run by another 'mob'. Adequate resourcing that gives Indigenous people with mental and cognitive impairment options beyond accessing a single organisation or single worker or none at all were seen as able to overcome such concerns.

Some services feel constrained in their ability to address the needs of Indigenous people with mental and cognitive disability by the legislation, rules and policies which govern their area of work. Many services have difficulty with the issue of coercive power and how/how much to exercise it. Some use coercive and punitive strategies to enforce client compliance and engagement and find that this approach compels clients to meet service requirements and receive appropriate support. Alternatively, coercive strategies can lead to conflict, distrust, and relationship breakdown between service and client.

### 9.3.3 Problematic Contracting and Accountability Systems

Both Commonwealth and State funding/contracting regimes appear to work against providing appropriate services to Indigenous people with multiple and complex support needs. There is a perception amongst some community members, carers and services that some sections of the workforce are unproductive and unaccountable in providing services to IAMHDCD, especially those in government agencies and in remote service arrangements. Funding models and cycles have a significant impact on the ability of services to recruit and retain skilled front-line staff. Funding changes and cuts have reportedly lead government agencies to outsource various programs and services to NGOs. Relationships and rapport between staff and clients are severed when services are outsourced and new staff are introduced. NGOs are not automatically governed under the regulatory frameworks that currently govern district health services, instead they operate under unique contractual arrangements established with state departments. District health services also report that tender processes undertaken by state departments are not always open and competitive.



### 9.3.4 Need for Integrated, Flexible, Culturally Appropriate, Community-Based Services

Services and individuals identified small pockets of good practice in service response. Such practice acknowledges and enacts principles of reciprocity, consistency, flexibility, accountability, fairness and cultural/social sensitivity in service delivery. Services that take a preventative approach to addressing complex support needs appear to achieve better outcomes for Indigenous people with mental and cognitive impairment. Therapeutic and person-centered service models enable services to engage and build a rapport with clients while their behavioural, emotional and health needs are assessed. This approach leads to positive outcomes when all relevant services are involved in the development and implementation of case plans. Services that are flexible in their delivery of programs reportedly observe better outcomes for Indigenous people with mental and cognitive disability. This is the case across most areas of service provision. In order to respond flexibly and adaptively, however, individual staff often need to 'bend the rules' and act outside official service policies and guidelines. In especially complex cases, measures such as MOUs can enable services to work around service guidelines and eligibility criteria.

Innovative services are trialing self-determining models where the client is wholly or partly the driving force behind their care plans, increasing their sense of agency and empowerment. Such models are similar to that proposed under the NDIS; it is important that models already successfully operating are preserved and used as an exemplar for practice in the NDIS. Services which involve the family and gain their support feel more equipped to identify and pursue outcomes for Indigenous clients with mental and cognitive disability. In some cases, the family also benefits from several of its members receiving services concurrently. Family mapping helps services understand the structure of the family and identify individual and collective needs. There was a clear need expressed for culturally appropriate rehabilitation services to be located in people's own communities, staffed with professionals trained in both mental health and wellbeing and cognitive disability principles and practice.







# 10. RECOMMENDATIONS AND SOLUTIONS<sup>17</sup>

## 10.1 OVERARCHING PRINCIPLES

Based on the qualitative and quantitative findings of our study, we recommend that the following five principles and associated strategies should underpin policy review and implementation:

Based on the qualitative and quantitative findings of our study, we recommend that the following five principles and associated strategies should underpin policy review and implementation:

### 10.1.1 Self-Determination

Self-determination is key to improving access to and exercise of human rights and to the wellbeing of Aboriginal and Torres Strait Islander people with mental and cognitive disability, especially for those in the criminal justice system.

#### Strategies:

- Indigenous-led knowledge and solutions and community-based services should be appropriately supported and resourced.
- The particular disadvantage faced by women and people in regional and remote areas should be foregrounded in any policy response to this issue.
- Resources to build the cultural competency and security of non-Indigenous agencies, organisations and communities who work with Aboriginal and Torres Strait Islander people with mental and cognitive impairment who are in contact with the criminal justice system should be provided.

<sup>17</sup> The IAMHDCD project reiterates and endorses the recommendations of the report by the Aboriginal Disability Justice Campaign, *No End in Sight: The Imprisonment and Indefinite Detention of Indigenous Australians with a Cognitive Impairment* (2012) and the report by the Australian Human Rights Commission, *Equal Before the Law: Towards Disability Justice Strategies* (2014). Members of the IAMHDCD project team contributed to these reports based on our research. Many of the findings and recommendations contained in those reports have regrettably not been acted on, so we emphasise their continuing relevance and urgency.





## 10.1.2 Person-Centred Support

Person-centred support which is culturally and circumstantially appropriate is essential for Aboriginal and Torres Strait Islander people with mental and cognitive disability, placing an individual at the centre of their own care in identifying and making decisions about their needs for their own recovery.

### Strategies

- Disability services in each jurisdiction, along with the NDIS should ensure there is a complex support needs strategy supporting Aboriginal and Torres Strait Islander people with disability in contact with criminal justice agencies.
- Specialised accommodation and treatment options for Aboriginal and Torres Strait Islander people with mental and cognitive disability in the criminal justice system should be made available in the community to prevent incarceration and in custodial settings to improve wellbeing.
- Aboriginal and Torres Strait Islander people with mental and cognitive disability who are at risk of harm to themselves or others and who have been in the custody of police or corrections should not be returned to their community without specialist support.

## 10.1.3 Holistic and Flexible Approach

A defined and operationalised holistic and flexible approach in services for Aboriginal and Torres Strait Islander people with mental and cognitive disability and complex support needs is needed from first contact with service systems.

### Strategies

- Early recognition via maternal and infant health services, early childhood and school education, community health services and police should lead to positive and preventive support allowing Aboriginal and Torres Strait Islander children and young people with disability to develop and flourish.
- A range of 'step-down' accommodation options for people with cognitive impairment in the criminal justice system should be available. The NSW Community Justice Program (CJP) provides a useful template.
- Community based sentencing options should be appropriately resourced, integrated and inclusive so they have the capacity and approach needed to support Indigenous people with mental and cognitive disability.





## 10.1.4 Integrated Services

Integrated services are better equipped to provide effective referral, information sharing and case management to support Aboriginal and Torres Strait Islander people with mental and cognitive disability in the criminal justice system.

### Strategies

- Justice, Corrections and Human Services departments and relevant non-government services should take a collaborative approach to designing program pathways for people with multiple needs who require support across all the human and justice sectors
- All prisoners with cognitive impairment must be referred to the public advocate of that jurisdiction.

## 10.1.5 Culture, Disability and Gender-informed practice

It is vital that Aboriginal and Torres Strait Islander people's understandings of 'disability' and 'impairment' inform all approaches to the development and implementation of policy and practice for Indigenous people with mental and cognitive disability in the criminal justice system, with particular consideration of issues facing Aboriginal and Torres Strait Islander women.

### Strategies

- Better education and information are needed for police, teachers, education support workers, lawyers, magistrates, health, corrections, disability and community service providers regarding understanding and working with Aboriginal and Torres Strait Islander women and men with cognitive impairment, mental health disorders and complex support needs.
- Information and resources are needed for Indigenous communities, families and carers, provided in a culturally informed and accessible way.
- The distinct and specific needs of Aboriginal and Torres Strait Islander women should be foregrounded in such education and information.



## 10.2 SERVICE RESPONSES

With these five principles in mind we recommend the following:

### CRIMINAL JUSTICE

#### 10.2.1 Legislation/Sentencing

- Mental illness and cognitive impairment should not be conflated in legislation. There is the need for specific processes and diversionary pathways for people with cognitive impairment.
- Mandatory sentencing has specific and significant negative impacts on Aboriginal and Torres Strait Islander people with a cognitive impairment and its application to this group should be repealed.
- The principle of imprisonment as the last resort should apply to everyone and particular care must be taken to apply this principle to Aboriginal and Torres Strait Islander people with cognitive impairment and people considered unfit to plead under mental health legislation.
- All relevant mental health and forensic legislation should comply with the Convention on the Rights of Persons with Disabilities and the Rights of Indigenous Peoples.
- Indigenous people who are detained under mental health legislation are neither prisoners nor offenders. Legislation, policy and practice should reflect this.

#### 10.2.2 Police

- Ongoing education and training should be provided for police to assist in recognising, understanding and appropriately responding to children, young people and adults with multiple and complex support needs, and cognitive impairment in particular.
- Community-police collaboration should be prioritised to build positive approaches to support children, young people and adult with mental and cognitive disability and complex support needs and to keep them out of the criminal justice system.
- Police Local Area Commands should be accountable for demonstrating community liaison and collaboration with Elders and other Aboriginal community members, including through the Local Area Command Police Aboriginal Consultative Committee (PACC).





### 10.2.3 Legal Aid/Aboriginal Legal Service

- More resourcing should be provided for Legal Aid and Aboriginal Legal Services to allow relationship building with a client to establish their background and any indication of mental or cognitive disability.
- Support for Legal Aid and Aboriginal Legal Services to arrange for assessment and diagnosis where indicated.

### 10.2.4 Court

- Education and training should be provided for lawyers, court support workers and magistrates in recognising, understanding and appropriately responding to in children, young people and adults with complex support needs, cognitive impairment in particular. Particular attention is needed in relation to Fetal Alcohol Syndrome Disorder (FASD).
- A special court list for cognitive impairment and mental health disorders should be introduced in jurisdictions where it does not exist.
- More resourcing should be provided for local courts, especially circuit court in regional areas, and for lawyers to reduce caseloads and allow time for appropriate hearings for Aboriginal and Torres Strait Islander people with mental and cognitive disability.

### 10.2.5 Diversionary programs

- Jurisdictions that have legislative but no actual options for community-based accommodation and support for Aboriginal and Torres Strait Islander people with cognitive impairment should redress this lack as a matter of urgency.
- Specialised disability case managers should be funded to work with solicitors to assist in making applications (such as Sec 32 in NSW) for diversionary programs or non-custodial sentencing options for Aboriginal and Torres Strait Islander people with mental and cognitive disability.
- Diversionary programs that can address underlying causes of offending for Aboriginal and Torres Strait Islander people with mental and cognitive disability, including AOD dependency should be developed.
- Expansion of diversionary options appropriate for Aboriginal and Torres Strait Islander people with mental and cognitive disability, in particular specialist women's programs and greater options for people living in regional and remote areas are urgently required.



## 10.2.6 Corrections

- Screening tools, such as those available for mental health, for cognitive disability including for FASD should be applied for all people on remand as well as those being received on sentence, such as those available for mental health.
- People identified as having a cognitive disability should be diverted from remand to a community support service.
- Programmatic support should be available for people with cognitive disability who do end up in remand, even for very short periods.
- No person should be sent to prison for the purposes of having a psychiatric assessment. Such assessments should be available in the community for consideration by magistrates before sentencing.
- No person with a mental or cognitive disability should be imprisoned in order to access a service.
- No individual with a cognitive impairment should be detained indefinitely in prison. Jurisdictions that currently allow for indefinite detention should legislate for the use of limiting terms for people with a cognitive impairment and abide by the principle of least restrictive support.
- Aboriginal and Torres Strait Islander people with cognitive impairment detained under mental health legislation must be provided support and intervention that is of significant benefit to that person.
- Detention of Aboriginal and Torres Strait Islander people with cognitive impairment under mental health legislation must be accompanied by a justice plan that identifies pathways from high security to low security detention and to community and from the most restrictive to the least restrictive arrangement.
- In-prison programs to address offending behaviour, including alcohol and other drug rehabilitation, should be designed to be inclusive of people with a cognitive impairment and complex support needs.
- Each jurisdiction should ensure there is a culturally appropriate disability support program in prison.
- For all prisoners with disability, remand or sentenced, the NDIA and each corrections agency should come to an agreement regarding assessment, support and referral into the NDIS upon release from prison.
- In each jurisdiction, corrections agencies should build a working relationship with the NDIA (through Local Area Coordinators) and NGOs that work with people with disability to best support people with disability leaving prison.
- Where a person with mental and cognitive disability is imprisoned, a pathway referral out of prison into disability support and case management in the community must be ensured.

## 10.2.7 Post-release

- Resources and funding should be provided to Indigenous organisations to ensure the building of skills and capacity to work with people with a cognitive impairment and complex support needs returning to community after completing criminal justice orders or sentences.
- Specialist long-term accommodation, wrap-around services and case management support should be provided post-release for Aboriginal and Torres Strait Islander people with mental and cognitive disability across the country.





## HUMAN SERVICES

### 10.2.8 Community Services

- Early diagnosis and positive culturally appropriate support for Aboriginal and Torres Strait Islander children and young people with cognitive impairment and complex support needs should be resourced and supported.
- Culturally appropriate support and respite are needed for families and carers of Aboriginal and Torres Strait Islander children with cognitive impairment and complex support needs.
- Aboriginal and Torres Strait Islander children with disability who are in out of home care must be provided with appropriate community and school based support to promote well being and positive life pathways.

### 10.2.9 Schools

- Education and information is required to enable school personnel to better recognise and respond to children with a cognitive impairment and complex support needs.
- Schools where there are enrolments of Aboriginal and Torres Strait Islander children with cognitive impairments should be linked with agencies to provide specialist behaviour interventions where those behaviours are assessed as of concern.
- Culturally appropriate information and support for families of Aboriginal and Torres Strait Islander children with cognitive impairment should be made available through schools in all jurisdictions.

### 10.2.10 Disability

- Improved identification, assessment and referral processes and pathways for Aboriginal and Torres Strait Islander young people with cognitive impairment are required urgently.
- Concerted effort is needed to enable appropriate and early diagnosis and treatment for Aboriginal and Torres Strait Islander children and young people with FASD, particularly through adequate resourcing of professionals and through community education programs.
- Alternative appropriate models of care should be provided to Aboriginal and Torres Strait Islander people with FASD to avoid imprisonment of those unable or unfit to plead.
- Respite options should be provided to families and other members of Aboriginal and Torres Strait Islander communities supporting people with mental and cognitive disability.
- Specialist Indigenous violence intervention programs should be linked with disability supports in Indigenous communities.
- Particular attention must be paid to the planning and support options for Aboriginal and Torres Strait Islander people with mental and cognitive disability and complex support needs through the NDIS.





## 10.2.11 Mental and other health concerns

- Improved referral pathways and greater case coordination between corrections and community-based health providers in regard to medication and therapeutic services and support for Aboriginal and Torres Strait Islander people with mental health disorders and complex support needs.
- Maintenance and provision of up to date medical reports and assessments are vital for consideration in court matters when sentencing Aboriginal and Torres Strait Islander people with mental health disorders and complex support needs
- Culturally appropriate, community-based holistic specialised mental health services able to address the whole range of complex support needs should be available in all areas and communities with significant numbers of Aboriginal and Torres Strait Islander people.
- Indigenous community health care clinics should be resourced to assess and respond to Aboriginal and Torres Strait Islander children and adults, in particular to children with FASD.

## 10.2.12 Housing

- A range of culturally appropriate supported housing, depending on need, should be available in their communities for Aboriginal and Torres Strait Islander people with mental and cognitive disability and complex needs.
- Step down supported housing should be available for Aboriginal and Torres Strait Islander people with mental health disorders and cognitive disability leaving prisons.







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