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)

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1. BACKGROUND TO THE SECTION 32 REPORT

The Section 32 Report concerns the 'Section 32 MHDCD Project' which is a nested study within the Australian Research Council (ARC) Linkage project, 'People with Mental Health Disorders and Cognitive Disabilities (MHDCD) in the Criminal Justice System (CJS) in NSW' (the 'Section 32 MHDCD Project').

1.1 THE MHDCD PROJECT

A brief discussion of the MHDCD Project is appropriate in order to contextualise the Section 32 MHDCD Project. The MHDCD Project concerns a cohort of 2,731 men and women, both Indigenous and non-Indigenous, who have been in prison in New South Wales and whose mental health disorder and cognitive disability diagnoses are known (the 'MHDCD cohort'). The cohort was drawn from the 2001 NSW Inmate Health Survey (IHS) and from the NSW Department of Corrective Services State-wide Disability Service Database (SDD). Ethics approval was obtained from all of the relevant ethics bodies, including from the University of New South Wales Human Research Ethics Committee.[1]

The MHDCD cohort is a purposive not a representative sample, intentionally focusing on those individuals whose mental health disorder and cognitive disability diagnoses are known and who have been in prison, but with a no-diagnosis group for comparative purposes.[2] This is intended to provide in depth information on life course pathways for people diagnosed with mental health disorder and cognitive disability in the CJS. In the MHDCD cohort 35% of individuals (965) have a history of anxiety, affective disorders or psychosis (MH), 54% (1463) a cognitive disability

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[1] See generally *Australians with MHDCD in the CJS Project* (29 June 2012) Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System <http://www.mhdcd.unsw.edu.au/australians-mhdcd-cjs-project.html>.

[2] The no-diagnosis group is not included in the Section 32 MHDCD Project cohort as this cohort consists only of those individuals who have ever had a section 32 order (where eligibility for a section order is dependent in part upon a diagnosis of certain Mental Health Disorder and Cognitive Disability).

(including those with intellectual disability (ID) and those with borderline intellectual function (BID)), 56% (1518) a substance use disorder (AOD) and 22% (609) a personality disorder (PD). There is a great deal of cross over between these categories. Given that a history of mental health disorder and the presence of intellectual disability and borderline intellectual disability was a key concern of the MHDCD Study, members of the cohort are classified utilising these diagnoses as primary. Consequently, the presence of a diagnosis of intellectual disability and mental health disorder or a diagnosis of borderline intellectual disability and mental health disorder does not necessarily indicate the absence of a history of alcohol and/or substance use problems but rather that these problems are additional to the primary diagnosis of 'ID and MH' or 'BID and MH'.

For all 2,731 individuals the MHDCD project has assembled a detailed dataset on life-long human services and criminal justice involvement using extant administrative records from criminal justice and human service agencies: Police, Corrections, Justice Health, Courts, Juvenile Justice, Legal Aid, Disability, Housing, Health and Community Services. These data have been merged and linked to provide a detailed description and analysis of the pathways by which people with diagnoses of mental health disorder and cognitive disability enter, move through, exit and return to the criminal justice system (CJS) and an understanding of the interactions between the justice and human service agencies affecting people diagnosed with mental health disorder and cognitive disability, with a view to developing effective integrated system interventions that can be employed to address the over representation of these people in the CJS.[3]

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[3] For an overview of some of the key findings, see Eileen Baldry, Leanne Dowse and Melissa Clarence, 'People with Intellectual and Other Cognitive Disability in the Criminal Justice System' (Family & Community Services: Ageing, Disability & Home Care, 2012); Eileen Baldry, Leanne Dowse and Melissa Clarence, 'People with Mental and Cognitive Disabilities: Pathways into Prison' (Australian Correctional Leadership Program, October 2011); Eileen Baldry, Leanne Dowse and Melissa Clarence, 'Background Paper for Outlaws to Inclusion Conference February 2012: People with Mental and Cognitive Disabilities: Pathways into Prison' (University of New South Wales, 2012). For an overview of the findings specifically related to members of the MHDCD cohort with acquired brain injury, see Leanne Dowse et al, 'People with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System: Impact of Acquired Brain Injury' (Brain Injury Association of NSW and Brain Injury Australia, 2011).

1.2 THE SECTION 32 MHDCD PROJECT

The Section 32 MHDCD Project, which is the subject of this report, aims to mine the MHDCD dataset discussed above to explore and report on:

(i)   the patterns of the use of orders made pursuant to s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) 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

(ii)   the demographic characteristics and longitudinal human service and criminal justice pathways of the individuals the subject of these section 32 orders.[4]

Ethics approval for the Section 32 MHDCD Project was obtained from the University of Sydney Human Research Ethics Committee, and this approval was ratified by the University of New South Wales Human Research Ethics Committee.

Sampling involved selecting all members of the MHDCD cohort who have ever been the subject of one or more section 32 applications, a total of 149 individuals. This group of 149 individuals is a relatively small proportion (6.2%) of the total 2,392 members of the MHDCD cohort who have diagnoses of mental health disorder and/or cognitive disability (and hence on a prima facie level have a diagnosis that can meet one of the key eligibility requirements for a section 32 order).[5]

There are 5 study groups for the purposes of the Section 32 MHDCD Project. These are:

(i)   ID: Intellectual Disability

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[4] Section 32 orders can only be made in the Local Court or the Children's Court: *Mental Health (Forensic Provisions) Act 1990* (NSW) s 3 (1) (definition of 'Magistrate').

[5] This observation should be qualified by noting that section 32 orders can only be made in the Local Court or the Children's Court and cannot be made in the District and Supreme Courts. Some individuals in the MHDCD cohort might have only ever had their charges dealt with in the higher courts (ie the District and Supreme Courts) and never have had charges finalised in the Local Court or Children's Court and hence never had the opportunity to have their charges dealt with by way of section 32 order.

Individuals with an intellectual disability diagnosis only, that is with *no* mental health disorder diagnosis.

(ii)   BID: Borderline Intellectual Disability

Individuals with a borderline intellectual disability diagnosis only, that is with *no* mental health disorder diagnosis.

(iii)   MH_ID: Mental Health Disorder and Borderline Intellectual Disability

Individuals with a mental health disorder diagnosis (including individuals with an alcohol or other drug disorder diagnosis and individuals with a personality disorder diagnosis) *and* an intellectual disability diagnosis.

(iv)   MH_BID: Mental Health Disorder and Borderline Intellectual Disability

Individuals with a mental health disorder diagnosis (including individuals with an alcohol or other drug disorder diagnosis and individuals with a personality disorder diagnosis) *and* a borderline intellectual disability diagnosis.

(v)   MH: Mental Health Disorder

Individuals with a mental health disorder diagnosis only (including individuals with an alcohol or other drug disorder diagnosis and individuals with a personality disorder diagnosis), that is with *no* intellectual disability or borderline intellectual disability diagnosis.

One key difference in categorisation between the cohort in the Section MHDCD Project ('section 32 cohort) and the MHDCD cohort is that the former does not have separate study groups for individuals with alcohol or other drug disorders. Rather, diagnoses of alcohol or other drug disorder are classified as a diagnosis of a mental health disorder, and hence individuals in the section 32 cohort with these diagnoses are subsumed under the study groups containing individuals with a diagnosis of mental health disorder in their diagnostic profile (ie MH, MH_BID, MH_ID).

Additional to the diagnostic study groups above, the report also uses the term 'cognitive disability' to refer collectively to intellectual disability and borderline intellectual disability.

Data was then drawn on the section 32 cohort's demographic characteristics, criminal justice contacts, social and health factors, disability service usage, and patterns of section 32 orders. Data was linked and de-identified for quantitative analysis. This analysis focused on key areas of inquiry clustered around four areas:

- Demographic characteristics (notably markers of social disadvantage)

- Criminal justice pathways

- Human and disability service pathways

- Patterns of section 32 usage

The themes were informed by issues that have emerged from earlier analysis and findings on the MHDCD cohort by Baldry and Dowse et al.[6] They were also informed by the themes that have emerged from Steele's PhD research on section 32 and specifically her qualitative thematic analysis of a small sample of section 32 court files and transcripts for persons diagnosed with cognitive disability in the CJS.

The cohort is described and analysed at a number of levels/and across a range of categorical breakdowns including

- Whole section 32 cohort

- Study groups

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[6] For references providing an overview of the MHDCD Project, see n 3 above.

- All study groups containing individuals with cognitive disability in their diagnostic profile (ID, MH_ID, BID, MH_BID) v single diagnosis MH study group

- Single diagnosis study groups (ID, BID, MH) v complex diagnosis study groups (MH_ID, MH_BID)

- Indigenous/non-Indigenous and male/female at the levels of the section 32 cohort and the study groups

- ABI across the section 32 cohort at the levels of the section 32 cohort, the study groups and at the further levels of Indigenous/non-Indigenous and male/female

The data was analysed in this way in order to draw out the general characteristics across the section 32 cohort, as well the significant complexities and nuances related to diagnoses and demographics.

Analysing the data at these different levels provides a detailed picture of people diagnosed with mental health disorder and cognitive disability in the CJS who have been the subject of section 32 orders. This moves beyond a simple diagnostic descriptor[7] and shows the complex dynamics of diagnoses, social marginalisation, institutional interventions and criminalisation.

The section 32 cohort was also compared to the broader MHDCD cohort.[8] That is, those who are *in* the section 32 cohort and who have *ever* been the subject of a section 32 order were compared with the MHDCD cohort which includes these individuals *as well as* those incarcerated individuals who, by their may be deemed to be eligible but have *never* received a section 32 order. The purpose here was to identify whether there were particular dynamics of social marginalisation or human service

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[7] In this respect, the Section 32 MHDCD Project can be distinguished from existing quantitative research on section 32 which focuses principally on the diagnoses of individuals subject to section 32 orders: Jenna Macnab, 'S32/33 Research: A Report on Successful Orders Provided Under Sections 32 and/or 33 of the Mental Health (Forensic Provisions) Act NSW 1990 with Respect to People With an Intellectual Disability and/or a Psychiatric Disability in Four Local Courts' (Diversity Services, NSW Department of Attorney General and Justice, 2011); New South Wales Law Reform Commission, 'People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion' (New South Wales Law Reform Commission, 2012) 68 [4.70] – 69 [4.76].

[8] For an overview of some of the key findings of the MHDCD Project, see n 3 above.

and criminal justice pathways that distinguish the section 32 cohort from individuals who have never had a section 32 order. The purpose of this comparison is to assist in illuminating some reasons for the relatively low number of individuals across the MHDCD cohort who have used section 32 orders (5.5%).[9]

1.2.1 Study Limitations

It is important at the outset to note the limitations of this study which are present in relation to the data regarding both the use of section 32 and the subjects of section 32 themselves.

First, the sampling of the broader MHDCD cohort is purposive and not representative. As such the findings in the Section 32 Report are not indicative of *all* persons diagnosed with mental health disorder and cognitive disability who have been in custody and who have been the subject of a section 32 order.

Secondly, the sample available in the MHDCD cohort is a selective sample of all prisoners (drawn from the IHS and DCS SDD) and therefore will not capture individuals who have *not been* prisoners. As such, the findings are not representative of *all* persons diagnosed with mental health disorder and cognitive disability in the CJS who have been the subject of a section 32 order because it does not include those individuals who have had a section 32 order but have *never* been in custody, or those who were in custody but were not identified as having mental health disorder and cognitive disability through the IHS or SDD. It is important then to understand that the findings presented in this report are of a selective and small sample of individuals who have been the subject of section 32 and who have been incarcerated in NSW.

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[9] In light of the purpose of the comparisons, wherever there was available data at the level of the MHDCD Cohort study groups, the 339 individuals in the ND or 'no diagnosis' group were excluded from the comparisons because they do not have a diagnosis of Mental Health Disorder and Cognitive Disability and hence would not be eligible for section 32.

Further research is needed to quantify the numbers of individuals who have been the subject of a section 32 order with and without histories of incarceration and to qualitatively study any differences in the demographics and human service and CJS pathways between these two groups. Nonetheless, to the extent that the findings in this study are specific to persons who *have been* incarcerated and have been the subject of section 32, it is relevant to section 32's significance as an *alternative* to incarceration for the large number of people diagnosed with mental health disorder and cognitive disability who *are* incarcerated.

A further indication of the 'snapshot' view provided in this report is the fact that whilst this report relates to only 149 individuals who have been the subject of section 32 orders at any point in their lives, this reflects a small proportion of the total number of individuals across New South Wales who are the subjects of section 32 orders. For example, NSWBOCSAR data indicates that the following number of individuals have been the subject of section 32 orders on an annual basis: 2006: 957 individuals; 2007: 1046 individuals; 2008: 1078 individuals; 2009: 1143 individuals; and 2010: 1335 individuals[10]

Thirdly, the cohort was established on 30 April 2008 and reforms subsequent to this date might mean that the cohort does not reflect the impact of the current legal and service framework around section 32. Legal and disability service provision vis-à-vis section 32 is in a process of ongoing development and enhancement. For example, there have been some reforms in relation to forensic community disability service provision and there have been a number of projects involving systemic advocacy and professional education in relation to the use of section 32, all of which may have resulted in more frequent use of section 32 since the MHDCD cohort was established in April 2008.

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[10] New South Wales Law Reform Commission, above n 7, 68 [4.73].

2. ANALYSIS

The following section presents information on a cohort of 149 individuals drawn from the MHDCD dataset ('section 32 cohort') who have been identified as ever having been the subject of a section 32 order. It focuses on the nature of the use of orders made pursuant to section 32 and the demographic characteristics and longitudinal human service and criminal justice pathways of the individuals the subject of these section 32 orders.

In Part 2.1, the characteristics of the section 32 cohort are explored in relation to their demographic characteristics (including diagnoses, age, gender and Indigenous/non-Indigenous). Parts 2.2-2.4 explore the section 32 cohort's agency interactions with human service and criminal justice agencies and their disability service usage. In Part 2.4 the patterns and nature of the use of section 32 orders are explored.

2.1 DEMOGRAPHIC CHARACTERISTICS

Part 1 explores the demographic characteristics of the cohort of 149 individuals drawn from the MHDCD dataset who have been identified as ever having been the subject of a section 32 order. Figure 1 shows the breakdown of diagnostic study groups for the section 32 cohort.[11] It indicates that individuals with diagnoses which include cognitive disability (MH_ID, MH_BID, ID, BID) constitute 87% of the section 32 cohort, which is a significant proportion of the cohort. Individuals in the cohort with a complex diagnoses, that is, those with diagnoses of MH_ID and MH_BID represent 60% (90) of the total section 32 cohort.

The complex diagnoses groups each constitute a greater proportion than each of the single diagnosis groups. Individuals diagnosed with MH_ID constitute 34% and individuals diagnosed with MH_BID constitute 26%, whereas individuals diagnosed with ID constitute 13%, individuals

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[11] See Part 1.2 above for a discussion of the categorisation process.

diagnosed with BID constitute 13% and individuals diagnosed with MH constitute 13%. Individuals who were identified as having diagnoses of MH_ID were most highly represented in the section 32 cohort, making up 34% (51) of individuals to have had a section 32 order, followed by those with diagnoses of MH_BID, making up 26% (39).

	MH_ID	MH_BID	ID	BID	MH
■ Total	51	39	19	20	20
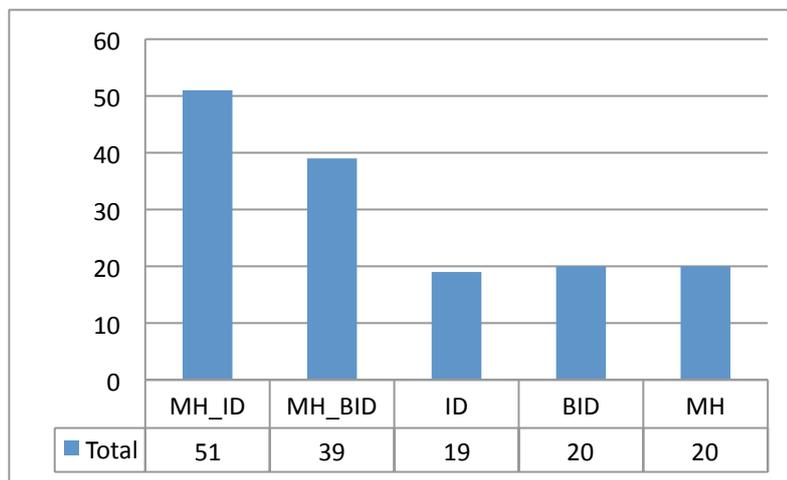
The high proportion of section 32 cohort members with complex diagnoses can be compared to the relatively lower proportion of individuals with single diagnoses. Individuals with a single diagnosis constitute a minority of the section 32 cohort, comprising 40% (59) of the section 32 cohort. Similarly, individuals with a single diagnosis of ID (19), BID (20) or MHD (20) are each in a minority in the cohort of 13%.

Individuals with any cognitive disability diagnosis (ie a diagnosis of intellectual disability or borderline intellectual disability, either alone or in combination with a mental health disorder diagnosis) represent a higher proportion of the section 32 cohort of 87% (129) than individuals with any mental health disorder diagnosis (either alone or in combination with a diagnosis of borderline intellectual disability or intellectual disability), comprising 74% (110) of the section 32 cohort.

	MH_ID	MH_BID	ID	BID	MH	No Diagnosis
■ No s32	414	478	196	246	911	337
■ s32	51	39	19	20	20	
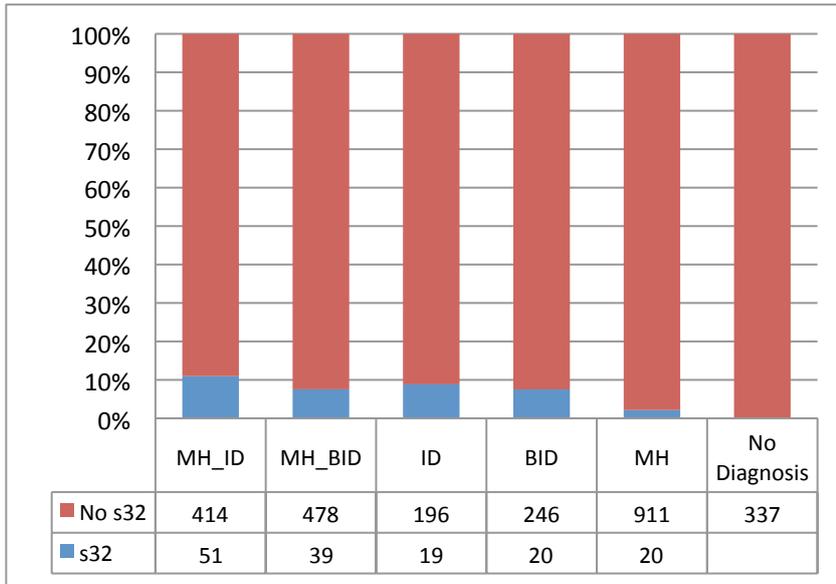
Figure 2 indicates that only 6% of diagnosed individuals in the broader MHDCD cohort (ie excluding individuals in the No Diagnosis study group of the MHDCD cohort) have ever received a section 32 order.

Interestingly, each of the study groups containing individuals with either intellectual disability or borderline intellectual disability in their diagnostic profiles have a higher proportion of section 32 order recipients, compared to individuals with a single diagnosis of MH: 11% of individuals diagnosed with MH_ID, 8% of individuals diagnosed with MH_BID, 9% diagnosed with ID and 8% diagnosed with BID, compared to only 2% diagnosed with MH.

On a similar note, 9% of individuals in the MHDCD cohort with a diagnosis of ID or BID in their diagnostic profile (either alone or in combination with a diagnosis of mental health disorder) have received a section 32 order, compared to the lower proportion of 6% of individuals in the MHDCD cohort with mental health disorder in their diagnostic profile (either alone or in combination with a diagnosis of intellectual disability or borderline intellectual disability).

2.1.1 Age

This Section discusses the age demographics of the section 32 cohort.

Figure 3 shows the average age of the individuals with a section 32 order across the study groups (taken at the establishment of the cohort in April 2008).

Figure 3: Average Age Across Study Groups

	MH_ID	MH_BID	ID	BID	MH
Total	34.22	34.46	37.42	32.35	37.55
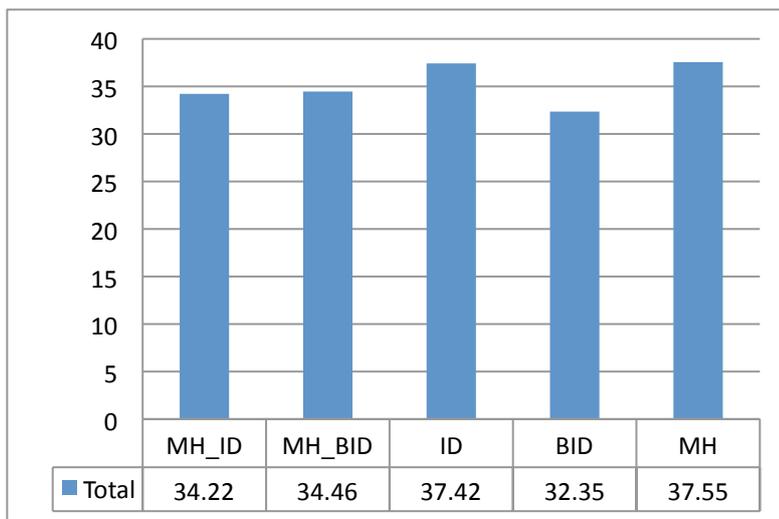
The average age across the section 32 cohort is 35.2 years. On average, individuals in the section 32 cohort with complex diagnoses or diagnosis of BID are younger than individuals with a single diagnosis of ID or a single diagnosis of MH. The group in the cohort with the youngest average is the BID group (32.4 years). Those with complex diagnoses also have a relatively lower average age of 34.4 years. This can be compared to the higher average ages for individuals with a *single* diagnosis of either ID (37.4 years) or MH (37.6 years).

2.1.2 Gender

This Section discusses the gender makeup of the section 32 cohort.

Figure 4 shows the breakdown of gender across the section 32 cohort study groups. Overall, the section 32 cohort is comprised of a significant majority of males as compared to females, at 89%

(132) and 11% (17) respectively. This is not surprising and is reflective of the underrepresentation of women with mental health disorder and cognitive disability in the MHDCD cohort more broadly,[12] where there are 276 females (12%) in the cohort with diagnoses of mental health disorder and/or cognitive disability and 2417 (88%) males with diagnoses of mental health disorder and/or cognitive disability, with one person having an unknown sex.

Figure 4: Gender Across Study Groups

	MH_ID	MH_BID	ID	BID	MH
Male	41	36	19	19	17
Female	10	3		1	3

In terms of the gender distribution across the section 32 cohort study groups, it is interesting to note that females are more likely to have complex diagnoses and/or a single MH diagnosis.

Overall, the overwhelming characteristic of the females in the section 32 cohort is mental health disorder diagnosis. Ninety four per cent (16) of females in the section 32 cohort have a mental health disorder diagnosis (whether alone or in combination with a diagnosis of intellectual disability or borderline intellectual disability), whereas 82% have a diagnosis of cognitive disability and for this latter group of females this is overwhelmingly in combination with a diagnosis of mental health disorder because there is only 1 female in the section 32 cohort with a diagnosis of cognitive disability (ie 1 female with a single diagnosis of BID). This follows the pattern noted in the overall

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[12] This also reflects the higher proportion of men in the prison population generally. For example, pursuant to 2012 figures from the Department of Corrective Services, only 7% of inmates in NSW full-time custody were female: Corrective Services NSW, *Facts & Figures: Corporate Research, Evaluation and Statistics* (March 2012) <http://www.correctiveservices.nsw.gov.au/__data/assets/pdf_file/0004/406840/facts-and-figures.pdf>.

MHDCD cohort where there are 8 females with a single diagnosis of ID and 12 females with a single diagnosis of BID, compared to 54% of females in the MHDCD dataset with complex diagnoses. Keeping in mind that the MHDCD cohort is not intended to be representative of all females diagnosed with mental health disorder and cognitive disability in prison, it is known that females diagnosed with intellectual disability tend to be less often recognised or referred within the CJS not necessarily because female offenders have lower rates of cognitive impairment.

The negligible presence of females with a single diagnosis of ID or BID in the section 32 cohort and the overwhelming presence of mental health diagnosis (whether alone or in combination with a diagnosis of intellectual disability or borderline intellectual disability) might point to the gendered nature of mental health diagnosis, with females' behaviour and emotional responses being more prone to pathologising than males'. It might also be that the higher incidence of mental health disorder diagnosis in relation to females in the section 32 cohort reflects the higher incidence of trauma linked to sexual and physical violence against women.[13] The low representation of females with cognitive disability might also be due to the overriding presentation of trauma and personality disorder that masks a diagnosis of cognitive disability.

Another interesting finding from Figure 4 is that complex diagnoses are a characteristic of females in the section 32 cohort. Females with complex diagnoses represent over ¾ (76%) of all females in the section 32 cohort. The highest proportion of all females in the section 32 cohort is found in the MH_ID complex diagnoses group (59% of all females). This is different to the broader MHDCD cohort where females with complex diagnoses of MH_ID or MH_BID represent only 25% of all diagnosed females in the MHDCD cohort, with females more highly represented in the single diagnosis MH study group. It has been noted in the field that those females who are in the CJS tend to have greater complexity in their diagnoses. As will be shown in the analysis that follows and as

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[13] See, eg, Mary Stathopoulos, 'Addressing Women's Victimisation Histories in Custodial Settings' (Australian Centre for the Study of Sexual Assault, 2012).

has been shown by Baldry and Dowse,[14] complexity in diagnosis is linked to greater social disadvantage and CJS involvement. As such females in the section 32 cohort might experience relatively high levels of disadvantage.

Figure 5 shows the variation in age according to gender and by diagnostic study group.

Figure 5: Average Age and Gender Across Study Groups

	MH_ID	MH_BID	ID	BID	MH
■ Female	34.10	39.67		34.00	39.00
■ Male	34.24	34.03	37.42	32.26	37.29
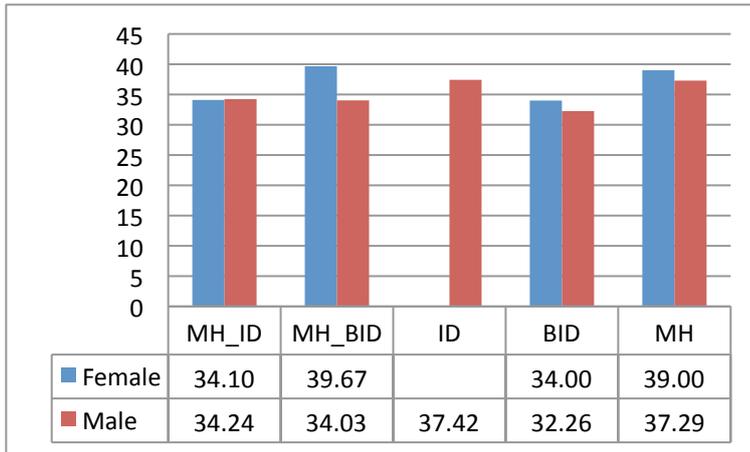
Overall, Figure 5 shows that females in the section 32 cohort are generally older than males. The average age across the cohort for females is 36.7 years, whereas for males it is 35 years. In all but one of the study groups (where the age is relatively equal between the genders) females are older on average than males in the section 32 cohort.

2.1.3   Indigenous Australians

This section discusses the representation and profile of Indigenous Australians in the section 32 cohort and within the study groups.

Figure 6 shows the proportion of the section 32 cohort in each of the different study groups who are Indigenous Australians.

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[14] See, eg, Baldry, Dowse and Clarence, above n 3, 14.

	MH_ID	MH_BID	ID	BID	MH
■ Unknown	2	1	2		2
■ Not ATSI	33	24	13	14	16
■ ATSI	16	14	4	6	2
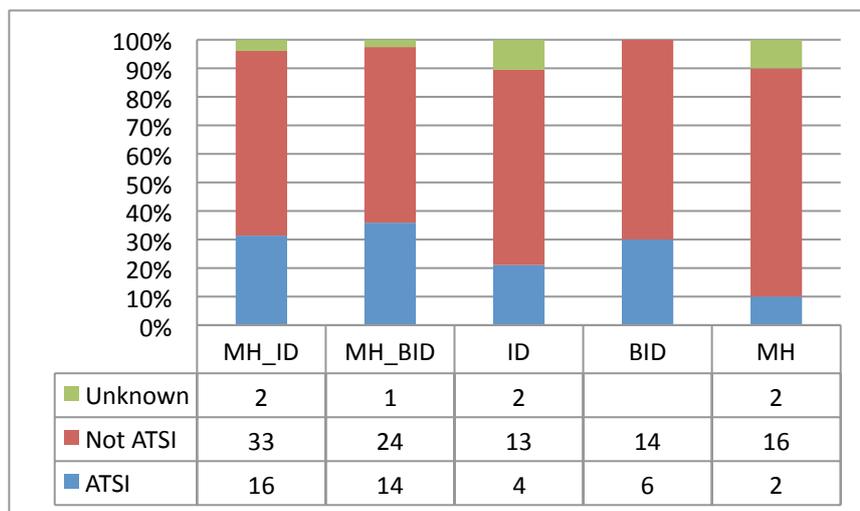
Overall, Indigenous Australians constitute 28% (42) of the members of the section 32 cohort. This is slightly higher than in the broader MHDCD cohort where Indigenous people make up 25%. It is an interesting finding that Indigenous Australians are overrepresented in the section 32 cohort, particularly in light of the generally greater disadvantage and incarceration rates of Indigenous people, and might invite further research.

Figure 6 shows the overwhelming incidence of diagnoses of cognitive disability in relation to Indigenous Australians in the section 32 cohort. Of the 42 Indigenous Australians in the section 32 cohort, 40 (95%) have a diagnosis of cognitive disability (ie either a diagnosis of intellectual disability or borderline intellectual disability, either alone or in combination with a MH diagnosis). This percentage is higher than the percentage of individuals diagnosed with cognitive disability across the section 32 cohort generally (87%). Moreover, of those Indigenous Australians with a

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[15] This figure represents non-Indigenous Australians in terms of two categories of 'Not ATSI' and 'Unknown'. This is in order to add descriptive context to the figure in showing the incomplete nature of Indigenous data in the dataset (ie that some individuals are recorded as neither Indigenous nor not Indigenous and hence whether they are in fact Indigenous remains unknown). However, all subsequent figures and tables concerning Indigenous Australians will collapse these two categories into the one category of Not ATSI because this detail does not contribute to the analysis.

single diagnosis, the majority have a single diagnosis of ID or BID (83%) as opposed to a single diagnosis of MH.

Figure 6 also illustrates that Indigenous Australians in the section 32 cohort are more likely to have complex diagnoses (ie diagnoses of MH_ID or MH_BID) than a single diagnosis, and that the proportion of Indigenous Australians with complex diagnoses at 71% (30) is higher than that of non-Indigenous Australians with complex diagnoses (56%), and is also slightly higher than the 60% of individuals with complex diagnoses across the section 32 cohort generally. The proportion in the section 32 cohort who have a diagnosis of cognitive disability (either single diagnosis or complex) and are Indigenous is 31% (40), thus this group constitutes a significant proportion of the total section 32 cohort. As a proportion of the total number of individuals in each study group, the highest representation of Indigenous Australians is seen in the 36% (14) of those with diagnoses of MH_BID, closely followed by the 31% (16) of those with diagnoses of MH_ID, while the lowest proportion is found in the MH only study group with 10% (2).

Figure 7 demonstrates the gender breakdown of Indigenous Australians across the study groups.

Figure 7: ATSI and Gender Across Study Groups

	ATSI Female	ATSI Male	Not ATSI Female	Not ATSI Male
■ MH_ID	3	13	7	28
■ MH_BID	1	13	2	23
■ ID		4		15
■ BID	1	5		14
■ MH		2	3	15
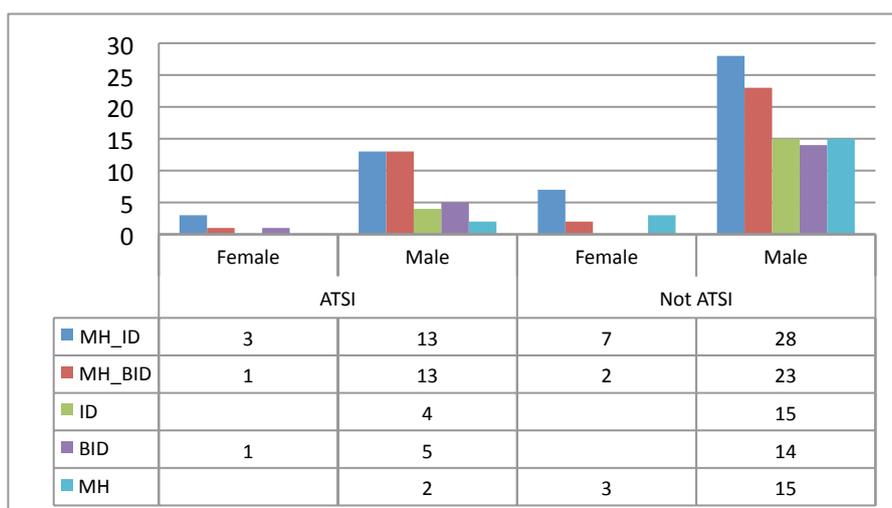
Overall, Figure 7 reveals that the majority of Indigenous Australians in the section 32 cohort are male. Males constitute 88% (37) of all Indigenous Australians in the section 32 cohort. This is only marginally lower than the figure of 89% males across the whole section 32 cohort.

Indigenous females constitute only a minority of all Indigenous Australians in the cohort 12% (5), but this is only slightly higher than the proportion of females in the section 32 cohort generally of 11%.

Indigenous Australian females overwhelmingly have complex diagnoses as shown in Figure 7. Of the 5 Indigenous Australian females in the section 32 cohort, 80% (4) have complex diagnoses of MH_ID or MH_BID, with diagnoses of MH_ID constituting the highest proportion of Indigenous Australian females (3). Although this is in no way representative because the numbers are not significant, broader populations of Indigenous Australian females in the CJS do tend to have the most complex presentations and the individuals captured in this cohort who are female and Indigenous fit that picture.[16] Moreover, the distribution of Indigenous Australian females across the study groups in the larger MHDCD cohort similarly reflects their overwhelming complex diagnoses, with only 26% (23) of all diagnosed Indigenous females in the MHDCD cohort having a single diagnosis.

Indigenous Australian males in the section 32 cohort are also more highly represented in the complex diagnoses groups (ie MH_ID and MH_BID) whether this is measured as a proportion of all Indigenous Australian males in the Indigenous sub-group of the section 32 cohort, as a proportion of all males in the particular study group, or as a proportion of all individuals in the section 32 cohort as a whole. For example, Indigenous Australian males with diagnoses of MH_ID constitute 30% of all members of the section 32 cohort who are Indigenous Australians, 31% of all males in the MD_ID study group and 9% of all individuals in the section 32 cohort. Indigenous

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[16] See, eg, Baldry, Dowse and Clarence, *Outlaws to Inclusion*, above n 3, 14.; Eileen Baldry, Catriona McComish and Melissa Clarence, 'Punishing the Vulnerable: Women with Mental Health Disorders & Cognitive Disabilities in the NSW Criminal Justice System' (Paper presented at the Sisters Inside Conference, Brisbane, 2009)

Australian males with diagnoses of MH_BID constitute 30% of all members of the section 32 cohort who are Indigenous Australians, 36% of all males in the MH_BID study group and 9% of the section 32 cohort.   Of the single diagnosis groups, the lowest proportion of Indigenous males is found in the MH study group, which again highlights the significance of complex diagnoses and of diagnoses of cognitive disability in relation to the Indigenous Australian members of the section 32 cohort.

Figure 8 shows the average age of Indigenous Australians across the study groups.

Figure 8: ATSI and Average Age Across Study Groups

	MH_ID	MH_BID	ID	BID	MH
ATSI	32.63	29.36	31.50	33.00	34.00
Not ATSI	34.94	37.32	39.00	32.07	37.94
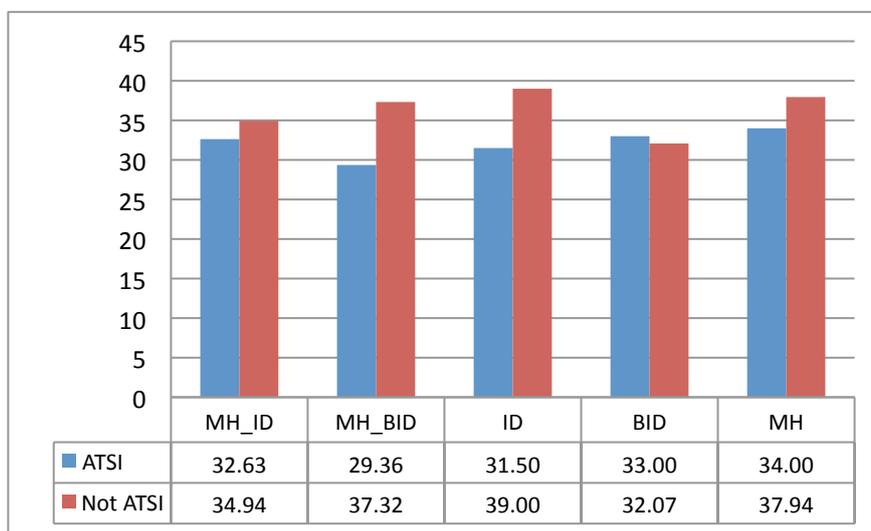
Overall, Figure 8 indicates that across the section 32 cohort, Indigenous Australians are on average younger (32 years old) than non-Indigenous Australians in the cohort (35 years old).

In four out of the five study groups in the section 32 cohort, Indigenous Australians are on average younger than non-Indigenous individuals. Indigenous Australians with complex diagnoses of MH_BID are on average the youngest of all groups and have the most significant age differential as compared with their non-Indigenous counterparts, at over 8 years.   Indigenous Australians with single diagnosis ID, at an average age of 32 years old, are also considerably younger than their non-Indigenous Australian counterparts by an average of over 8 years.   Only in relation to those with

single diagnosis BID is the average age of Indigenous Australian members slightly higher, at 33 years as compared to 32 years.

2.1.4   Presence of ABI

This section discusses the presence of ABI in the individuals in the section 32 cohort, and offers basic demographic description of these individuals.

An individual is identified in the MHDCD dataset as having experienced an ABI through two different means:

- A recorded flag in the CS NSW Statewide Disability Service Database for an individual as having an ABI.

- Self-report on the Justice Health 2001 Inmate Health Survey as receiving at least one head injury resulting in unconsciousness. Individuals who reported sequalae following on from the head injury were included in the ABI group.[17]

It is important to note that the nature of the data collection in relation to ABI means that it is not comprehensive and hence the data on ABI discussed in this section might not represent all individuals with ABI in the section 32 cohort. For example, the nature of the IHS data focuses on ABIs which are the result of blows to the head or falls, and hence will be unlikely to capture particular ABIs such as those relating to substance use.

Figure 9 shows the number of individuals in the section 32 cohort with ABI across the study groups.

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[17] Dowse et al, above n 3, 15.
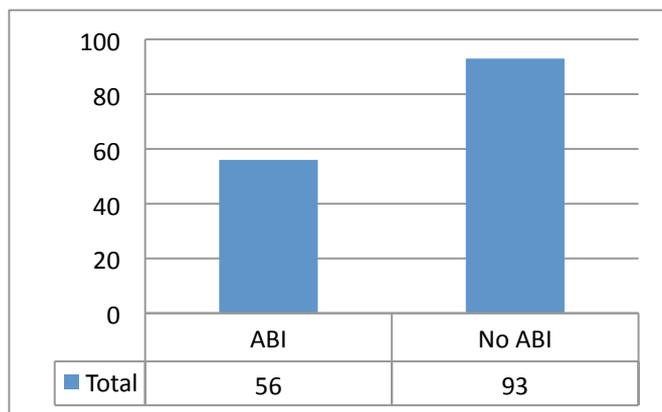
Figure 9 shows a proportionally high rate of ABI in the section 32 cohort – 38% (56) of individuals were identified as having the presence of an ABI. It is interesting to note that this is much higher than the rate of ABI in the larger MHDCD cohort at 23%.[18] Individuals with ABI are overrepresented in the section 32 cohort. As a proportion of all individuals with an ABI and a diagnosis of mental health disorder and/or cognitive disability (ie ID or BID) in the larger MHDCD cohort, those with a section 32 order represent quite a high proportion of 10%. This can be compared to the proportion of individuals with no ABI and a section 32 order which comprise only 5% of the total number of individuals with no ABI in the larger section 32 cohort.

Figure 10 indicates the presence of ABI across the section 32 study groups. It reveals that at least one quarter of all individuals in each of the study groups has ABI. Figure 10 also shows that when ABI is introduced as a diagnostic dynamic, an overwhelming majority of 90% (134) of all individuals in the section 32 cohort have one or more forms of cognitive disability (ie intellectual disability, borderline intellectual disability and/or ABI), thus further strengthening the point made in Part 2.1 above concerning the significance of cognitive disability in the section 32 cohort.

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[18] Ibid 15.

	MH_ID	MH_BID	ID	BID	MH
■ No ABI	31	24	8	15	15
■ ABI	20	15	11	5	5

Interestingly, the single diagnosis ID study group has the highest representation of ABI, with 58% (11) of individuals in that study group having an ABI. This suggests that even though in terms of the section 32 study groups, ID is a 'single' diagnosis, a great proportion of this group have in fact 'complex' diagnoses in having diagnoses of both ID and ABI. Across the ID and BID single diagnosis study groups, there is a very small number (23 individuals) who are truly 'single' diagnosis (ie have no ABI diagnosis). Thus, in the section 32 cohort, cognitive disability is overwhelmingly complex, with only 18% of individuals with a diagnosis of intellectual disability or borderline intellectual disability in their diagnostic profile not additionally having diagnoses of MH and/or ABI.

More broadly, across the section 32 cohort, 74% of the individuals have more than one diagnosis (ie more than one diagnosis of mental health disorder, intellectual disability, borderline intellectual disability and ABI). When looking across the three 'single' diagnosis study groups, there are 21 individuals with ABI and 38 without, giving a percentage of 36% with ABI: over one third of all

individuals with 'single' diagnosis in the section 32 cohort actually have complex diagnoses. This in turn points to the significance of diagnostic complexity for the section 32 cohort.[19]

Furthermore, individuals with complex/ABI 'single' diagnosis cognitive disability are over represented in the section 32 cohort when compared to the single diagnosis study groups in the larger MHDCD cohort. Whereas 60% of individuals in the section 32 cohort with a single diagnosis of ID also have ABI, in relation to the MHDCD cohort only 21% of individuals in the single diagnosis ID study group have ABI. The difference is less striking in relation to BID: 25% of individuals in the section 32 cohort in the single diagnosis BID study group have ABI, compared to the slightly lower proportion of 23 % of individuals in the MHDCD cohort with a single diagnosis BID who also have ABI. Therefore, complex 'single' diagnosis cognitive disability is particularly over represented in the cohort, and specifically in relation to single diagnosis ID.

Over one third of all individuals in each of the complex diagnoses study groups in the section 32 cohort also have ABI. Of all individuals with diagnoses of MH_ID in the section 32 cohort, 39% (20) have ABI and 36% (15) diagnosed with MH_BID have ABI. This shows that for many with 'complex' diagnoses, their diagnosis is even more 'complex' by dint of the presence of ABI. This suggestion is further supported by the finding that as a proportion of the total 56 members in the section 32 cohort with ABI, the greatest proportion of 36% (20) were in the MH_ID study group, and 27% (15) were in the MH_BID study group. Therefore, for the complex diagnoses groups in the section 32 cohort, ABI constitutes a further dimension of diagnostic 'complexity' to already complex diagnoses.[20]

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[19] Dowse et al note in relation to the MHDCD cohort that the 'higher prevalence of ABI in the ID and BID groups should be interpreted with care, as the definitions that have been applied to the MHDCD cohort could be responsible for this trend. Individuals are assigned to different study groups based on IQ scores, excluding age of onset and the adaptive functioning test. It is thereby likely that many individuals are in the ID and BID groups as a result of their acquired brain injury, instead of their IQ score reflecting a developmental disorder.': ibid 16.

[20] Dowse et al note that similar findings in relation to the MHDCD cohort 'pose the significant and key question as to whether these individuals with complex needs are more vulnerable to and likely to experience ABI or in fact whether the presence of ABI is a causative factor in the conglomeration of complex needs.': ibid 18.

One final observation that can be made from Figure 10 is that the intellectual disability study groups have the highest proportion of individuals with ABI as a proportion of all individuals in those two study groups, constituting 44%. This can be compared to individuals with a diagnosis of borderline intellectual disability (either alone or in combination with a diagnosis of mental health disorder) where only 34% have ABI, and individuals with a diagnosis of mental health disorder (either alone or in combination with a diagnosis of intellectual disability or borderline intellectual disability) with a proportion of 36%.

Figure 11 shows the average age of individuals with ABI in the section 32 cohort by diagnostic study group.

Figure 11: ABI and Average Age Across Study Groups

	MH_ID	MH_BID	ID	BID	MH
ABI	36.35	37.40	33.64	31.60	37.60
No ABI	32.84	32.63	42.63	32.60	37.53
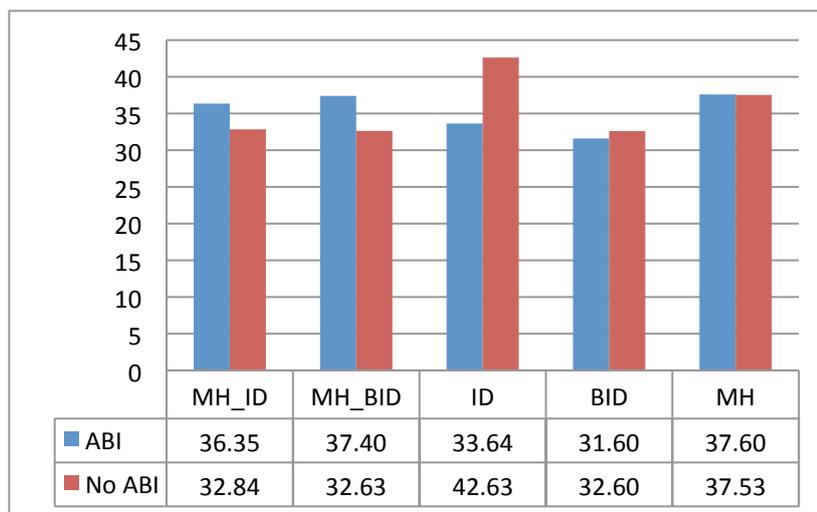
Overall, Figure 11 shows that there is little difference in the average age between individuals with ABI and those without ABI. The average age of individuals with ABI across the section 32 cohort is 35.3 years, whilst the average age across the section 32 cohort of individuals without ABI is 35.6 years.

The study group where there is the greatest difference in the average age based on the presence of an ABI is in those with a single diagnosis of ID, where on average individuals with ABI are 9 years younger than those without ABI.

It is interesting to note that the average age is lower for individuals with ABI with a single diagnosis cognitive disability than their counterparts without ABI, but the average age is higher for individuals with complex diagnoses of mental health disorder and cognitive disability.

Figure 12 shows the gender breakdown of individuals with ABI in the section 32 cohort by diagnostic study group.

Figure 12: ABI and Gender Across Study Groups

	Female	Male	Female	Male	Male	Female	Male	Female	Male
	MH_ID		MH_BID		ID	BID		MH	
No ABI	8	23	2	22	8	1	14	3	12
ABI	2	18	1	14	11		5		5
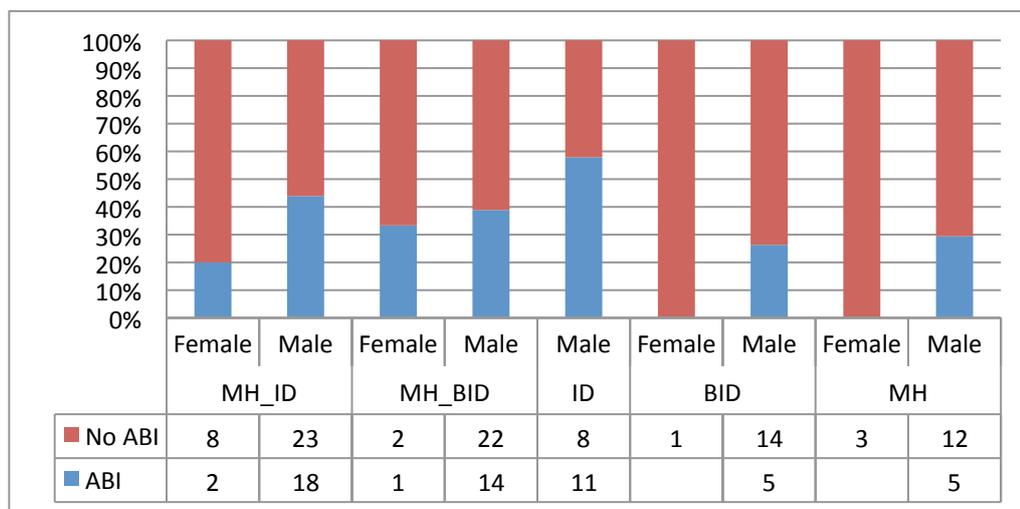
Overall, Figure 12 shows that males are numerically 95% (53), more likely to have ABI than females 5% (3). This is most likely due to the underrepresentation of females in the section 32 cohort more generally. As a proportion of each gender in the section 32 cohort, 40% (53) of males have ABI and 18% (3) of females have ABI. The lower proportion of females with ABI is contrary to statements made elsewhere suggesting a higher incidence of ABI in females (and specifically substance use or domestic violence related ABI), however the very limited sample may be responsible for this finding.[21] The lower proportions in the section 32 cohort might be in part due to the factors discussed above in Part 2.1.2 concerning the gendered nature of diagnosis and perhaps

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[21] See, eg, ibid 19; Nick Rushworth, 'Out of Sight, Out of Mind: People with an Acquired Brain Injury and the Criminal Justice System' (Brain Injury Australia, 2011) 8, 10.

also because of the nature of the ABI data collection in the MHDCD Project (eg data collection did not extend to substance use related ABI).

It is interesting to note that given that in the MHDCD cohort 15% of females have ABI,[22] there is a slightly larger proportion of females with ABI in the section 32 cohort as opposed to that in the general MHDCD cohort (although the figures of females in the section 32 cohort and those with ABI are so small as to not be representative or statistically significant). All of the three females with ABI in the section 32 cohort are in the two complex diagnoses study groups, thus confirming observations made earlier in Part 2.1.2 of this report concerning the complexity of female diagnoses.

There is a considerably higher proportion of males in the section 32 cohort with ABI, constituting 40% (53) of all males in the section 32 cohort, than there are males with ABI in the general MHDCD cohort, constituting 21% (433) of all diagnosed males.

Over one third of all males with complex diagnoses of either MH_ID or MH_BID – 42% (32) – also have ABI, thus showing that for many males in the section 32 cohort ABI is a further aspect of already 'complex' diagnoses.

An interesting finding shown in Figure 12 is that 58% (32), or over half, of the males in the section 32 cohort with 'single' diagnosis of ID also have ABI. This proportion does not similarly hold for the single diagnosis BID where only 26% (14) of males have ABI. It might be that this differential between the two single diagnosis cognitive disability study groups is in part because of the nature of the data collection: the single diagnosis BID group might not have been subject to the same level of assessment and diagnosis vis-à-vis the SDS database, as those with a single diagnosis of ID.

Figure 13 shows the breakdown of individuals with ABI in the section 32 cohort who are Indigenous Australian.

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[22] Dowse et al, above n 3, 15.

	MH_ID		MH_BID		ID		BID		MH	
	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI
No ABI	7	24	10	14	1	7	4	11		15
ABI	9	11	4	11	3	8	2	3	2	3

Overall, Figure 13 shows that a higher proportion of Indigenous Australians in the section 32 cohort have ABI relative to non-Indigenous Australians. Across the five study groups, 48% (20) of all Indigenous Australians have ABI, whereas 34% (36) of all non-Indigenous Australians have ABI.

When looking at the breakdown of ABI and Indigenous Australians across the study groups, there is a relatively consistent incidence of ABI between the groups that have cognitive disability as a part of, or as their full, diagnostic profile where 45% (18) have ABI, and groups that have mental health disorder as a part of their full diagnostic profile where 47% (15) have ABI. Yet, when these proportions are compared to the proportions of ABI in relation to non-Indigenous Australians, it becomes apparent that a larger proportion of Indigenous Australians in the section 32 cohort have ABI in combination with either cognitive disability or mental health disorder or both. This is evidenced by the 39% (35) of non-Indigenous Australians in the groups that have cognitive disability as a part of or their full diagnostic profile and 32% (25) of non-Indigenous Australians in the groups that have mental health disorder as a part of their full diagnostic profile.

Figure 13 also shows that Indigenous Australians have disproportionately high rates of ABI. Just over one third, or 36% (20), of individuals with ABI in the section 32 cohort are Indigenous Australians compared with the lower proportion of 23% (21) individuals in the section 32 cohort who are Indigenous Australians without ABI as a proportion of all individuals without ABI.

The proportion of Indigenous Australians with ABI in the section 32 cohort is slightly higher than the proportion of individuals with ABI in the larger MHDCD cohort where 30% are Indigenous Australians. As Indigenous Australians comprise 28% of the section 32 cohort, they are slightly overrepresented in the sub-group of individuals with ABI. As per comments made above in Part 2.1.3 in relation to the representation of Indigenous Australians in the section 32 cohort generally, this overrepresentation of Indigenous Australians with ABI in the section 32 cohort compared with Indigenous Australians with ABI in the MHDCD cohort is an interesting finding in light of the generally greater disadvantage and incarceration rates of Indigenous people, and might invite further research.

While gender is not shown, within the section 32 cohort there is only one Indigenous female who have ABI and she has diagnoses of MH_ID. It could be expected that with issues around substance use and domestic violence that there might be more Indigenous females with ABI in the section 32 cohort.[23]

2.2 CRIMINAL JUSTICE CONTACT

The following section reports on the patterns of contact that those individuals in the section 32 cohort have with criminal justice agencies. It includes contact with police (as a person of interest, as a victim and under civil mental health legislation) and contact with juvenile justice and adult corrections. It also reports on the types of convicted offences for members of the section 32 cohort.

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[23] Note in particular research cited by Rushworth: Rushworth, above n 21, 10.

2.2.1 CJS History

This section provides a general overview, across the lifecourse, of contact with police, which is followed in Sections 2.2.2 and 2.2.3 with discussion of contact with CJS agencies as a young person and as an adult.

Figure 14 shows the average age of first police contact (FPC) for individuals in the cohort, together with the average age at their first adult custody episode.

Figure 14: Average Age of First Police Contact (FPC) and Average Age of First DCS Custody across Study Groups

	MH_ID	MH_BID	ID	BID	MH
Average of Age at FPC	15.78	15.95	18.79	16.60	19.00
Average of First DCS Custody	23.04	23.67	26.31	22.92	27.63
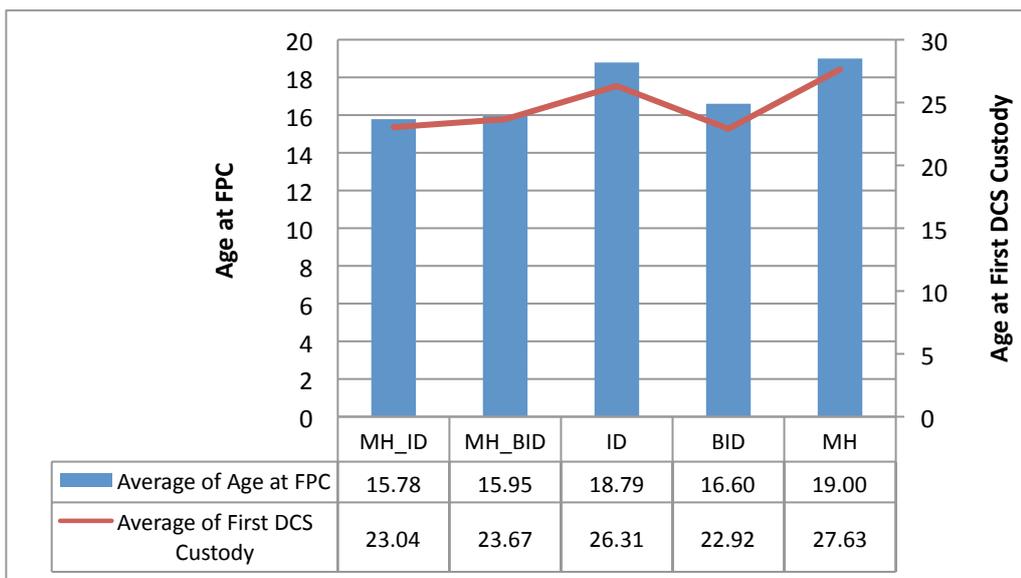
It should be noted that the averages in Figure 14 are quite high. Therefore, the two tables below (Table 1 and Table 2) list the different diagnostic study groups and their corresponding age range together with the standard deviations.

Table 1: Age of First Police Contact

Study Group	Mean	Median	Standard Deviation	Minimum	Maximum
BID	16.60	15.50	5.175	10	30
ID	18.79	17.00	6.754	12	34
MH	19	17.50	6.545	11	40
MH_BID	15.95	14	5.577	9	39
MH_ID	15.78	15	4.115	9	25

Table 2: Age of First DCS Custody

Study Group	Mean	Median	Standard Deviation	Minimum	Maximum
BID	26.19	26.30	6.178	18	38
ID	24.29	23.66	5.455	18	38
MH	20.96	18.91	3.335	18	30
MH_BID	23.72	22.47	6.059	18	39
MH_ID	25.08	21.81	8.069	17	52

These two tables show that there is a considerable spread across the individuals in relation to the ages of first police contact and DCS custody. The tables show that there are individuals in a number of the study groups who are considerably older at their first police contact and first DCS custody. For example the maximum age of first police contact for individuals with a single diagnosis of MH is 40 years old and with diagnoses of MH_BID is 39 years old, and the maximum age of first DCS custody of individuals with MH_BID is 39 years old. At the other end of the spectrum, the tables also show that the minimum ages of first police contact are 12 years and under across all of the study groups and that the minimum age across all of the study groups for age of

first DCS custody is 18 and under. This shows that there is some skewing of the averaged results in Figure 14 which makes the averages ages of first contact appear older than they are. Whilst this limits the inferences that can be drawn from the analysis of age at first contact shown in Figure 14, it does suggest the possible value of greater research into the significance of the dynamic of age in the CJS pathways of people diagnosed with mental health disorder and cognitive disability who are the subject of section 32 orders, notably whether there are any key differences that generally characterise younger and older CJS entry and how these differences might be related to or impact on the use of section 32 orders (a point which is discussed further in Part 2.5, Figure 46 below).

Table 1 also serves to indicate that there is a significantly low minimum age for first police contact and for first DCS custody. The discussion in Part 2.2.2 of DJJ history gives further nuance and detail to these findings around childhood contact with the CJS.

Overall, Figure 14 shows that across the section 32 cohort, the average age at first police contact ('FPC') is 17.2 years, and the average age of first DCS custody (ie adult custody) is 24.7 years.

In relation to the study groups, Figure 14 shows that the MH_ID and the MH_BID study groups have the youngest ages of FPC: the average age for individuals with diagnoses of MH_ID is 15.8 years, whereas the average age for individuals with diagnoses of MH_BID is 16 years. In relation to the average age of first DCS custody, individuals with single diagnosis of BID have the younger average age of 22.9 years, but this is closely followed by the two complex diagnoses study groups with average ages of 23 years for MH_ID and 23.7 years for MH_BID. Single diagnosis ID and single diagnosis MH have consistently older average ages of FPC and first DCS custody. This suggests that complex diagnoses are associated with earlier and hence longer term involvement in the CJS.

Figure 15 shows the average age of FPC and of DCS custody by gender and across the study groups. Taking into account the limitations in the age data as per Figure 14 above, some findings

can be drawn by comparing the average ages between the genders. Overall, Figure 15 shows an older average age of first police contact for females across the section 32 cohort (22.7 years), compared to males (16.7 years).

Figure 15: Average Age of First Police Contact (FPC) and Average Age of First DCS Custody by Gender and Across Study Groups

	Female	Male	Female	Male	Male	Female	Male	Female	Male
	MH_ID		MH_BID		ID	BID		MH	
Average of Age at FPC	16.60	15.59	20.00	15.61	18.79	27.00	16.05	27.33	17.53
Average of First DCS Custody	23.08	23.03	27.10	23.39	26.31	27.61	22.67	31.48	26.95
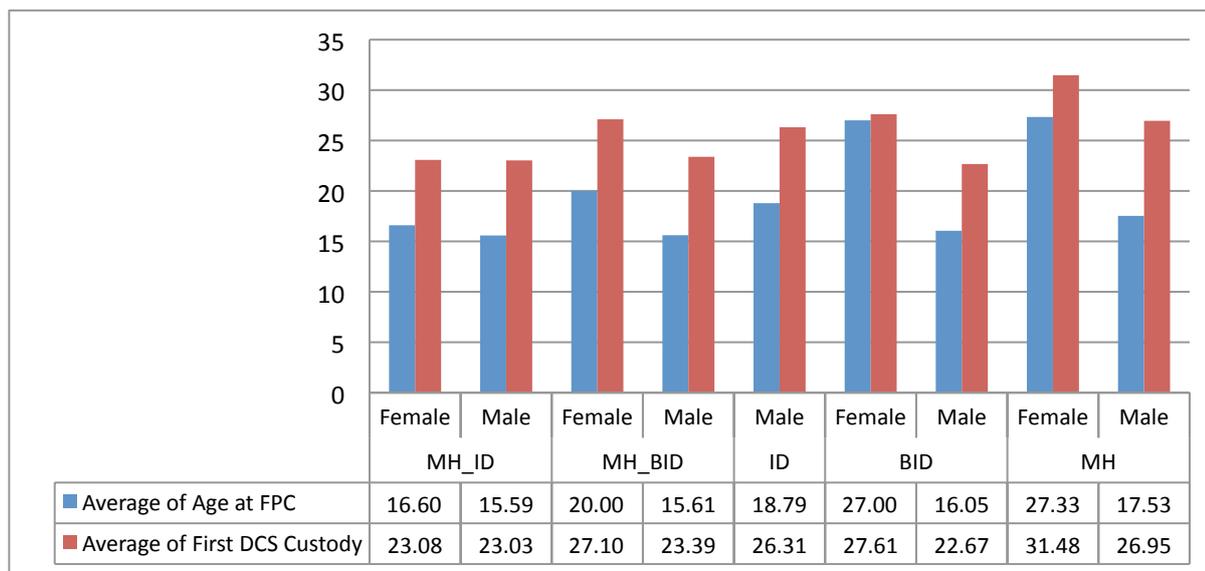
Interestingly, analysis at the level of the study groups shows that in relation to average age of FPC the gender difference in average age is most pronounced in relation to the single diagnosis study groups, with closer average ages in the complex diagnoses study groups, perhaps suggesting that complexity of diagnoses dominates as a dynamic of first police contact and first custodial episode to a greater extent than gender. For example, the difference in the average age of FPC in relation to the MH_BID study group is 4.4 years older on average for females than males, but in the single diagnosis BID study group the difference is 11 years on average older for females. There is a similar pattern between the genders in relation to the average of first DCS custody, but the difference is not as great.

The lowest average ages for FPC for females and for males are in the two complex diagnoses study groups, which shows the significance of complex diagnoses in relation to early (and long term) CJS

involvement. However due to the small number of females in the study cohort, these results cannot be said to be representative.

Figure 16 shows the average age of first police custody and the average age of first DCS custody in relation to Indigenous Australians and across the study groups.

		MH_ID		MH_BID		ID		BID		MH	
		ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI
■	Average of Age FPC	15.38	15.97	12.71	17.76	17.25	19.20	17.17	16.36	12.00	19.78
■	Average of First DCS Custody	22.46	22.50	19.74	25.59	21.40	26.69	20.63	22.40	18.34	28.22
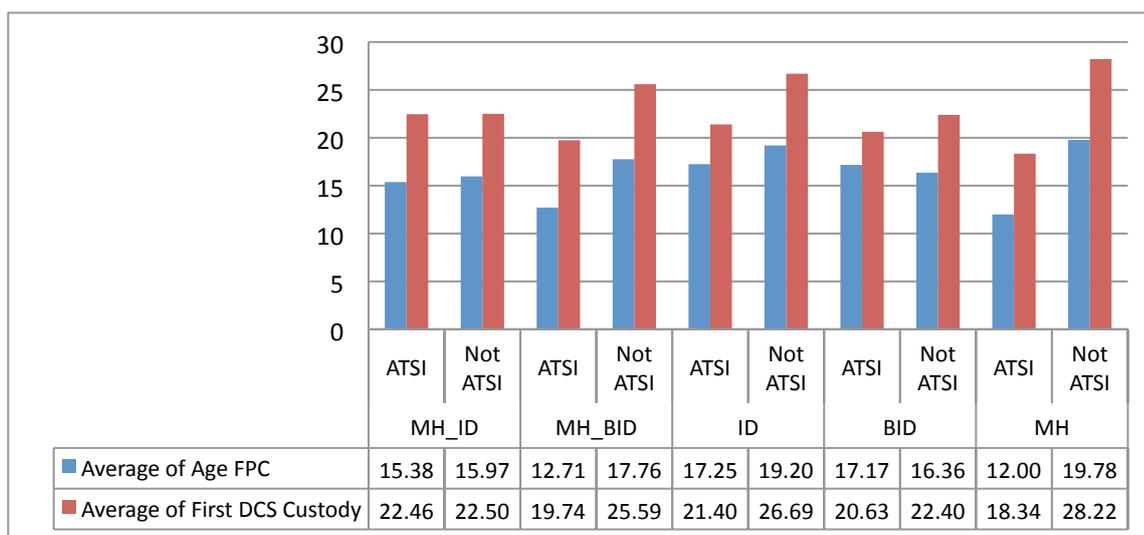
Overall, Figure 16 shows that the Indigenous Australians in the section 32 cohort have a lower age of first police contact and of first DCS custody. Across the study groups, the average age of first police contact for Indigenous Australians is 14.9 years, which can be compared to the average age of 17.4 years for individuals who are not Indigenous. Similarly, the average age of first DCS custody for Indigenous Australians is 21.8 years, which can be compared to the higher average age for non-Indigenous Australians of 25.3 years.

In relation to Indigenous Australians with cognitive disability in their diagnostic profile (whether alone or in combination with a diagnosis of mental health disorder), again there is a lower average age of both first police contact and first DCS custody for Indigenous Australians as compared to non-Indigenous Australians. The average age of first police contact for Indigenous Australians diagnosed with cognitive disability in their diagnostic profile is 15.6 years, compared to the average

age of 17.2 years for non-Indigenous Australians. The average age of first DCS custody for Indigenous Australians diagnosed with cognitive disability is 21.9 years and for non-Indigenous Australians the average age is 24.8 years. Thus, here Indigenous Australians diagnosed with cognitive disability are on average younger than their non-Indigenous Australian counterparts when they first enter the CJS (although, this needs to be qualified by noting that there are two occasions in the study groups where Indigenous Australians are on average older than their non-Indigenous counterparts – first DCS custody of individuals diagnosed with MH_ID and FPC of individuals diagnosed with BID). It is important to note here that whilst there is a considerable differential in the average age of first DCS custody for the MH study group, this must be tempered by the fact that there are only two Indigenous Australian individuals in this study group.

Figure 17 details the average person of interest (POI) contacts together with the average victim contacts across the study groups. It is important to note that this figure details data on victim *contacts with police*, as opposed to actual victimisation per se (and thus it might be that actual victimisation is higher than the number of incidences of police contact depicted here).

Figure 17: Average Person of Interest (POI) Contacts and Average Victim Contacts Across Study Groups

	MH_ID	MH_BID	ID	BID	MH
Average of POIContacts	152.00	95.90	75.89	93.85	68.75
Average of VictimContacts	19.86	12.41	16.68	16.00	8.70
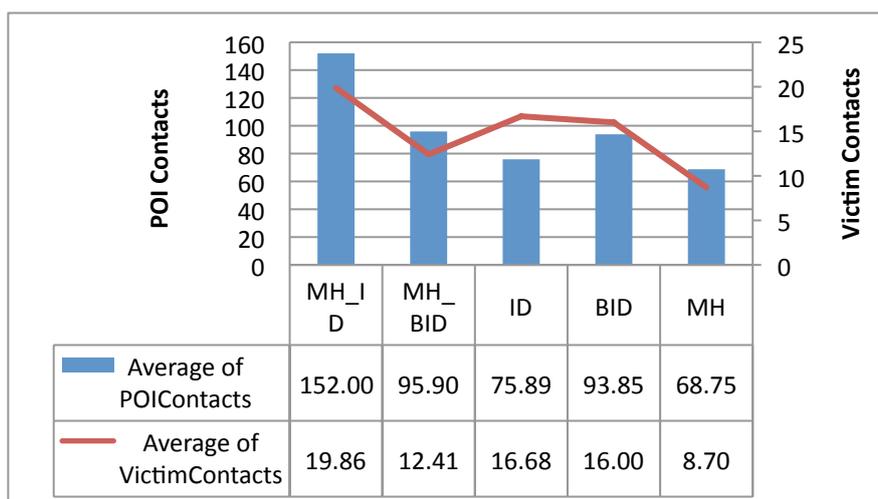
Figure 17 shows that the average POI contacts for individuals in the section 32 cohort is 97 and the average victim contacts for individuals in the section 32 cohort is 15. This clearly shows that individuals in the section 32 cohort are not only having contact with police in relation to the charges that their section 32 order relates, but are having multiple contacts with police as a person of interest, thus showing long term and ongoing criminalisation. That these individuals are also having contact with police as victims shows that an absolute division between victim and offender does not hold for this group of individuals and that over time they are not only criminalised but also victimised. This suggests multiple levels of vulnerability and the importance of a longitudinal approach to appreciating pathways through the CJS (because such an approach enables exploration of the complex dynamics of and between criminalisation and victimisation).

Figure 17 suggests that on average for many individuals in the section 32 cohort cognitive disability is associated with higher criminalisation and victimisation. Individuals with diagnoses of MH_ID have the highest average victim and POI police contacts. The average POI contacts for all individuals in the section 32 cohort with cognitive disability in their diagnostic profile (whether as a single diagnosis or in combination with a diagnosis of MH) is 104 and their average victim contacts is 16, and for individuals with single diagnosis of ID or BID the average POI contacts is 85 and the average victim contacts is 16. This can be compared to individuals with single diagnosis MH: the average POI contacts for this group is 69 and the average victim contacts is 9. This suggests the greater significance of victimisation to people diagnosed with cognitive disability in the CJS compared to those with a single diagnosis of MH.

Figure 18 below highlights the proportion of POI to victim contacts. It shows that of their victim and POI contacts with police, on average individuals in the section 32 cohort have a high proportion of POI contacts of 87%, thus showing that whilst these individuals do have contact with police as victims they are overwhelmingly having contact with police as offenders.

	MH_ID	MH_BID	ID	BID	MH
■ Average of Victim Contacts	19.86	12.41	16.68	16.00	8.70
■ Average of POI Contacts	152.00	95.90	75.89	93.85	68.75

As a proportion of both POI and victim contacts for each study group, on average individuals in the single diagnosis cognitive disability study groups have the highest proportion of victim contacts. The ID study group has experienced the greatest proportion of victim contacts with 18% (17), followed by the BID study group with 15% (16). It is interesting that out of all study groups it is these single diagnosis groups that on average have experienced the highest *proportion* of their police contacts as victims, given that it is the complex diagnoses study group of MH_ID that has the highest *number* on average of victim contacts. The significance of victimisation to the overall criminal justice contacts of people with a single diagnosis of ID or BID is an interesting finding that will benefit from further nuanced research to draw out how disability diagnoses might figure in this phenomenon.

Moreover, whilst it was observed in relation to Figure 17 above that individuals with a single diagnosis of MH have the lowest average number of POI contacts and victim contacts, the proportion of victim and POI contacts for this study group is very similar to the complex diagnoses study groups all with a proportion of victim contacts of 11-12%.

Figure 19 details the average POI contacts and average victim contacts by gender and across the study groups.

	Female	Male	Female	Male	Male	Female	Male	Female	Male
	MH_ID		MH_BID		ID	BID		MH	
Average of POIContacts	115.50	160.90	106.67	95.00	75.89	5.00	98.53	66.67	69.12
Average of VictimContacts	32.30	16.83	20.67	11.72	16.68	0.00	16.84	26.33	5.59
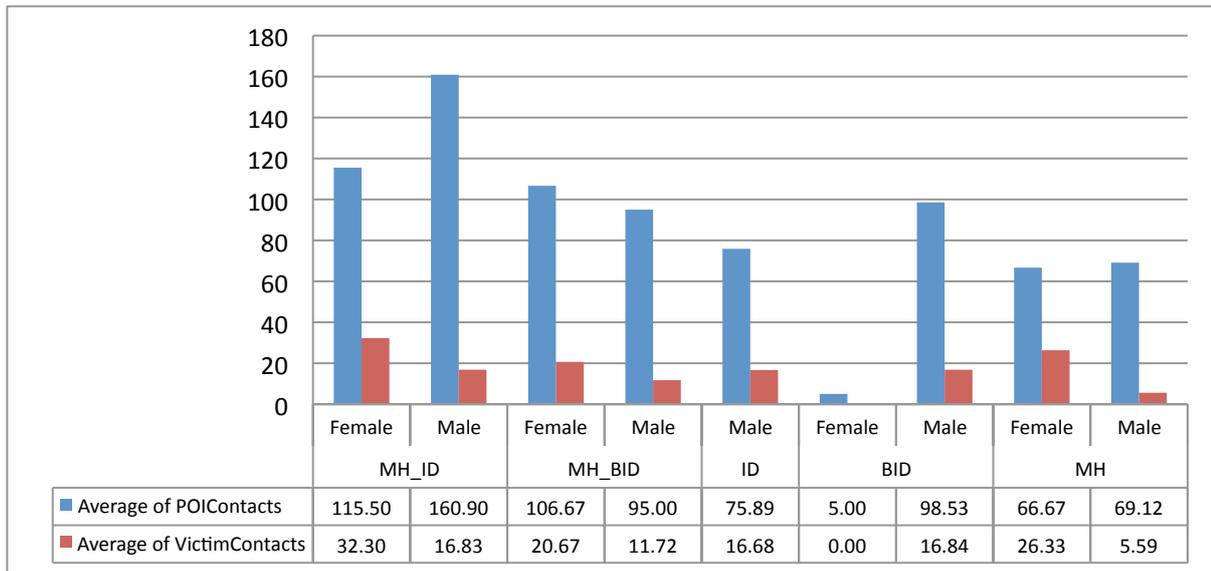
Overall, Figure 19 shows that females generally have much higher average numbers of victim contacts with police comparative to males. This holds for every study group where females are present, with the exception of the single diagnosis BID study group where there is only one female. Across the section 32 cohort, females have on average 26 victim contacts, whereas males have 14 victim contacts (just under 50% less than females). This suggests that there is a gendered dynamic to the victimisation of individuals in the section 32 cohort with females in the section 32 cohort being more vulnerable to victimisation than males (and/or more likely to be *recognised by police* as presenting with complaints of victimisation). Females with complex diagnoses have the highest average number of victim contacts, thus suggesting an association between complex diagnoses and victimisation. The most significant disparity in relation to victim contacts between the genders is in the single diagnosis MH study group where females have on average 21 more victim contacts than males (even though both females and males in this study group have on average relatively equal numbers of POI contacts).

Figure 19 also shows that males, particularly males with a diagnosis of cognitive disability (ie ID, BID, MH_ID, MH_BID), still have high averages of victim contacts with police – even if these are lower on average than for females. Males with a single diagnosis of MH have a considerably lower average number of victim contacts when compared to all other study groups, thus suggesting that males in this group are not as vulnerable to victimisation as males in other study groups.

Females in the two complex diagnoses groups have the highest average numbers of POI contacts of any of the figures for women in the study groups, suggesting that these women have higher levels of criminalisation than women with single diagnosis of mental health disorder. When this finding is taken in conjunction with the finding above concerning the high average numbers of victim contacts for women with complex diagnoses, it becomes evident that for females their pathways through the criminal justice system are generally characterised by criminalisation *and* victimisation. This pattern is not as consistent for males, which suggests that this has a gendered dynamic.

For males, there is not as clear a comparison between individuals with single and complex cognitive disability diagnoses and instead the data suggests that there is an association between cognitive disability (whether single diagnosis or complex diagnoses) and victimisation and criminalisation (as compared to single diagnosis MH) and that this is particularly apparent on average for individuals with diagnosed with MH_ID. Again, for males with single diagnosis of MH, there is a significantly lower number of victim contacts when compared with either female counterparts or with other diagnoses.

Figure 20 below details the average POI contacts and average victim contacts by Indigenous Australians and across the study groups. The figure shows that, overall, Indigenous Australians have lower average numbers of victim contacts when compared to their non-Indigenous counterparts: Indigenous Australians have on average 10 victim contacts, whereas non-Indigenous Australians have on average 17 victim contacts. This differential is most pronounced in the BID study group, and least pronounced in the MH single diagnosis study group. Noting that Figure 20

details *police contact* as a victim, as opposed to actual victimisation per se, certainly it would be interesting to look further into this finding to see whether the over criminalisation but under protection of Indigenous persons (particularly Indigenous women) is one dynamic operating here to give such huge differentials between Indigenous and non-Indigenous people. Indigenous people might also be much less likely to report to Police when they are victims of crime.

Figure 20: Average POI contacts and Average Victim Contacts by Indigenous Australians and Across Study Groups

	MH_ID		MH_BID		ID		BID		MH	
	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI
Average of POI Contacts	112.00	170.29	119.21	82.84	75.75	75.93	84.00	98.07	95.00	65.83
Average of Victim Contacts	15.00	22.09	8.57	14.56	11.25	18.13	6.50	20.07	7.50	8.83
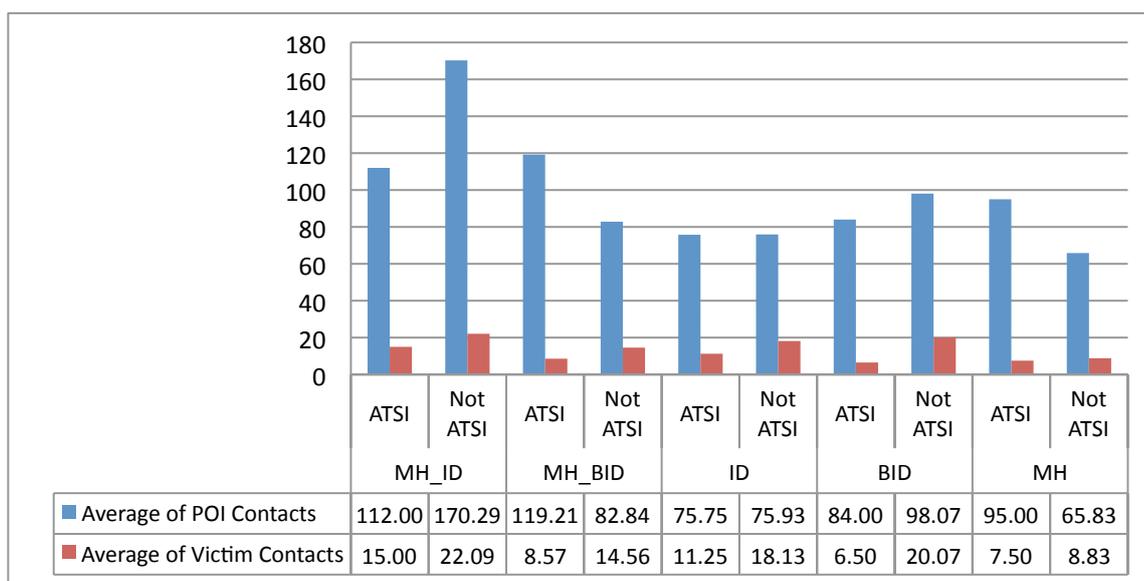
On average, Indigenous Australians in the section 32 cohort have slightly less POI contacts than non-Indigenous individuals in the cohort: Indigenous Australians have on average 97, whereas non-Indigenous Australians on average have 102. This is an interesting finding given the common assumption that Indigenous Australians have been over policed and over criminalised in a discriminate manner when compared with non-Indigenous Australians, and certainly it invites further consideration. This finding is given greater complexity when one looks at average POI contacts at the level of the five study groups: Indigenous Australians have lower POI contacts than non-Indigenous Australians when they have diagnoses of MH_ID, ID or BID, but on average have higher POI contacts than non-Indigenous Australians when they have diagnoses of MH_BID or MH. Again due to the small numbers in the sample these findings may not be extrapolated to the

wider population of Indigenous Australians in the CJS with diagnoses of cognitive disability and mental health disorder.

Figure 21 shows the number of individuals in the study groups in relation to whom the police have used the civil mental health legislation, ie the NSW *Mental Health Act*. Having an event dealt with in this way requires police to transport the individual to the nearest declared mental health facility or to an agreed hospital under local protocol agreements. Apprehension under these circumstances indicates that police believe the person is experiencing a mental health issue at the time of contact. This contact does not necessarily mean that the individual will subsequently receive a mental health related diagnosis, rather it means that the police believe their behaviour is due to such impairment.

Figure 21: Number in Study Groups to have had Police use the Mental Health Act

	MH_ID	MH_BID	ID	BID	MH
Mental Health Act	43	25	11	15	10
No Mental Health Act	8	14	8	5	10
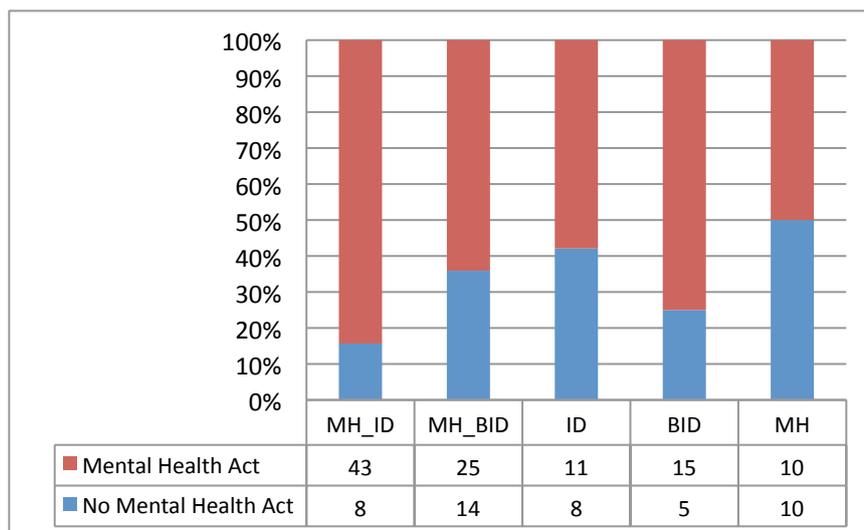
Figure 21 shows that, overall, 70% (104) of the section 32 cohort have had the civil mental health legislation used by the police. This in itself shows that individuals are coming into contact with police in relation to their (actual or perceived) mental health disorder, and hence this is a further dynamic of their criminalisation which is particular to them having disability.

An extremely interesting finding to emerge from Figure 21 is that high numbers of individuals diagnosed with cognitive disability have had the police use the mental health legislation. The

proportion of individuals who have had the civil mental health legislation used by police is relatively consistent between individuals with any mental health disorder (whether alone or in combination with a cognitive disability diagnosis) of 71% (78) and individuals with any diagnosis of cognitive disability (whether alone or in combination with a cognitive disability diagnosis) of 73% (94). These proportions show that mental health diagnosis alone is not the distinguishing factor for civil mental health legislation use by police since this high proportion of individuals who have not had a mental health related diagnosis are being detained by Police under the MHA. In fact, Figure 21 shows that high proportions of individuals in the section 32 cohort with *single* diagnosis ID or BID (ie with *no* diagnosis of mental health disorder) have had mental health legislation used by the police: 64% (26) overall or 58% (11) of individuals with single diagnosis ID and 75% (15) of individuals with BID.

A further interesting finding is that there is a higher proportion of individuals with complex diagnoses of MH_ID or MH_BID that have had the civil mental health legislation used by police, when compared with the proportion of individuals with single diagnosis MH: 76% (68) of all individuals with complex diagnoses, 84% (43) of all individuals with diagnoses of MH_ID, 64% (25) of all individuals with diagnoses of MH_BID, compared to 50% with single diagnosis MH.

Certainly these findings in relation to cognitive disability and police use of civil mental health legislation invite further consideration of how and why the civil mental health legislation is being used by police vis-à-vis individuals with a single of cognitive disability and individuals with complex diagnoses.[24] This could look at the response of public health services to police use of the legislation, the extent to which these individuals are diagnosed and admitted into mental health facilities, and how the use of this legislation by police factors as a dynamic in criminalisation (particularly to reduce or increase the incidence of charge and police/DCS custody). These findings

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[24] See also discussion by New South Wales Law Reform Commission on this issue: New South Wales Law Reform Commission, above n , 209-218 [8.6]-[8.38].

also invite consideration of why police are using this legislation in relation to individuals with no diagnosis of mental health disorder – it could be due to anomalies in the diagnostic categorisation of the cohort or misrecognition by Police of cognitive disability as mental health disorder in that an individual apprehended under the MHA may not actually be diagnosed with a mental health disorder. It could also be that this legislation is the only civil framework for coercion available to police to use on an immediate and ad hoc basis (cf guardianship legislation[25] which vests coercion in a specific individual/public body after a formal application and tribunal hearing). Further research can explore whether civil mental health legislation might be used by police against individuals diagnosed with cognitive disability in order to avoid charging or otherwise dealing with these individuals through the CJS by shifting the responsibility for these individuals to the mental health service system, particularly in a context of the absence both of any lawful basis for the police to coerce and detain these individuals (otherwise than through charge) and of any related crisis response capacity within the health and human service system vis-a-vis people diagnosed with cognitive disability.

All of the preliminary considerations in this section hint at the (perhaps under-recognised) significance of civil mental health legislation and the roles and powers of police in this legislation to the criminalisation of people in the section 32 cohort, particularly those diagnosed with cognitive disability.

2.2.2 DJJ History

This section details the history of the section 32 cohort's contact with the Department of Juvenile Justice, including DJJ custody.

Figure 22 shows the individuals in the section 32 cohort who have been DJJ clients. It distinguishes between two mutually exclusive groups: those who experienced DJJ custody ('DJJ Client – DJJ

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[25] *Guardianship Act 1987* (NSW).

Custody') and those were 'DJJ Client – Only' (ie who were never in DJJ custody but still have involvement with DJJ such as through community supervision).

Figure 22: DJJ Client Status and DJJ Custody Across the Study Groups

	MH_ID	MH_BID	ID	BID	MH
■ DJJ Client - Only	6	2	2	2	1
■ DJJ Client - DJJ Custody	13	14	4	7	2
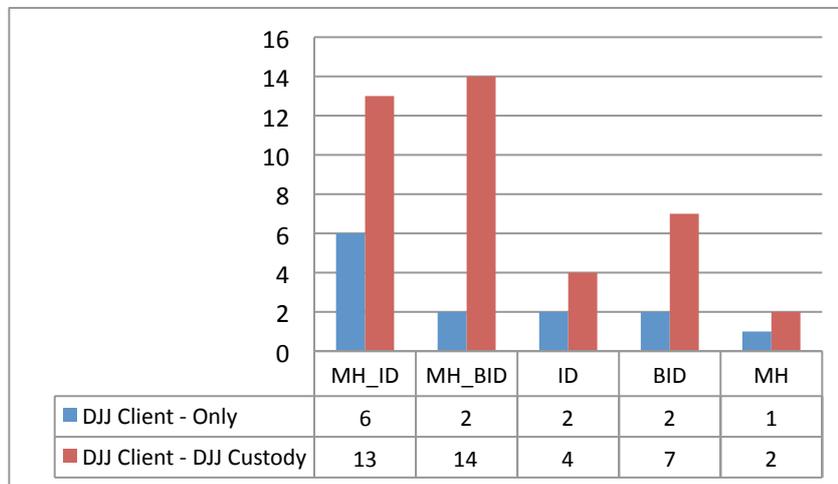
Figure 22 shows that just over a third of the section 32 cohort have been clients of DJJ. Overall, 36% (53) of individuals in the section 32 cohort were clients of DJJ, and that 9% (13) of the section 32 cohort were clients of DJJ but not in DJJ custody and 27% (40) of the section 32 cohort were in DJJ custody. Thus, a significant proportion of the section 32 cohort have been clients of DJJ and have been in DJJ custody, and hence have had involvement with the CJS, and might have also been incarcerated as a young person. This shows early and long term incarceration for many of the individuals in the section 32 cohort.

Significantly, a higher proportion of individuals in the section 32 cohort with a diagnosis of cognitive disability (whether alone or in combination with a diagnosis of mental health disorder) have been in contact with criminal justice institutions and even incarcerated from an early age compared to those with a single diagnosis of MH. Of all individuals in the section 32 cohort with a diagnosis of cognitive disability (whether alone or in combination with a diagnosis of mental health disorder), 39% (50) have been clients of DJJ, and of these 68% have been incarcerated in DJJ custody. Of all individuals in the section 32 cohort with complex diagnoses, 39% (35) have been

clients of DJJ and 77% of these have been in DJJ custody. Of all individuals with a single diagnosis 31% (18) have been clients of DJJ and 50% (9) of these have been in DJJ Custody. This can be compared to the 15% (3) of individuals in the section 32 cohort with a single diagnosis of MH who have been clients of DJJ.

Figure 22 also shows that while the two complex diagnoses study groups have the highest numbers of individuals, those in the MH_BID study group have the highest frequency of DJJ custody as a proportion of all those in the cohort who have been in DJJ custody, (35% n=14), closely followed by the complex diagnoses MH_ID study group with 33% (13). Yet, as a proportion of all individuals in each study group, the two groups in which borderline intellectual disability is present in the diagnostic profile (MH_BID and BID) have the highest proportion of individuals as DJJ clients and in DJJ custody as a proportion of all individuals in each study group: 36% (DJJ custody) and 41% (DJJ clients of any nature) of all individuals in the complex diagnoses MH_BID study group and 35% (DJJ custody) and 45% (DJJ clients of any nature) of all individuals in the single diagnosis BID study group. This highlights a trend that is evident in the MHDCD cohort more generally where individuals in the MHDCD cohort with complex diagnoses of MH_BID come into contact with the CJS earlier than individuals in other study groups.[26] Yet it is interesting to note that the rates of contact with DJJ across the section 32 cohort were lower than the rates across the larger MHDCD cohort,[27] perhaps suggesting that individuals with fewer convictions and shorter offending histories invite a section 32 order more easily than those who are more entrenched in the CJS.

Figure 23 shows DJJ client status and DJJ custody by ATSI and gender across the section 32 cohort. It shows that for the section 32 cohort, DJJ involvement is a considerably gendered phenomenon. This is because 18% (3) of all females in the section 32 cohort and 36% (48) of all

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[26] Baldry, Dowse and Clarence, *Outlaws to Inclusion*, above n 3, 13.

[27] Baldry, Dowse and Clarence, *Outlaws to Inclusion*, above n 3,12.

males in the section 32 cohort have been clients of DJJ. These figures are also reflective of the lower rates of female as compared to male juvenile incarceration generally.

Figure 23: DJJ Client Status and DJJ Custody by ATSI and Gender Across the Cohort

	Female	Male	Female	Male	Male	Male	Male
	MH_ID	MH_ID	MH_BID	MH_BID	ID	BID	MH
ATSI - DJJ Client - Only		3			1		
ATSI - DJJ Client - DJJ Custody	1	5	1	8	2	2	1
Not ATSI - DJJ Client - Only	1	2		2	1	2	1
Not ATSI - DJJ Client - DJJ Custody		7		5	2	5	1
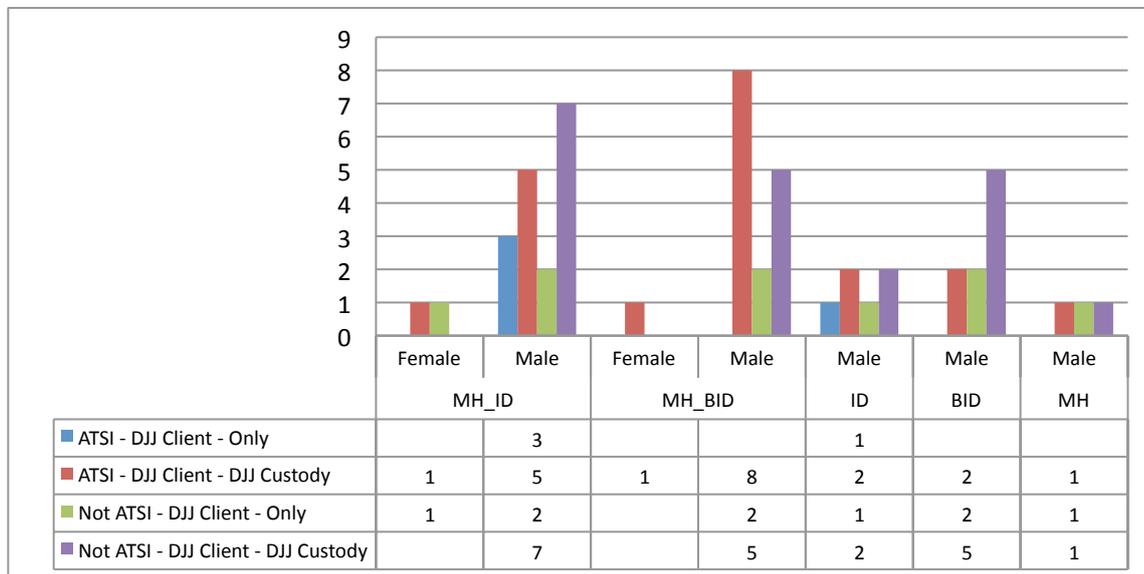
Interestingly, when compared with the findings in the larger MHDCD cohort, there is a smaller proportion of females in the section 32 cohort who have been clients of DJJ when compared to the 24% of females in the MHDCD cohort who have been DJJ clients. On the other hand, there is a slightly higher proportion of males in the section 32 cohort who have been DJJ clients compared to the proportion of 31% of males in the MHDCD cohort who have been DJJ clients.

Figure 23 also shows that a higher proportion of all Indigenous individuals in the section 32 cohort have been clients of DJJ. Whilst the figures of DJJ clients along Indigenous lines are relatively consistent, when analysed as a proportion of the total number of Indigenous and non-Indigenous individuals in the cohort, there is a much higher proportion of Indigenous individuals in the cohort who have been DJJ clients. Of all of the Indigenous Australians in the section 32 cohort 57% (24) have been clients of DJJ and 25% (27) of non-Indigenous Australians have been DJJ clients. Moreover, whilst Indigenous Australians constitute 28% of the section 32 cohort, they constitute 47% of all individuals in the section 32 cohort who have been clients of DJJ.

Figure 23 also shows striking differentials specifically in relation to DJJ custody. Indigenous Australians constitute 53% of all individuals in the section 32 cohort who have been in DJJ custody. As a proportion of all Indigenous Australians who have been clients of DJJ, 83% have been in DJJ custody (as opposed to DJJ – Client Only) which can be compared to 66% of non-Indigenous Australians who have been in DJJ Custody. These findings show the significance of juvenile incarceration of Indigenous Australians in the section 32 cohort.[28]

Whilst the numbers are extremely small, it is interesting to note that two of the three females in the section 32 cohort who have been DJJ clients are also Indigenous (and have complex diagnoses), and that both of these Indigenous females have been in DJJ custody (these being the only two females in the section 32 cohort who have been in DJJ custody). Whilst the numbers are too small to be representative, these findings confirm comments made earlier in Part 2.1.3 concerning the complexity of diagnosis and social marginalisation for Indigenous females with mental health disorder and cognitive disability in the CJS.

2.2.3   DCS Custodial Episodes

This section discusses the DCS custodial episodes of the section 32 cohort.

Figure 24 shows the average of custody episodes and average of custody days across the study groups. Overall, individuals in the section 32 cohort have on average a number of custody episodes across their life course. When this finding is taken in conjunction with the average number of custody days, it is likely that these individuals cycle in and out of prison on short prison stays. Across the section 32 cohort the average number of custody episodes is 11, and the average number of custody days is 959 days.

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[28] See also Tom Calma, 'Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues' (Australian Human Rights Commission, 2008).

	MH_ID	MH_BID	ID	BID	MH
Average of CustodyEps	15.92	12.36	7.89	10.60	8.00
Average of CustodyDays	1135.96	1240.74	783.26	783.00	850.20
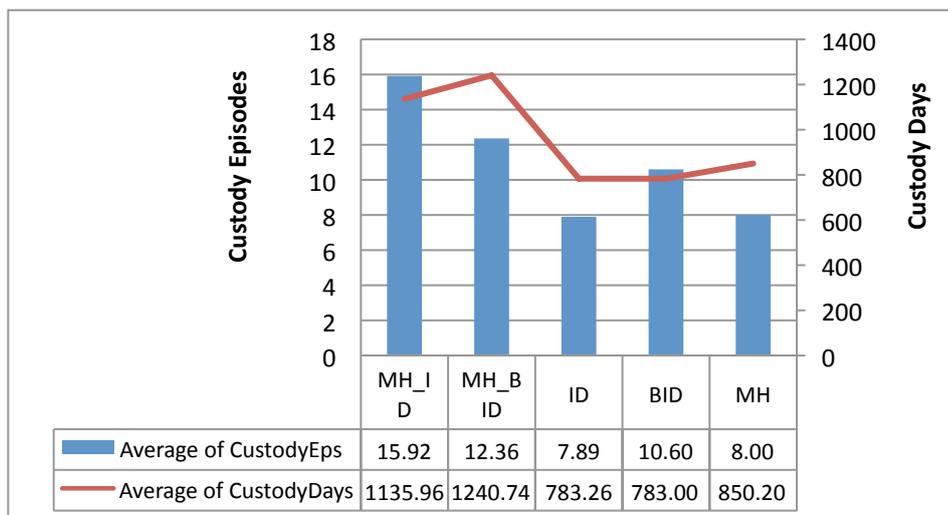
Individuals in the complex diagnoses study groups (MH_ID, MH_BID) have higher average numbers of custody episodes and custody days than individuals with single diagnosis. Across the two complex diagnoses study groups, individuals have an average of 14 custody episodes and on average 1188 custody days. This can be compared to the average 26 custody episodes and 805 average custody days across the three single diagnosis study groups.

Individuals in the section 32 cohort with any diagnosis of cognitive disability have on average similar numbers of custody episodes and slightly lower custody days compared to individuals with any diagnosis of mental health disorder. Individuals with any diagnosis of cognitive disability on average have 12 custody episodes and 986 custody days, compared to individuals with any diagnosis of mental health disorder who on average have 12 custody episodes and 1076 custody days. Yet the difference here is clearly less significant than the difference between complex and single diagnoses, suggesting that the length and frequency of incarceration is more associated with relative complexity of diagnoses, than with the particular disability diagnosis. This confirms the general trend also noted in relation to the MHDCD cohort[29] that complex diagnoses are related to greater disadvantage and more cycling in and out of the CJS. Yet, across all groups in the cohort

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[29] Baldry, Dowse and Clarence, *Outlaws to Inclusion*, above n 3, 13-14.

the average number of custody episodes and custody days is still notable and paints a picture of individuals cycling in and out of prison and having relatively short prison stays which could potentially have a disruptive effect on housing, drug treatment, medical treatment and disability service access, as well as being additionally disadvantageous because these individuals could be prevented from accessing services in prison available to those who are serving longer sentences.

Figure 25 details the average number of custody episodes and custody days by gender and across the section 32 cohort study groups.

Figure 25: Average of Custody Episodes and Average of Custody Days by Gender and Study Groups

| | MH_ID | | MH_BID | | ID | BID | | MH | |
	Female	Male	Female	Male	Male	Female	Male	Female	Male
Average of CustodyEps	15.50	16.02	19.33	11.78	7.89	2.00	11.05	6.33	8.29
Average of CustodyDays	1317.90	1091.59	2620.00	1125.81	783.26	238.00	811.68	273.00	952.06
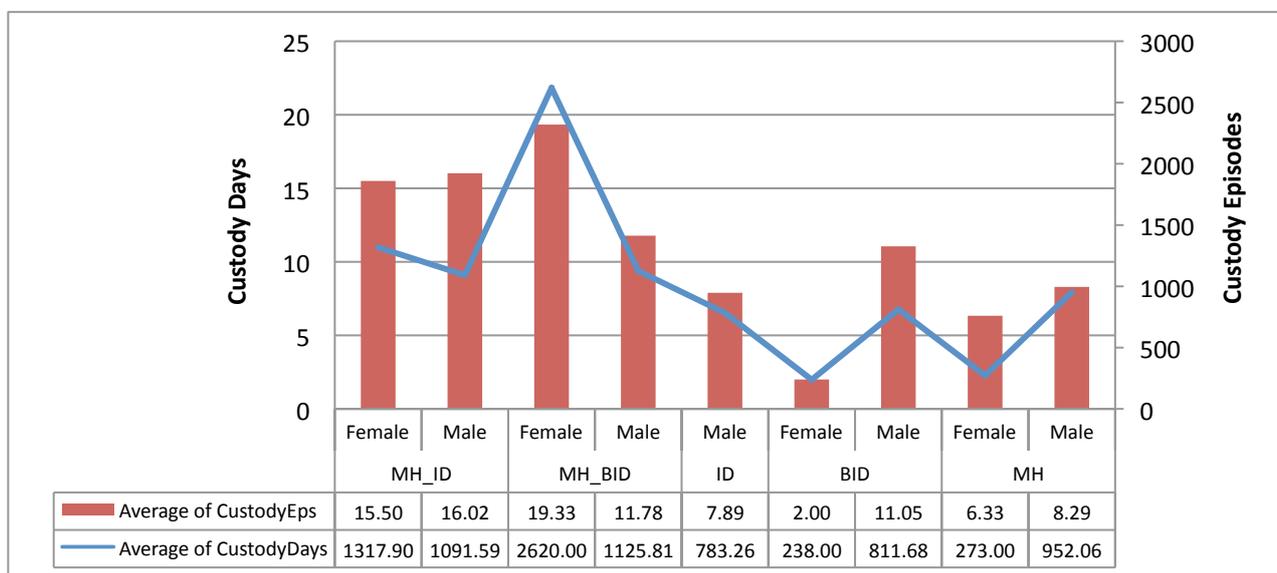
Overall, Figure 25 shows that females in the complex diagnoses study groups (the groups that as per the discussion above in relation to Figure 24 general have the highest average custody days and custody episodes) on average have higher custody days than males. Across the two complex diagnoses study groups, females have spent an average of 1969 days in custody, compared to males who have spent an average of 1109 days in custody. The gendered distinction is most notable in relation to the MH_BID study group where on average females have spent twice as many days in custody than their male counterparts – at a striking 2620 days. It is important to note here that there are only 3 females in this study group and hence the results are not representative nor statistically

significant, but rather descriptive of those small numbers on the cohort. The greater length and frequency of incarceration for females with complex diagnoses in the section 32 cohort is in line with findings from the broader MHDCD cohort relating to the extreme disadvantage and criminalisation of females with complex diagnoses.[30]

Another interesting finding demonstrated in Figure 25 is the relatively low number of custody days and episodes for females in the single diagnosis MH study group when compared to women in the complex diagnoses study groups.

Figure 26 shows the average custody episodes and average custody days in relation to Indigenous Australian and non-Indigenous Australian members of the section 32 cohort.

Figure 26: Average of Custody Episodes and Average of Custody Days by ATSI

	ATSI	Not ATSI
Average of Custody Eps	13.57	11.64
Average of Custody Days	1259.21	943.76
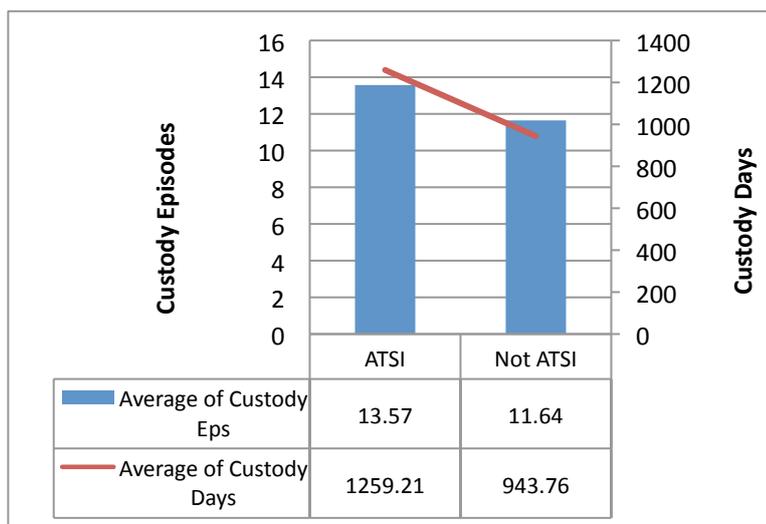
Figure 26 shows that Indigenous Australian members of the section 32 cohort on average have only a marginally greater number of custody *episodes*, but a significantly higher number of custody *days* (258 days, or 26% more days than non-Indigenous Australian).

Figure 27 shows the average custody episodes and average custody days of individuals with ABI in the section 32 cohort as compared to individuals in the cohort without ABI.

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[30] See Parts 2.1.2 and 2.1.3 above.

Figure 27: Average Custody Episodes by ABI

	ABI	No ABI
Average of CustodyEps	13.75	11.25
Average of CustodyDays	1286.68	879.73
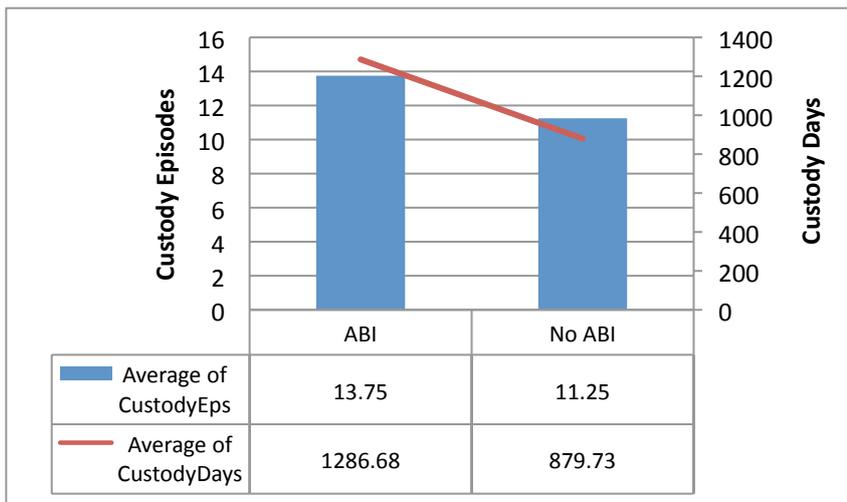
Figure 27 shows that individuals in the section 32 cohort with ABI have a higher average number of custody episodes and a higher average number of custody days. While numbers are small and results do not reach significance, the trends noted here reveal the greater length and frequency of incarceration experienced on average by individuals with ABI in the section 32 cohort, compared to those without ABI.

Figure 28 shows the number of individuals in section 32 cohort who have recorded instances of self harm in custody (ie both DJJ and DCS custody).

Figure 28: Self Harm Recorded in Custody

	MH_ID	MH_BID	ID	BID	MH
No SelfHarm	14	14	12	9	7
SelfHarm	37	25	7	11	13
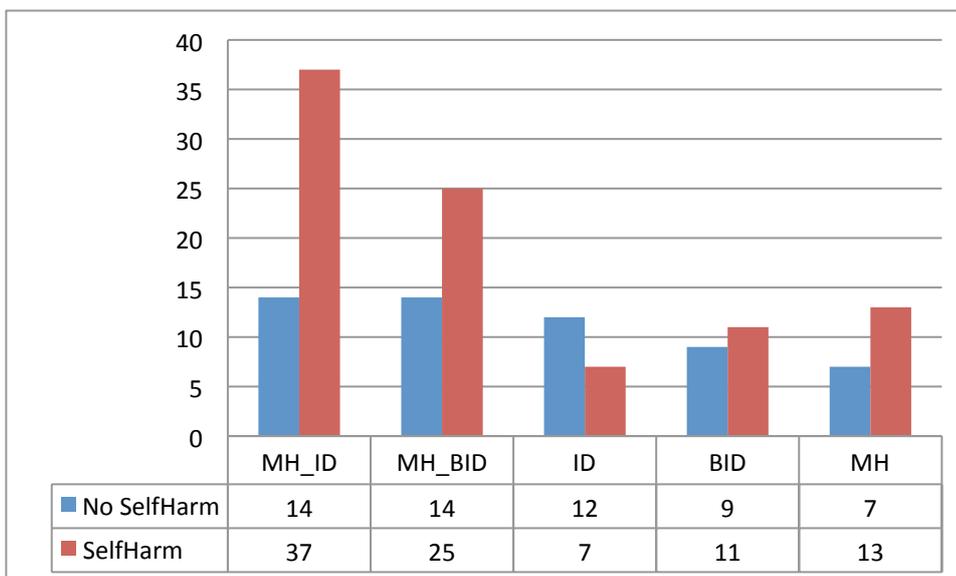
Overall, Figure 28 shows that over half, or 62%, of individuals in the section 32 cohort have recorded instances of self harm in custody (noting that this data relates to recorded rather than actual instances of self harm, which might be higher). This suggests a significant dynamic of vulnerability specifically for people diagnosed with mental health disorder and cognitive disability in prison who have been the subject of section 32 orders at some stage.

Figure 28 shows that individuals in the complex diagnoses study group MH_ID have the highest proportion of recorded instances of self harm in custody of any of the study groups. The single diagnosis ID study group have the lowest proportion of recorded instances of self harm in custody of any of the study groups. Figure 28 suggests that high proportions of self harm are associated with complex diagnoses and (to a lesser extent) with mental health disorder diagnosis. Of all individuals across the study groups that have mental health disorder in their diagnostic profiles, 68% have recorded instances of self harm, whereas 62% of individuals across the study groups that have cognitive disability in their diagnostic profile have recorded instances of self harm. Yet, there is a greater disparity in relation to complexity of diagnoses: 69% of individuals across the two complex diagnoses study groups have recorded instances of self harm, whereas 53% of individuals across the three single diagnosis study groups have recorded instances of self harm. In relation to the single diagnosis study groups, the single diagnosis mental health disorder study group have 53% recorded instances of self harm, compared to a slightly lower proportion of 46% of individuals across the two single diagnosis cognitive disability study groups.

Figure 29 shows the proportion in the section 32 cohort that has been referred to the Mental Health Review Tribunal (ie a higher court matter resolved through the forensic mental health system). It shows that only a small minority of 4.7% (7 of 149) of the section 32 cohort has had a referral to the Mental Health Review Tribunal at some stage.
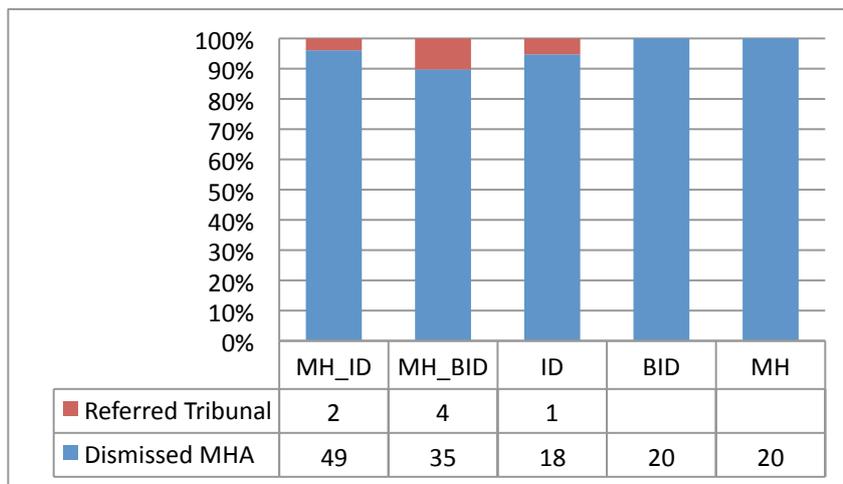
This has occurred in three of the five study groups: 10% (4) of the individuals in the MH_BID study group has been referred to the MHRT, 4% (2) of the individuals in the MH_ID study group has been referred to the MHRT, and 5.26% (1) of all individuals in the intellectual disability single diagnosis study group has been referred to the MHRT.

2.2.4   Convictions

This section discusses the nature of the convicted offences for the individuals in the section 32 cohort. The offences in this section have been drawn from the BOCSAR data and the offence categories used in this section are the ones that are used in the BOCSAR data and which are also used in the ANZSOC[31] categorisation of offences.

Table 3 and Table 4 show the frequency of convicted offences by the study groups, with Table 3 showing the frequency according to the ANZSOC[32] categories of offences.

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[31] Brian Pink, 'Australian and New Zealand Standard Offence Classification (ANZSOC) Australia' (Australian Bureau of Statistics, 2011) <http://www.abs.gov.au/ausstats/abs@.nsf/mf/1234.0>.

[32] Ibid

Table 3: Frequency of Convicted Offences (by ANZSOC categories)

ANZSOC Offence Category	MH_ID	MH_BID	ID	BID	MH
Theft and related offences	457	305	48	179	211
Public order offences	398	173	62	105	84
Acts intended to cause injury	298	228	90	149	51
Traffic and vehicle regulatory offences	187	205	124	72	82
Offences against government procedures, security and operations	221	142	76	87	72
Property damage and environmental pollution	158	107	29	80	31
Unlawful entry with intent/burglary, break and enter	85	83	6	51	44
Illicit drug offences	79	88	7	29	23
Fraud, deception and related offences	82	56	7	26	26
Abduction, harassment and other offences against the person	32	30	12	34	10
Robbery, extortion and related offences	38	30	6	12	17
Dangerous or negligent acts endangering persons	2	53	7	19	22
Sexual assault and related offences	25	22	10	7	0
Prohibited & regulated weapons & explosive offences	19	19	2	4	4
Homicide and related offences	1	3	0	0	3
Miscellaneous offences	2	0	1	0	1
Total convicted offences	2084	1544	487	854	681

Table 4 shows the top 10 most frequent convicted offences across the section 32 cohort by the 5 study groups.

Table 4: Frequency of Convicted Offences (by specific offence)

Specific Offence	MH_ID	MH_BID	ID	BID	MH
Non-aggravated assault	285	214	85	138	48
Theft (except motor vehicles), other	212	91	22	66	69
Property damage, other	141	103	28	78	29
Receiving or handling proceeds of crime	93	87	4	39	76
Driving while licence cancelled, suspended or disqualified	75	80	58	33	31
Unlawful entry with intent/burglary, break and enter	85	83	6	51	44
Offensive behaviour	129	51	22	48	12
Breach of domestic violence order	82	38	35	29	30
Trespass	85	34	8	16	46
Offensive Language	88	44	20	26	7

Overall, Table 3 and Table 4 show that the most frequently convicted offences are generally not the most serious of criminal offences. Across the study groups containing individuals with cognitive disability in their diagnostic profile the most frequent convicted offence was non-aggravated assault (a less serious category of assault offences). Yet, there were a moderate number of aggravated sexual assault convictions (64) across the four study groups with cognitive disability in their diagnostic profile (and interestingly no such convictions in relation to individuals in the MH study group). Across the section 32 cohort, there were no instances of murder, only 1 instance of manslaughter (an individual with a single diagnosis of MH), 4 instances of attempted murder

(individual/s with complex diagnoses of MH_ID or MH_BID) and 2 instances of drive causing death (individual/s with a single diagnosis of MH).

Across the section 32 cohort, the most frequent convicted offences by ANZSOC category are theft and related offences (21%) and public order offences (15%). In relation to the larger MHDCD cohort, [33] theft and traffic / vehicle regulatory offences were the most common offences (comprising 20% each of all convicted offences).

The relatively high incidence of public order offences, notably breach of domestic violence orders, offensive behaviour, offensive language and trespass offences, is particularly significant in highlighting the dynamics of the state, the justice system, the public space and the general public in the convicted offences for members of the section 32 cohort.

Table 5 shows the four most frequent serious offences in each diagnostic study group, each number indicating the frequency that individuals in each diagnostic study group have this as their most serious offence. The offence categories have been drawn from the Australian and New Zealand Standard Offence Classification 2011.[34]

Table 5: Most Serious Convicted Offences by Study Group

Most Serious Offence ANZSOC - 2011	Frequency
MH_ID	
Non-aggravated assault	16
Unlawful entry with intent/burglary: break and enter	5
Aggravated robbery	5
Aggravated sexual assault	4
MH_BID	
Non-aggravated assault	7
Illegal use of motor vehicle	6
Aggravated assault	2
Aggravated sexual assault	2
ID	
Non-aggravated assault	5

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[33] Baldry, Dowse and Clarence, *Outlaws to Inclusion*, above n 3, 12-13.

[34] For further information, see Pink, above n 31.

Driving while licence cancelled, suspended or disqualified	2
Theft	2
Unlawful entry with intent/burglary, break and enter	1
BID	
Non-aggravated assault	6
Theft of motor vehicle	2
Aggravated assault	1
Aggravated robbery	1
MH	
Non-aggravated assault	5
Unlawful entry with intent/burglary, break and enter	3
Driving offences	3
Theft (other)	3

Overall, Table 5 shows that the most frequent most serious offence for each study group and across the study groups is non-aggravated assault, this offence being the most frequent most serious offence for 26% (39) of the section 32 cohort. This offence was the most frequent most serious offence for 28% (16) individuals with single diagnosis, compared to 26% (23) individuals with complex diagnoses. This offence was the most serious offence for 26% (34) individuals with any diagnosis of cognitive disability (whether alone or in combination with a mental health disorder diagnosis) and a slightly smaller proportion 25% (28) of individuals with any diagnosis of mental health disorder (25%). The study group with the highest proportion of individuals for which non-aggravated assault was the most frequent most serious offence was the MH_ID study group, and the lowest proportion of 18% was found in the MH_BID study group. Thus, when Table 5 is taken together with Table 3 and Table 4 it is clear that non-aggravated assault is generally the most frequent offence in the cohort and the most frequent most serious offence. Non-aggravated assault is the least serious form of assault, possibly not even involving any injury to the victim.

The second most frequent most serious offence (albeit for only 6% or 9 individuals in the section 32 cohort) is unlawful entry with intent / burglary, break and enter. Aggravated robbery, aggravated sexual assault and illegal use of a motor vehicle were the third most frequent most serious offences across the section 32 cohort each constituting 4% (6).

2.3 AGENCY INTERACTIONS

Part 2.3 discusses the contact that the section 32 cohort has had with human service agencies: out of home care, education, health, housing and Legal Aid.

2.3.1 State Care

Figure 30 indicates the number of individuals who were in DOCS Out of Home Care (OOHC) as a child.

	MH_ID	MH_BID	ID	BID	MH
OOHC	7	8	2	3	1
No OOHC	44	31	17	17	19
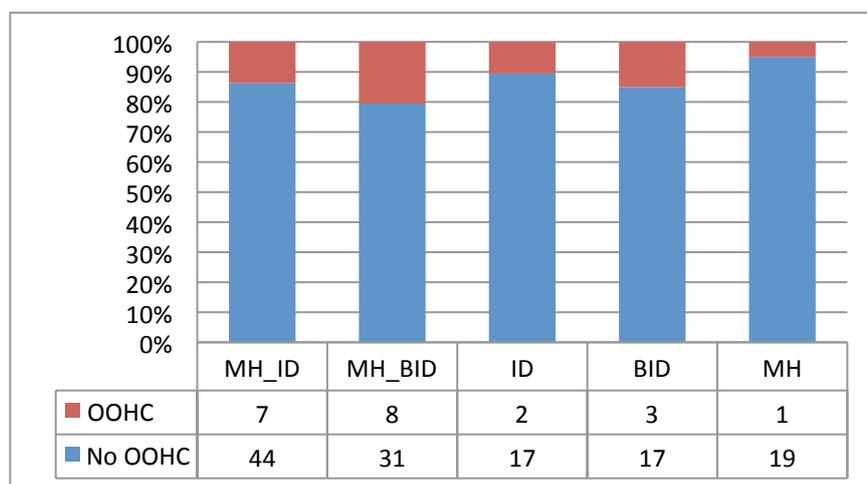
Overall, Figure 30 shows that 15% (21) members of the cohort were in OOHC. This is higher than the rate of 12% in the MHDCD cohort.[35] This is also considerably higher than the rate of OOHC in the general population of less than 1%.[36]

There is little difference between disability diagnoses groups in relation to out of home care: 16% (20) of individuals in the section 32 cohort with any diagnosis of cognitive disability (whether alone or in combination with a diagnosis of mental health disorder) have been in OOHC, whereas a slightly lower proportion of 15% (16) of individuals with any diagnosis of mental health disorder

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[35] Baldry, Dowse and Clarence, *Outlaws to Inclusion*, above n 3, 7.

[36] Ibid 7.

(whether alone or in combination with a cognitive disability diagnosis) have been in OOHC. However, individuals with single diagnosis of mental health disorder have the smallest proportion of OOHC across the study groups of only 5% (1), suggesting that higher levels of OOHC in the section 32 cohort is associated with the presence of cognitive disability.

Within the cognitive disability study groups, the complex diagnoses cognitive disability groups have slightly higher levels of OOHC than across the two single diagnosis cognitive disability groups: 17% and 13% respectively. The key difference in relation to OOHC vis-à-vis cognitive disability appears to be in relation to single v complex diagnoses. The MH_BID study group has the highest proportion of individuals experiencing OOHC of any study group, comprising 21% (8). Members of the complex diagnoses study groups on average experience the highest proportion of OOHC, thus supporting an argument about the greater disadvantage associated with complexity of diagnoses and in turn the compounding effect of social disadvantage and criminal justice involvement.

2.3.2 Education

Figure 31 shows the education levels attained by the section 32 cohort. It is important to note that for a large number of individuals this information was not available and they have been excluded from the data contained in this figure. The education data in the IHS was self-reported, and generally more available for those with a diagnosis of mental health disorder (whether alone or in combination with a diagnosis of intellectual disability or borderline intellectual disability) than those with a single diagnosis of ID or BID. There are thus significant limitations with this data and as such it only shows a small snapshot.

	Didnt complete	HSC/VCE/Leaving Certificate	primary school only	school certificate
■ MH_ID	16		4	8
■ MH_BID	19		2	5
■ ID	2	2	1	
■ BID	3			2
■ MH	15	3		2
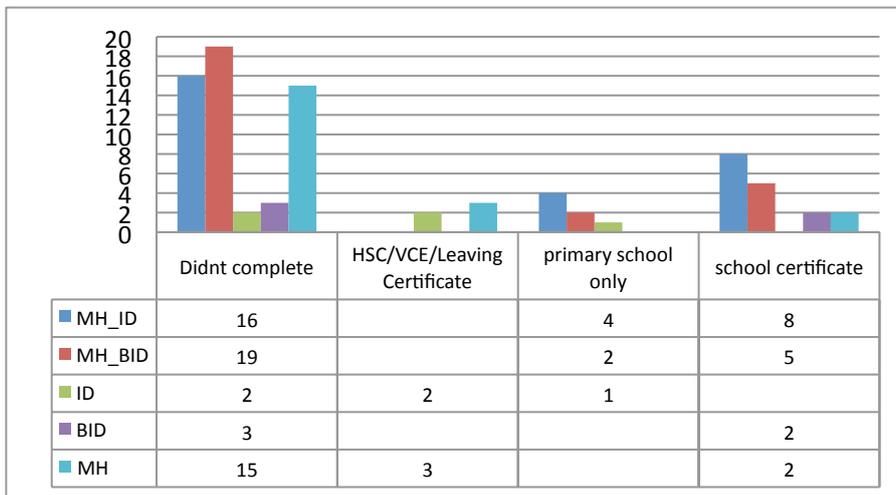
Overall,

Figure 31 shows (in relation to the individuals in the section 32 cohort for whom data is available) considerably low education outcomes. Nearly three quarters, or 74% (62), of the individuals have left school with no qualifications (ie have only attained primary school level schooling or have not completed their schooling).

Figure 31 suggests that poor education outcomes are associated with complexity of diagnoses. From the data that is available, across the two complex diagnoses study groups a striking 76% (41) of individuals have left school with no qualifications. The MH_BID study group has an exceptionally high proportion of individuals leaving school with no qualifications (81%, n=21) and as does the MH_ID study group with 71% (20) of individuals in this group leaving school with no qualifications. This suggests a particular dynamic of disadvantage for individuals with complex

diagnoses and a link between complex diagnoses, educational disadvantage and in turn criminalisation (in light of findings elsewhere in Part 2.2 of this report concerning complex diagnosis and criminal justice contact).

2.3.3   Health

This section discusses health related issues of individuals in the section 32 cohort.

Figure 33 shows the average numbers of health service contacts for individuals in the section 32 cohort. This consists of hospital admissions, psychiatric admissions and Mental Health Act (MHA) use by the police. The hospital admissions, psychiatric admissions and MHA are mutually exclusive. The hospital admissions are general hospital admissions not counting psychiatric admissions and the MHA is the use of the Mental Health Act by police whereas psychiatric admissions are hospital admissions on the basis of psychiatric health.

As a preliminary note, the exceptionally high average rate of MHA for the ID study group stands out immediately. However, this average is skewed as there is one individual in the ID study group who has a very large number of MHA (216), psychiatric admissions (89) and hospital admissions (175), meaning that one needs to take this into account in analysis of the data for the ID group as the averages are grossly inflated.

	MH_ID	MH_BID	ID	BID	MH
Average of Psych Adm	8.28	7.54	16.86	4.92	11.19
Average of MHA	9.40	7.72	23.36	4.80	8.90
Average of Hosp Adm	24.55	14.41	20.25	9.33	17.72
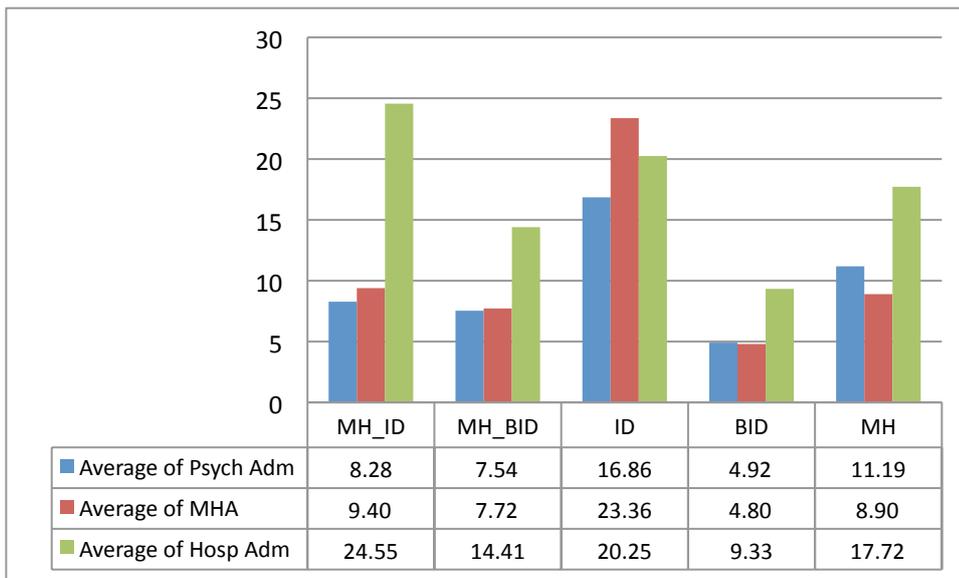
Overall, Figure 33 shows that, on average, the number of health admissions for individuals across the section 32 cohort is 38 admissions.

In relation to the study groups, the two study groups containing individuals who have intellectual disability (ID; MH_ID) have the highest average health admissions. Individuals with single diagnosis ID have the highest average number of health admissions with 60 and the highest average number of hospital (ie general health), and individuals with complex diagnoses MH_ID have an average of 42 health admissions. It is interesting to note that the two study groups containing individuals diagnosed with borderline intellectual disability (BID and MH_BID) have relatively low average numbers of health admissions: 30 (MH_BID) and 19 (BID).

In relation to hospital admissions, the average across the section 32 cohort generally is 17 hospital admissions. This high average number of hospital admissions is particularly significant given the average age for individuals in the cohort is still quite young (mid 30s as per Figure 3) and hence cannot be explained as escalating hospital admissions associated with old age. This is shown further by the following Figure 34 which shows the average rates of admissions.

Figure 33 shows high numbers of mental health related contact with hospitals (ie psychiatric admissions and MHA contacts). Overall, individuals in the section 32 cohort have an average of 21 mental health related hospital contacts. The average mental health contacts were relatively constant between individuals in each of the three study groups containing individuals who have been diagnosed with mental health disorder in their diagnostic profiles (ranging between 16-20 contacts). Whilst the averages for these study groups were higher than those for the BID study group (and might also be higher for the ID study group when the one individual with extremely high MHA is taken out of the calculations as per comments above), it is important to note that on average individuals in the single diagnosis cognitive disability study groups still have a number of instances of psych admissions and MHA contacts.

It is interesting to note that the ID and MH_ID groups have the highest average number of MHA contacts, of 23 and 9 respectively, which shows something specifically about the use by police of *mental health* legislation in relation to individuals with diagnoses of *intellectual* disability. Individuals in the two intellectual disability study groups also have a high rate of psychiatric admissions, again showing the significance of *mental health* interventions in relation to this group, including for individuals with *no* diagnosis of mental health disorder (ie those in the ID study group). When these findings are coupled with the finding in Figure 21 concerning police use of the MHA in relation to people diagnosed with cognitive disability, the data clearly shows the use in a number of ways of civil mental health legislation and by a number of different agencies in relation to people that (on prima facie diagnostic grounds) are not the anticipated target of this legislation. The use of civil mental health legislation in relation to individuals diagnosed with cognitive disability in the section 32 cohort, particularly their location in these particular institutional spaces, is a significant finding in this report and certainly invites further research.

Figure 34 shows the average rate of hospital admissions over the course of individual's lives.

	MH_ID	MH_BID	ID	BID	MH
■ Average of Hospital Admission Rate	0.91	0.59	0.24	0.39	0.75
■ Average of Psychiatric Admission Rate	0.28	0.30	0.12	0.16	0.47
■ Average of Mental Health Act Rate	0.37	0.24	0.16	0.17	0.27
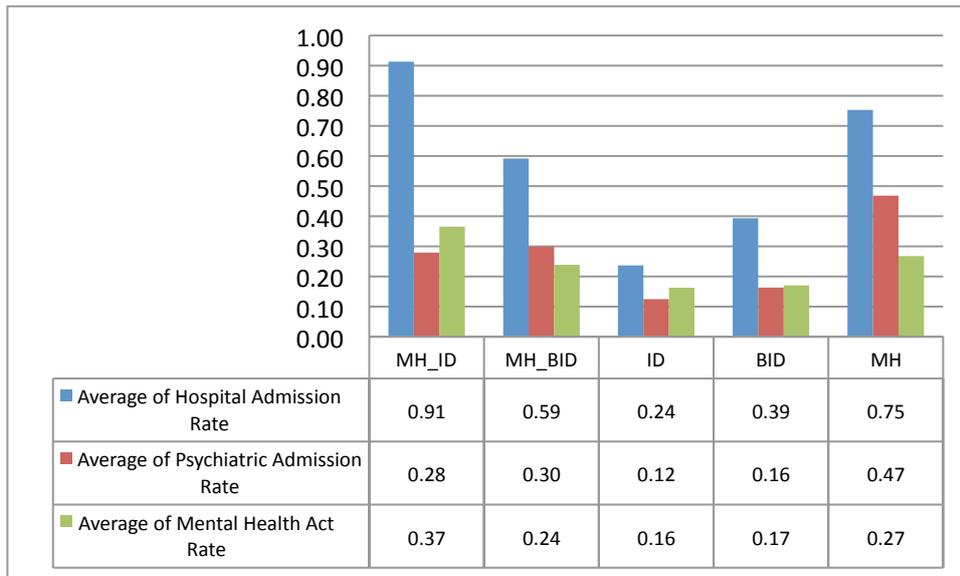
Overall, Figure 34 shows that on average individuals with a mental health diagnosis (whether alone or in combination with a cognitive disability diagnosis) have higher rates of health admissions compared to individuals with single diagnosis of cognitive disability.

Figure 35 shows the rate of Hepatitis C and HIV in the cohort across the study groups. This data has been drawn from the hospital admissions diagnoses, and hence might not reflect all individuals in the section 32 cohort who in fact have Hepatitis C and HIV.

	MH_ID	MH_BID	ID	BID	MH
■ No Hep C - No HIV	49	31	18	19	13
■ Hep C - No HIV	1	7	1	1	7
■ Hep C - HIV	1	1			

Overall, Figure 35 shows that 1% (2) individuals have Hepatitis C and HIV and 11% (17) of individuals in the section 32 cohort have Hepatitis C alone. The relatively low proportion of individuals in the section 32 cohort who have been identified in the data as having Hepatitis C and HIV might be related to the nature of the data collection (having been drawn from hospital admissions diagnoses) rather than an accurate reflection of all individuals in the section 32 cohort who have Hepatitis C and HIV.[37] That said, for this small minority of individuals who have been diagnosed with these physical health issues, this is an additional dynamic of diagnostic complexity, poor health outcomes and social marginalisation.

Figure 35 suggests that, for individuals in the section 32 cohort, HIV and Hepatitis C diagnosis appear to be more associated with mental health disorder diagnosis than with cognitive disability diagnosis. The highest proportion of HIV and/or Hepatitis C in the section 32 cohort (in each study group, single v complex and mental health disorder diagnoses v cognitive disability diagnoses) was for individuals with single diagnosis mental health disorder: 35% (7) and the lowest was for individuals with single diagnosis cognitive disability: 5% (2). As a proportion of all individuals in the study groups with mental health disorder in their diagnostic profile, 15% (17) has a diagnosis of

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[37] More general surveys of prison populations suggest higher proportions of individuals with Hepatitis C. For example, '[c]lose to one-third of the 2009 IHS sample tested positive to Hepatitis C virus (HCV) antibody': Devon Indig et al, '2009 NSW Inmate Health Survey: Key Findings Report' (Justice Health Statewide Service, NSW Health, 2010) 76.

HIV and/or Hepatitis C, whereas as a proportion of all individuals in the study groups with cognitive disability in their diagnostic profile, a lower proportion of 9% (12) of all individuals have a diagnosis of HIV and/or Hepatitis C.

There were also a high proportion of individuals in the section 32 cohort with HIV and/or Hepatitis C who has complex diagnoses and more specifically has diagnoses of mental health disorder and borderline intellectual disability. Of all individuals in the MH_BID study group, 21% (8) have Hepatitis C (and 13% (1) of these individuals also has HIV). The proportion of individuals in the MH_ID study group with HIV and/or Hepatitis C is much smaller (4% (2)), such that overall across the two complex diagnoses study groups the proportion with HIV and/or Hepatitis C is 11%. The two individuals in the section 32 cohort with a dual diagnosis of Hepatitis C and HIV are in the complex diagnoses study groups.

2.3.4   Housing

Figure 36 shows whether individuals in the section 32 cohort have ever been recorded as being homeless (ie 'no fixed place of abode' or 'NFPA'). It should be noted at the outset that this is an under-representation of homelessness in the cohort, as currently homelessness can only be detected when an individual has received a service whilst homeless or has come into contact with the CJS. Many more individuals are expected to have instances of homelessness in addition to those reported here.[38]   Moreover, NFPA recorded homelessness does not include marginalised and insecure housing such as boarding houses.

Figure 36: Proportion of Individuals Recorded as Having NFPA Across the Study Groups

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[38] Dowse et al, above n 3, 41.

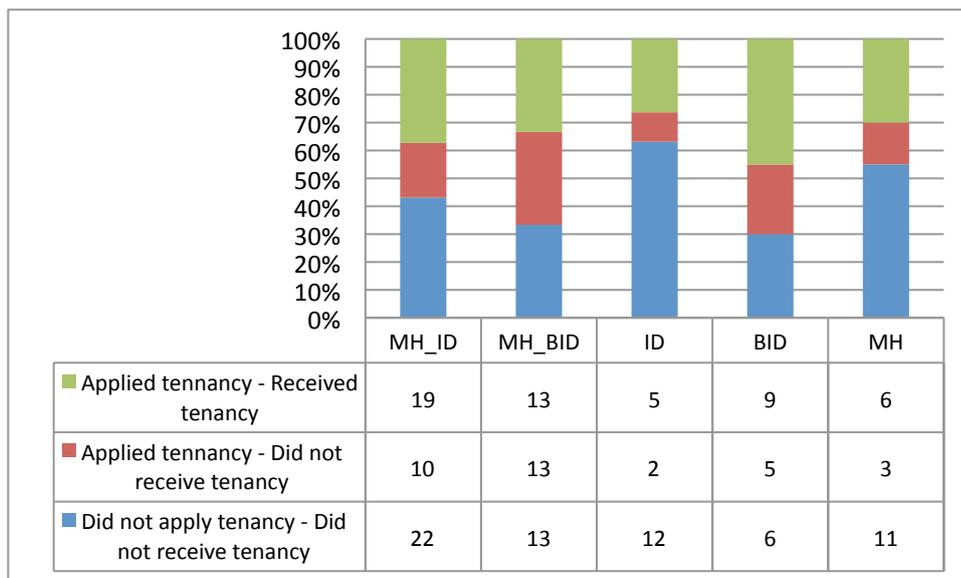|	MH_ID	MH_BID	ID	BID	MH
■ Not NFPA	17	15	12	11	6
■ NFPA	34	24	7	9	14

Overall, Figure 36 shows that across the section 32 cohort, 59% (88) of individuals have recorded instances of homelessness. Even though this is likely an under-representation of actual homelessness (as per the points made above), this is quite a significant proportion of homelessness in the section 32 cohort suggesting a significant dynamic of social marginalisation for the cohort.

As a proportion of the total number with recorded homelessness, the two complex diagnoses study groups overwhelmingly have the highest instances of recorded homelessness. In particular, the MH_ID study group makes up 39% of all instances of homelessness. Yet, these groups have the highest numbers of individuals and hence comparison in this way between the study groups says little of the relationship between homelessness and disability. So, as a proportion of the total cohort, individuals with single diagnosis of mental health disorder have the highest proportion of individuals with a recorded instance of homelessness as a proportion of the total number of individuals in that study group: 70% (14). As a proportion of the total number of individuals in each of the complex diagnoses study groups, those with recorded homelessness constitute 67% (MH_ID) and 62% (MH_BID) respectively. This can be compared to the relatively lower proportions of homelessness in the two single diagnosis cognitive disability study groups: ID (37%) and BID (45%). Across the study groups with mental health disorder in their diagnostic profile, the proportion of homelessness is 66% (72) which can be compared to the lower proportion of 57% (74) for individuals in the study groups with cognitive disability in their diagnostic profile. Thus, it

seems that homelessness is associated with mental health disorder and, to a slightly lesser extent, with complex diagnoses.

Figure 37 shows the range of Housing NSW tenancy applications and the relevant success rates for those applications.

Figure 37: Tenancy Applications in the Cohort

	MH_ID	MH_BID	ID	BID	MH
▣ Applied tennancy - Received tenancy	19	13	5	9	6
▣ Applied tennancy - Did not receive tenancy	10	13	2	5	3
▣ Did not apply tenancy - Did not receive tenancy	22	13	12	6	11

Overall, Figure 37 shows that 57% (85) of the section 32 cohort have applied for tenancy with Housing NSW. Of those who have applied for tenancy Housing NSW, 39% (33) did not receive the tenancy. This thus shows complex dynamics of social marginalisation vis-à-vis housing, because individuals are expressing a need for housing (in itself indicative of social marginalisation), but many of these individuals are not having this need met (a further dimension of social marginalisation). What the data does not disclose is what the ultimate housing, social and personal safety outcomes are for those individuals who have had their housing applications rejected. The available data also does not disclose the extent to which rejected applications impacted on pathways into the CJS and the extent to which these rejected applications were themselves related to past criminal justice contact and related social impacts of such contact.

The proportions of applications and rejected applications were relatively consistent across the study groups with cognitive disability in their diagnostic profile (59% applications, 43% rejected) and the study groups with mental health disorder in their diagnostic profile (58% applications, 41% rejected). Across the two complex diagnoses study groups there was a higher proportion of applications (61%) and rejections (42%) as compared to the proportions across the three single diagnosis study groups (51% applications, 33% rejections). This illustrates the link between complexity of diagnoses and social disadvantage in that individuals with complex diagnoses have high proportions of tenancy applications and rejected applications.

The study group with the highest proportion of individuals who have applied for Housing NSW tenancy was the single diagnosis BID study group, which has a proportion of 70% (14) having made applications, and the relatively low proportion of 36% (5) having had their application rejected. The MH_BID study group also has a high proportion of individuals who have made Housing NSW tenancy applications: 67% (26) individuals have applied for tenancy. This group also have the highest proportion of individuals who have had applications rejected, with 50% (13) of those who applied having had an application rejected.

The single diagnosis ID and MH study groups have the lowest applications for public housing tenancy, with 37% (7) and 45% (9) applying respectively. Whilst the ID group has the lowest proportion of rejections of any study group (29% (2)) thus showing the best housing outcomes of any of the study groups, the MH study group has a high proportion of rejections of 50% (3). This finding of low applications and high rejections in relation to individuals diagnosed with single diagnosis MH is particularly interesting given that Figure 36 above showed that 70% of this study group have been recorded as NFPA at some stage in their life, such that they have extremely poor housing outcomes (ie they have a higher incidence of homelessness and yet lowest incidence of tenancy applications).

Figure 38 shows rent assistance applications and approvals across the section 32 cohort study groups.

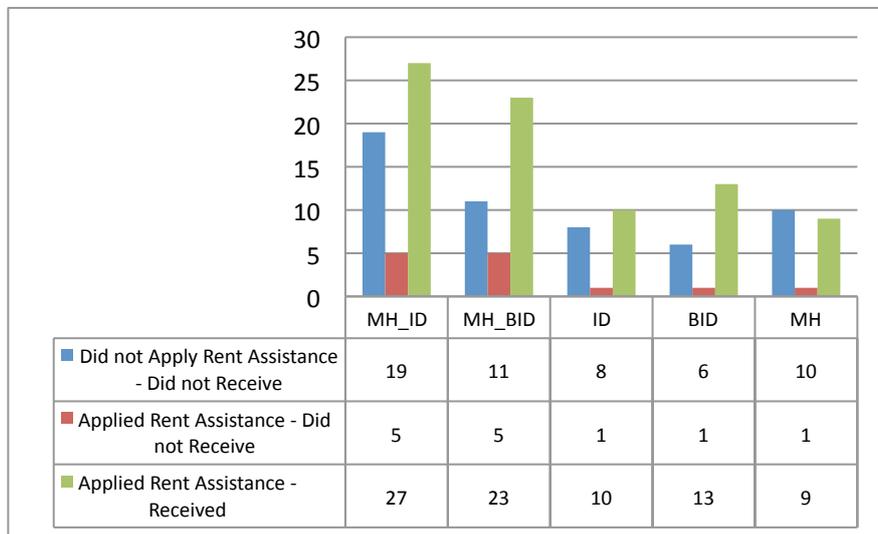|	MH_ID	MH_BID	ID	BID	MH
■ Did not Apply Rent Assistance - Did not Receive	19	11	8	6	10
■ Applied Rent Assistance - Did not Receive	5	5	1	1	1
■ Applied Rent Assistance - Received	27	23	10	13	9

Figure 38 shows that 64% (95) individuals in the section 32 cohort applied for rent assistance and that most individuals who applied did receive rent assistance with only 14% (13) having their applications rejected.

In the study groups, the highest proportions of individuals who have made applications for Rent Assistance were in the BID and MH_BID study groups. In the MH_BID study group 72% (28) of all individuals have applied for rent assistance. In the single diagnosis BID study group 70% (14) of all individuals have applied for rent assistance. Yet, there is significant disparity between these two groups in relation to rejected applications. Individuals in the single diagnosis BID study group have relatively positive outcomes for applications with only 7% (1) of individuals having an application rejected, whereas the complex diagnoses MH_BID study group have the highest proportion (18%, n=5) of individuals who have a rejected Rent Assistance application. This seems to follow a trend in the section 32 cohort where rejection of rent assistance applications is associated with complexity of diagnoses. Across the two complex diagnoses study groups, there is a proportion of 17% (10) rejected applications, compared to the lower proportion of 9% (3) across

the three single diagnosis study groups. The single diagnosis MH study group has the lowest proportion of applications of 50% (10) and the high proportion of successful applications of 90% (9).

Figure 39 shows the rate of evictions from Housing NSW tenancies. It shows that across the section 32 cohort as a whole, the rate of eviction from Housing NSW tenancies is 13% (20). Given that eviction is the involuntary removal from one's housing as opposed to an individual choosing to live elsewhere, this data adds an element of instability to an individual's living situation and thus this figure shows that eviction is a further dynamic of housing instability and hence social marginalisation for a sizeable minority of individuals in the section 32 cohort.

Figure 39: Evictions in the Cohort

	MH_ID	MH_BID	ID	BID	MH
Ever Evicted	7	5	1	5	2
Never Evicted	44	34	18	15	18
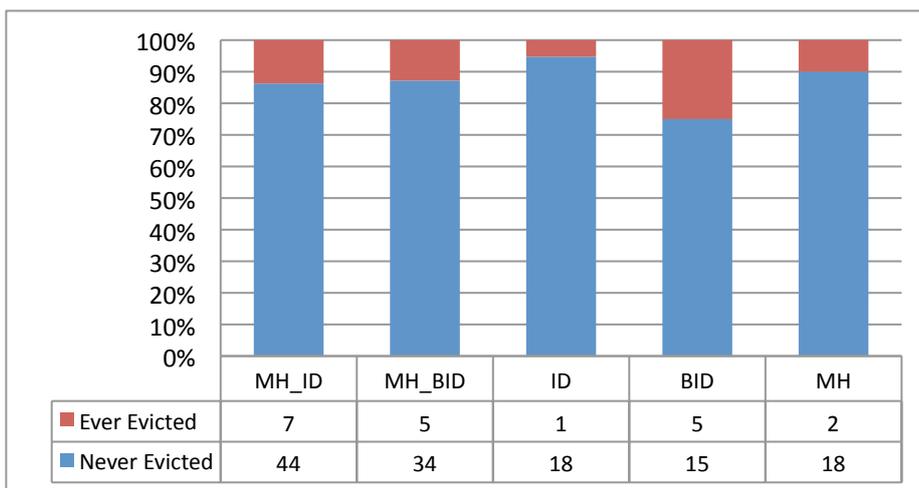
The proportion of individuals ever evicted from a Housing NSW tenancy is relatively consistent at 13-14% between individuals in the groups with cognitive disability in their diagnostic profiles (14%) and the groups with mental health disorder in their diagnostic profiles (13%), and between individuals in the complex diagnoses study groups (13%) and individuals in the single diagnosis study groups (14%). The key differences lie between the study groups themselves, with the strikingly high proportion of eviction for individuals in the single diagnosis BID study group of

25% (5) and the low proportion of evictions for individuals in the single diagnosis ID study group of 5% (1). This can be compared to the moderate proportion of eviction for individuals in the MH_ID study group (14%), the MH_BID study group (13%) and the MH group (10%).

Whilst the single diagnosis BID study group has the highest proportion of evictions, as a proportion of all individuals in the section 32 cohort who have ever been evicted by Housing NSW, it is the two complex diagnoses study groups as well as the single diagnosis BID study group that have the highest proportion of individuals who have ever been evicted by Housing NSW. Thus, for the section 32 cohort, eviction is associated with complex diagnoses and BID, confirming findings elsewhere in this report about the association between complex diagnoses and borderline intellectual disability diagnosis with social marginalisation.

2.3.5   Legal Aid

Figure 40 shows the proportion of each study group in the section 32 cohort that has made one or more applications for Legal Aid. Overall, it shows that across all of the study groups a majority of individuals of 86% (128) have applied for Legal Aid and, conversely, that a minority (14%) of individuals in the section 32 cohort have never applied for Legal Aid.

Figure 40: Applications for Legal Aid Across the Section 32 Cohort
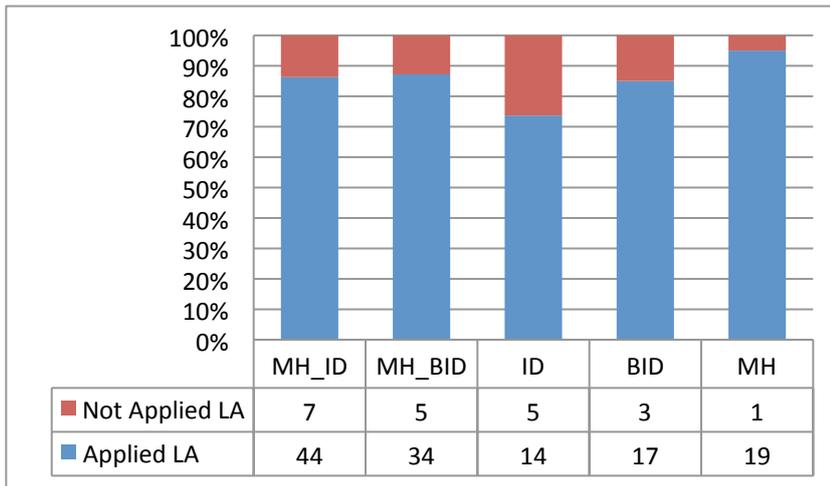
	MH_ID	MH_BID	ID	BID	MH
Not Applied LA	7	5	5	3	1
Applied LA	44	34	14	17	19

The single diagnosis MH study group has the highest proportion of individuals who have ever made Legal Aid applications with 95% (19) having applied at some stage. Only 74% (14) of individuals with single diagnosis ID have ever made a Legal Aid application. The other three study groups have 85%-87% of individuals having ever made Legal Aid applications.

Figure 42 shows the average success rate for Legal Aid applications made by individuals in the section 32 cohort in each of the study groups.

Figure 42: Average Legal Aid Cases Applied and Refused

	MH_ID	MH_BID	ID	BID	MH
Average of LA Cases Refused	2.25	1.60	1.25	5.29	1.13
Average of LA Cases Applied	13.08	9.50	7.54	18.50	8.11
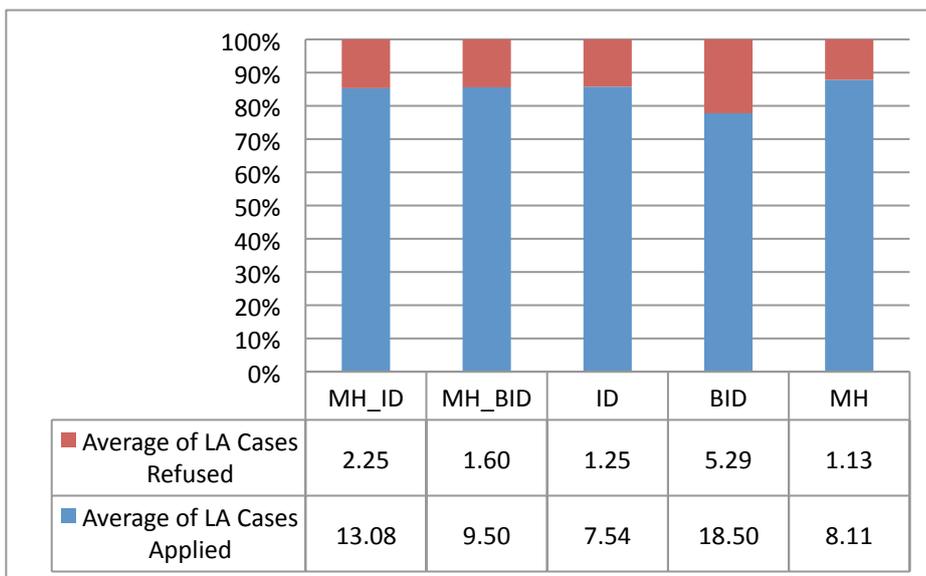
Overall, Figure 42 shows that across all of the study groups the majority of applications have been successful, with an average number of 11 Legal Aid cases applied for and an average of 2 cases refused. On average individuals with any diagnosis of cognitive disability (whether alone or in combination with a diagnosis of mental health disorder) have a slightly higher average number of Legal Aid applications of 12 cases and a slightly higher number average number of applications refused of 3. In comparison the individuals with any diagnosis of mental health disorder (whether alone or in combination with a diagnosis of intellectual disability or borderline intellectual disability) have a slightly lower average number of applications of 10 cases and an average of 2 refusals which is consistent with the overall average.

Individuals with a single diagnosis of BID have on average made the highest number of Legal Aid applications (19), but they also have on average the highest number of their applications being refused (5) representing on average a proportion of 29% refusals of all applications made. The average proportion of refused applications for each of the other study groups ranges between 14%-17%. Thus Figure 42 in conjunction with

Figure 40 above indicates that individuals in the section 32 cohort with a single diagnosis of BID have the poorest outcomes for Legal Aid access.

2.4 DISABILITY SERVICE USAGE

This section discusses the disability service usage of individuals in the section 32 cohort. As stated in the introductory background discussion, it is important to note that since the MHDCD cohort was drawn on April 30 2008 there have been some significant and ongoing reforms in relation to community forensic disability service provision which may mean that a greater number of individuals would be receiving disability services if the cohort had been drawn more recently.

Figure 43 shows the proportion of all individuals in each of the section 32 cohort study groups to have received disability support services from the NSW Human Services Ageing, Disability and Home Care ('ADHC'). This data does not extend to receipt of non government disability services or generalist human services, and hence it is likely that some individuals in the section 32 cohort will be accessing support services that are not captured in this data.

Figure 43: ADHC Services Received

	MH_ID	MH_BID	ID	BID	MH
Not ADHC	28	32	9	14	19
ADHC	23	7	10	6	1
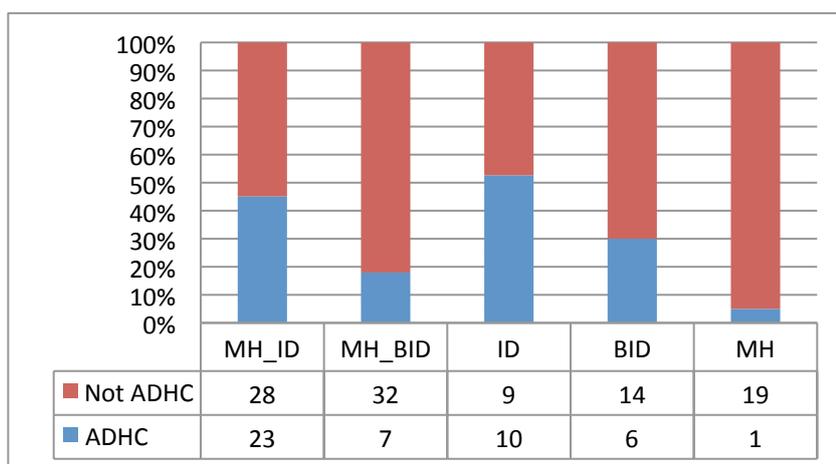
Only 1 individual with single diagnosis of MH received ADHC services. This is to be expected in light of ADHC's diagnostic eligibility criteria for services that focus principally on diagnosis of intellectual disability as opposed to mental health disorder. The Figure 43 that follows will thus focus on the four study groups containing individuals with cognitive disability in their diagnostic profile.

In relation to all members of the section 32 cohort with a diagnosis of cognitive disability, 36% (46) received ADHC services. This increases to 47% (33) in relation to only those with a diagnosis of intellectual disability (whether in combination or alone, as opposed to individuals with any diagnosis of borderline intellectual disability). Of the five study groups, the single diagnosis ID study group and the MH_ID study group each have the highest proportions of individuals in each of those study groups receiving services from ADHC, 53% (10) and 45% (23) respectively. Whilst this is a higher proportion when compared to other diagnoses, it still is a relatively low proportion.

Importantly, in analysing this data, it must be kept in mind that it cannot be assumed that every individual in the section 32 cohort has applied for ADHC services, such that not being in receipt of ADHC services cannot be automatically associated with a positive refusal by ADHC of an application for services. So, in assessing this proportion a number of dynamics might be at play: individuals applying for ADHC services and not being accepted (possibly for a number of reasons such as the lack of a formal diagnosis, incomplete documentation), individuals having unstable and chaotic life circumstances and no support person to assist in applying some individuals *not wishing to apply* or not aware of the option of applying for disability services, and also a lack of recognition or identification of a diagnosis of cognitive disability until entry to prison. This requires further nuanced consideration to appreciate how these different dynamics and others might play out in the specific context of ADHC service access for criminalised and marginalised individuals who are subject to section 32 orders.

Individuals in the section 32 cohort with a diagnosis of borderline intellectual disability (whether alone or in combination with a mental health disorder diagnosis) were less likely to receive ADHC services. Across the two study groups with borderline intellectual disability in their diagnostic profiles only a small proportion of 22% (13) have received ADHC services. Specifically, 18% (7) of individuals with complex diagnoses of MH_BID and 30% (6) of individuals with single diagnosis BID have received ADHC services. When considered in conjunction with their marginalisation in accessing generic human services such as housing and Legal Aid as discussed earlier, it is evident that people in the section 32 cohort diagnosed with borderline intellectual disability experience considerable social marginalisation. The findings in relation to ADHC service use and people diagnosed with borderline intellectual disability, require further nuanced qualitative research in order to draw out the various dynamics. For example, this might reflect ADHC eligibility requirements concerning IQ cut-offs as well as issues around the lack of formal diagnoses or an inability to make an application due to social circumstances. Yet, it might also reflect a lower level of demand for disability services by individuals diagnosed with borderline intellectual

disability who might not identify as having disability or as a disability service user, or might not be aware of these services if they have not historically been associated with the disability community or disability service sector.[39]

It is interesting to note that the proportion of individuals in the section 32 cohort accessing ADHC services is higher than the proportion in the MHDCD cohort generally where, for example, only 23% of the cohort diagnosed with intellectual disability (whether as a single diagnosis or with a diagnosis of mental health disorder) have received ADHC services at the time the cohort was drawn, and only 4% of individuals in the BID study group were ADHC clients.[40] This would support the proposition that section 32 orders are more likely to be made in relation to individuals who are receiving disability services. Yet, it is also interesting, given that section 32 orders typically require a treatment plan and evidence of disability service access, that a high proportion of these individuals who have section 32 orders have not accessed ADHC services. As such, Figure 43 indicates that section 32 orders are not exclusively related to ADHC disability service access, and might instead be made for a variety of other circumstances: in the absence of services or in anticipation of an individual applying to access ADHC services, for use of NGO disability services or generalist services, or with no current to anticipated disability service use without any services. Further qualitative research into the actual disability service use of the subjects of section 32 orders might point to a willingness on the part of Magistrates to make these orders for reasons other than to specifically channel individuals into disability services, or to a disconnect between section 32 orders and actual service engagement.

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[39] Eileen Baldry, Leanne Dowse and Linda Steele, 'Literature Review for the Community Justice Project, Human Services Ageing, Disability & Home Care Pro-Social Activities Project: Designing structured community activities for people with an intellectual disability and offending behaviour' (School of Social Sciences and International Studies UNSW, 2010) 26, 72.

[40] Baldry, Dowse and Clarence, *Outlaws to Inclusion*, above n 3, 7.

Figure 44 provides further details of ADHC service use, showing those individuals in the section 32 cohort specifically receiving Community Justice Program ('CJP') services, as opposed to those receiving non-CJP ADHC services.

Figure 44: ADHC and CJP Clients

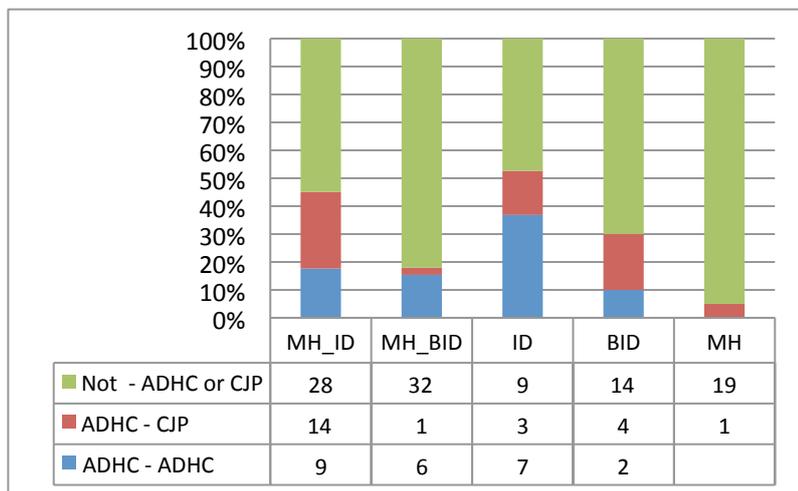|	MH_ID	MH_BID	ID	BID	MH
Not - ADHC or CJP	28	32	9	14	19
ADHC - CJP	14	1	3	4	1
ADHC - ADHC	9	6	7	2	

Figure 44 shows that, overall, of the individuals with diagnoses of cognitive disability in the section 32 cohort who are receiving ADHC services, 47% (22) are clients of CJP, and as a proportion of all individuals in the section 32 cohort with cognitive disability 17% are clients of ADHC. The lower proportion of individuals in the section 32 cohort who are receiving CJP services should be considered in light of the resource and eligibility restrictions of CJP which limit the number of individuals who can possibly access CJP as opposed to ADHC services more broadly.

As a proportion of the total members in each study group receiving ADHC services, it is individuals with single diagnosis ID (67%) and individuals with complex diagnoses of MH_ID (61%) who proportionately receive the highest CJP services of any of the study groups. Individuals with diagnoses of MH_BID represent the smallest proportion of individuals in CJP of any of the study groups containing individuals with cognitive disability in their diagnostic profile, with only 14% of this group who receive ADHC services specifically receiving CJP services.

Figure 45 shows ADHC and CJP service access by gender across the section 32 cohort study groups.

Figure 45: ADHC and CJP Clients by Gender

	MH_ID		MH_BID		ID	BID		MH	
	Female	Male	Female	Male	Male	Female	Male	Female	Male
ADHC - ADHC	2	7	1	5	7		2		
CJP - ADHC	2	12		1	3	1	3		1
Not CJP - Not ADHC	6	22	2	30	9		14	3	16
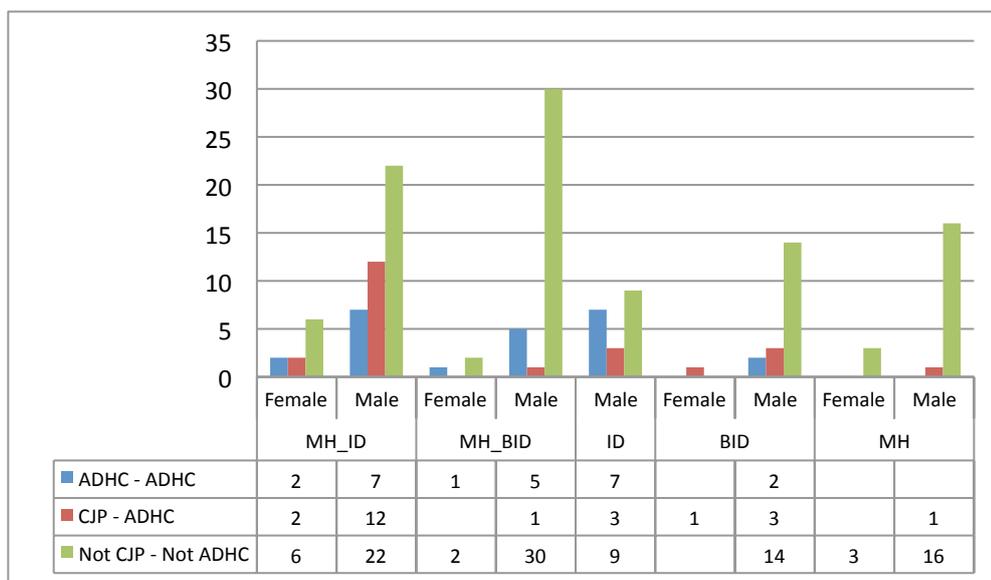
Overall, Figure 45 shows that females with a diagnosis of cognitive disability (whether alone or in combination with a diagnosis of mental health disorder) are very slightly overrepresented as ADHC clients (13-14%) as compared to their representation in the section 32 cohort generally (11%). Females comprise 13% (6) of all individuals with cognitive disability receiving any ADHC services, 13% (3) females of all individuals receiving non-CJP ADHC services, and comprise 14% (3) of all individuals receiving CJP ADHC services.

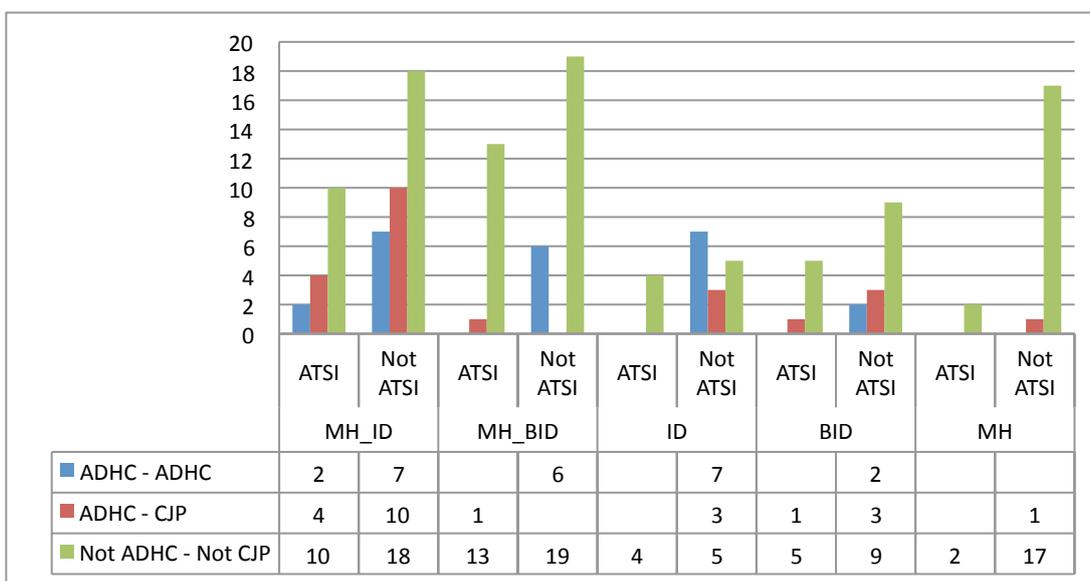Figure 46 below shows ADHC and CJP service access by Indigenous status. Overall, Figure 46 shows that Indigenous Australians with diagnoses of cognitive disability (whether alone or in combination with a diagnosis of mental health disorder) are underrepresented as ADHC clients, comprising 17% (8) of all individuals with cognitive disability accessing ADHC services as

compared to their representation in the section 32 cohort generally (31%). This shows that in the section 32 cohort, Indigenous Australians who have been the subject of section 32 orders are marginalised in relation to accessing ADHC services generally. Certainly the overrepresentation in the CJS and underrepresentation in disability services invites further research.[41] Yet, another point inviting further research is the fact that Indigenous Australians are overrepresented in the section 32 cohort (vis-a-vis the broader MHDCD cohort) but underrepresented in relation to ADHC services.

Figure 46: ADHC and CJP Clients by ATSI

	MH_ID		MH_BID		ID		BID		MH	
	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI	ATSI	Not ATSI
ADHC - ADHC	2	7		6		7		2		
ADHC - CJP	4	10	1			3	1	3		1
Not ADHC - Not CJP	10	18	13	19	4	5	5	9	2	17

Building on the comments made above in relation to ADHC services vis-à-vis section 32 orders, the low proportion of Indigenous Australians accessing disability services raises questions around the service basis (if at all) on which these orders are being made, and might point to a willingness on the part of Magistrates to make these orders for reasons other than specific channelling into disability services. Interestingly, Indigenous Australians in the section 32 cohort with a diagnosis of cognitive disability comprise a greater proportion of all individuals receiving CJP as opposed to

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[41] For example, see Stubblefield's discussion of the over-diagnosis but underrepresentation in terms of disability support services of African Americans: Anna Stubblefield, 'The Entanglement of Race and Cognitive Dis/Ability' in Eva Feder Kittay and Licia Carlson (eds), *Cognitive Disability and its Challenge to Moral Philosophy* (Wiley-Blackwell, 2010) 293.

non-CJP ADHC services. They comprise 8% (2) of all individuals receiving non-CJP ADHC services, and comprise 27% (6) of all individuals receiving CJP ADHC services.

Figure 47 shows the average age at which individuals in the section 32 cohort began receiving ADHC services. The average age of the MH study group is not noted as the one individual in this study groups has his age of commencement recorded as "null" and hence no age is available.

Figure 47: Average Age at Which Individuals Began Receiving ADHC Services

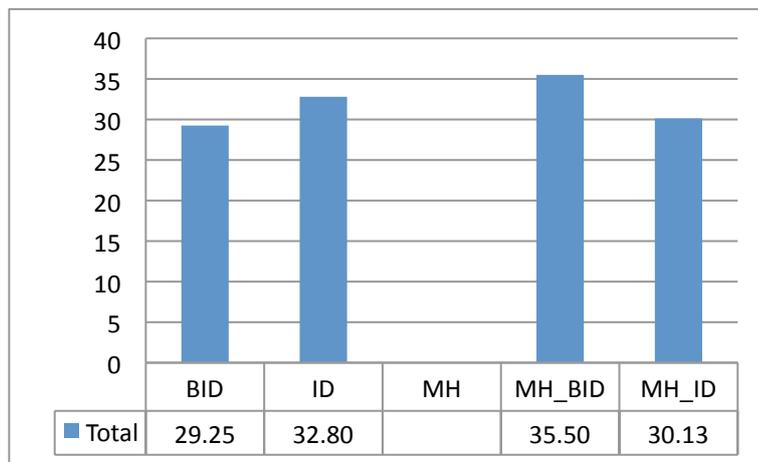|	BID	ID	MH	MH_BID	MH_ID
Total	29.25	32.80		35.50	30.13

Figure 47 shows quite strikingly the high average age of 31.9 years old at which individuals with a diagnosis of cognitive disability on average first received ADHC services. Given that Figure 14 shows that first adult custody across the cognitive disability study groups is in the early 20s, this suggests that on average individuals with cognitive disability have been in the CJS for quite some time prior to receiving disability support services.

Interestingly, individuals with single diagnosis of BID received ADHC services on average at the youngest age of the four cognitive disability study groups (29.3 years), whereas those with complex diagnoses of MH_BID received ADHC services for the first time on average at the oldest age (35.5 years) across the four groups.

2.5 SECTION 32 ORDERS

This section discusses section 32 use across individuals in the section 32 cohort.

Figure 46 shows the numbers of section 32 orders as young persons across the section 32 cohort, where 'young person' is defined as being aged below 18 years of age, as well as those who received their section 32 order as an adult.

Figure 46: Section 32 as a Young Person

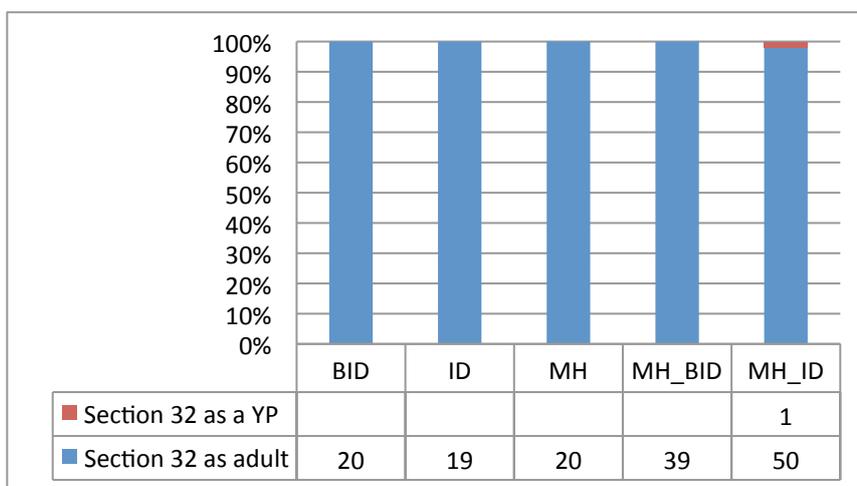|	BID	ID	MH	MH_BID	MH_ID
Section 32 as a YP					1
Section 32 as adult	20	19	20	39	50

Figure 46 strikingly shows that nearly every individual in the section 32 cohort have their section 32 order/s as an adult, with only 1 individual in the cohort receiving a section 32 order as a young person. This is significant given that many individuals begin their criminal justice involvement as young persons, as per Figure 14 above. Keeping in mind that the section 32 cohort only contains individuals who have ever been in custody and hence does not include individuals who have never been in custody and have received a section 32 order, it might be that individuals who are receiving section 32 orders as juveniles are *not* being channelled into adult custody at the same rate as individuals who are not having section 32 orders until they are in the CJS as adults, and might suggest the longitudinal significance of section 32 vis-à-vis criminal justice pathways throughout the life course. This invites further research around section 32 and young persons and the relationship of early section 32 orders to adult incarceration.

Table 6 shows the number of section 32 orders for each individual in the cohort.

Table 6: Number of Section 32 Orders by Study Group

Number of s32 Orders	Number of Individuals
MH_ID	
10	2
7	2
6	1
5	1
4	7
3	6
2	14
1	18
Total	**51**
MH_BID	
5	1
4	5
3	3
2	11
1	20
Total	**39**
ID	
9	1
3	2
2	10
1	6
Total	**19**
MH	
5	1
4	1
3	3
2	6
1	9
Total	**20**
BID	
6	1
5	1
3	2
2	1
1	15
Total	**20**
Total Overall	**149**

Overall, Table 6 shows that individuals do not on average have a high number of section 32 orders, despite the frequent cycling in and out of the criminal justice system. Overall, in relation to the 149 members of the sample, there are only 322 section 32 orders for the cohort. Significantly, the average number of section 32 orders across the cohort is 2, with a range from 1 to 10. Only two individuals (in the MH_ID study group) have received 10 section 32 orders and only 1 individual (in the ID study group) has have 9 section 32 orders. Nearly half (46%, n=68) individuals in the section 32 cohort have received only 1 section 32 order, and 85% (126) of the section 32 cohort have received 3 or less section 32 orders.

When these findings are taken in conjunction with discussion of criminal justice contact in Part 2.2, this suggests that section 32 orders do not necessarily prevent future criminal justice contact and thus this provision might not necessarily be effectively 'diverting' individuals out of the criminal justice system in an absolute and long term sense beyond the immediate charges. Thus, the relationship of section 32 orders to longitudinal criminal justice pathways and to successive and compounding criminal justice contacts is an area that invites further research. This is particularly because from the available data in this study it is not clear what the criminal justice involvement post-section 32 orders is of individuals in the cohort, since data on section 32 is identification of the presence of an order at any point in the individual's life, rather than chronologically distributed for each individual. Such temporal dynamics might illuminate why there are such a low number of section 32 orders, eg the extent to which this is explained by section 32 orders preventing future contact with the criminal justice system or the extent to which it is explained by Magistrates' hesitancy to make further orders once re-offending occurs post-section 32 orders.

Table 7 shows the offences resulting in a section 32 order, and indicates the number of individuals who have received section 32 orders in relation to such offences.

Table 7: Offences Resulting in Section 32 Order and Number of Individuals to Have Had Charge Dismissed Under Section 32

Charged offence relating to s32	Number of individuals to have had charge dismissed under s 32
Acts intended to cause injury	88
Theft and related offences	60
Justice offences	48
Public order offences	36
Property damage and environmental pollution	20
Unlawful entry with intent/burglary, break and enter	14
Miscellaneous offences	13
Road traffic and motor vehicle regulatory offences	13
Robbery, extortion and related offences	8
Illicit drug offences	7
Sexual assault and related offences	7
Deception and related offences	4
Weapons and explosives offences	2
Total	**320**

The relatively high number of section 32 orders for acts intended to cause injury, theft and related offences, public orders offences and property damage listed in Table 7 reflects the findings elsewhere concerning the high incidence of these convictions in the section 32 cohort. The relatively low number of illicit drug offences and road traffic and motor vehicle charges dismissed under section 32 is in contrast with the high number of these convictions as shown in Table 3 and Table 4 and the reasons why charges of this nature are not dismissed under section 32 are all issues that invite further inquiry.

3. CONCLUSION

This report has analysed data relating to the demographic characteristics and longitudinal human service and criminal justice pathways of individuals in the MHDCD cohort who have received a section 32 order, and has also discussed the use of section orders in relation to these individuals.

As reported by the MHDCD ARC project team, individuals diagnosed with mental health disorder and cognitive disability have high levels of social marginalisation, ongoing and multi-layered criminalisation, and relatively low numbers of section 32 orders as a proportion of convictions.[42]

Further analysis of the MHDCD data performed for this current report on individuals in that cohort with section 32 orders, shows that the individuals diagnosed with mental health disorder and cognitive disability who are the subject of section 32 orders also experience this complex social marginalisation including poor outcomes with Housing NSW and limited access to ADHC disability support services. The report has shown that for many in the section 32 cohort, this social marginalisation begins at an early age, with a high proportion having very poor educational outcomes and some having been in OOHC. These findings indicate that individuals in the section 32 cohort experience similar socio-economic and service disadvantages as others in the larger MHDCD cohort with compounding disability and disadvantage.

This report and other research by the MHDCD ARC Project Team has highlighted the need to look beyond diagnoses and to the significance of dynamics of social marginalisation in approaching the criminalisation of people with cognitive disability and mental health disorder in the criminal justice system. This report has also found that there is a low number of individuals in the MHDCD cohort who have received section 32 orders, and a low number of charges dismissed for those who have

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[42] Baldry, Dowse and Clarence, *Outlaws to Inclusion*, above n 3.

had section 32 orders. Taken together, these findings raise questions about section 32's underuse *as well* as about its limits when it is used. Section 32's rather modest significance in quantitative terms to the MHDCD cohort and to the section 32 cohort combined with the pervasive indications of long term marginalisation and criminalisation invites nuanced qualitative research about the extent to which section 32 can possibly address the ongoing and multilayered nature of criminalisation and the extent to which section 32 can prevent future marginalisation and acknowledge and address the significant *historical* marginalisation many of this group have experienced since childhood.

The report has also shown similar significant criminalisation for the section 32 cohort as for the rest of the individuals with complex diagnoses in the larger MHDCD cohort, which is ongoing across the life course (and for many beginning in childhood) and is multilayered involving contact as an alleged offender with police, the courts, DJJ and DCS, as well contact with police as a victim and as a perceived mentally ill person. The data showed that adult incarceration is characterised by relatively short prison stays and for some vulnerability in prison to self harm. Significantly, a section 32 order might not necessarily mean an end to criminalisation or incarceration of an individual over the life course – the low average number of section 32 orders when compared to the high average number of police contacts, convictions and custody episodes invites further qualitative research that explores section 32's longitudinal impacts or limitations. The report also found that certain offences (substance use offences and driving offences) that individuals in the section 32 cohort are frequently convicted of are not being dismissed under section 32 at the same frequency as other convicted offences. This is of particular interest notably in relation to substance use offences that might have complex relationships to disability, trauma and social marginalisation, and is also of importance in light of the ongoing definitional tension around substance use itself as a diagnosis that falls within the terms of section 32.[43]

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[43] See, eg, New South Wales Law Reform Commission, above n 7, 127 [5.94] - 130 [5.102].

The report showed the ways in which individuals in the section 32 cohort defy the dichotomy of victim and offender, particularly when a longitudinal approach to criminalisation is taken rather than focussing on one discrete set of charges. Many have had contact with police as victims and a number were vulnerable to self harm in prison. Further research could explore how the development of impairment for people the subject of section 32 orders is itself associated with the criminal justice system, social marginalisation and violence,[44] and how this might in turn impact on how one evaluates the possibilities and limits of section 32 orders. In particular, further research is necessary to appreciate the association between ABI and personal violence, including domestic violence for females with ABI in the cohort, which might reveal greater vulnerability to such violence.

A high proportion of individuals in the section 32 cohort have complex diagnoses and once ABI is factored into the diagnosis a very small minority of individuals in the cohort have a 'single' diagnosis. This is in itself an important finding given the focus in section 32 on discrete diagnostic categories and the emerging attention to 'complex needs' in the specific context of section 32.[45] Individuals with complex diagnoses of MH_ID or MH_BID in the section 32 cohort generally experienced greater levels of criminalisation and marginalisation than the minority of individuals in the section 32 cohort with a single diagnosis of MH, ID and BID.[46] Importantly, however, individuals with a single diagnosis of cognitive disability have higher levels of victim contacts with police than individuals with complex diagnoses. There are many similarities between individuals in the section 32 cohort with complex diagnoses and the rest of the complex diagnoses cohort. The

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[44] See generally Beth Ribet, 'Naming Prison Rape as Disablement: A Critical Analysis of the Prison Litigation Reform Act, the Americans with Disabilities Act, and the Imperatives of Survivor-Oriented Advocacy' (2010) 17(2) *Virginia Journal of Social Policy and the Law* 281; Beth Ribet, 'Emergent Disability and the Limits of Equality: A Critical Reading of the UN Convention on the Rights of Persons with Disabilities' (2011) 14 *Yale Human Rights and Development Law Journal* 155.

[45] New South Wales Law Reform Commission, above n 7, 130 [5.103] – 132 [5.109].

[46] The available data did not enable in-depth analysis of the human service use and criminal justice contact of people in the Section 32 cohort with a single diagnosis of ID, BID or MH and an ABI (ie those individuals referred to earlier in this report as having a complex 'single' diagnosis.

fact that on the basis of diagnosis (albeit only one of the criteria for a section 32 order) this latter groups of individuals were eligible for a section 32 order but did not receive any section 32 orders suggests that qualitative research could explore the underuse of section 32 for individuals with complex diagnoses. Moreover, the finding that individuals with complex diagnoses in the section 32 cohort have similar levels of marginalisation to those in the MHDCD cohort who did not receive any section 32 orders, suggests that section 32 orders might be limited in the extent to which they can address long term and multilayered criminalisation and early and ongoing social marginalisation, and hence that there is a need for qualitative research that looks at why section 32 orders do not assist this group and what else might be done for this group (including turning attention to non-criminal legal and systemic approaches).

Individuals with a diagnosis of cognitive disability (either alone or in combination with a mental health disorder diagnosis) were found to generally have more long term criminalisation and to have higher levels of social marginalisation than individuals with a diagnosis of mental health disorder. They also have higher levels of victim contacts with police.

The individuals in the section 32 cohort who were diagnosed with borderline intellectual disability (either alone or in combination with a mental health disorder diagnosis) have considerable levels of criminalisation and marginalisation in a number of areas. Further research is needed in relation to people diagnosed with borderline intellectual disability in the CJS: whilst individuals with diagnosed with borderline intellectual disability are being granted section 32 orders, they are marginalised in the legal terminology and in diagnostic and service frameworks around section 32 as well as experiencing significant social marginalisation and criminalisation.

Women were shown to be a small minority of all individuals in the section 32 cohort, yet, although their small numbers made it impossible to perform analyses of significance, it appears that the women have more complex diagnoses, higher levels of social marginalisation and higher levels of

victimisation than their male counterparts, suggesting that female subjects of section 32 orders are extremely disadvantaged.

The report also found that Indigenous Australians were represented in the section 32 cohort at a slightly higher rate than in the general MHDCD cohort. A high proportion of Indigenous Australians in the section 32 cohort have a cognitive disability diagnosis. At the same time, Indigenous Australians who have been the subject of section 32 orders were shown to have more complex diagnoses and higher numbers with ABI, higher levels of criminalisation and marginalisation and to have limited access to ADHC services (notably general ADHC services) when compared to non-Indigenous Australians in the section 32 cohort. The higher use of section 32, even in the face of their relatively higher degrees of disadvantage is a finding that invites further research, as is the question of whether and how section 32 orders are addressing their higher levels of marginalisation and criminalisation.

An unexpected and important finding was the significance of civil mental health legislation as a dynamic in the criminalisation and institutionalisation of people diagnosed with *cognitive* disability, including, surprisingly, individuals with a *single* diagnosis cognitive disability. Further research is necessary to appreciate the ways in which criminal or forensic legislation (including section 32) *and civil* mental health legislation figure in the criminalisation and institutionalisation of people with cognitive disability. Such an investigation should look to the police and other services' *perceptions* of cognitive disability as a mental health disorder thus addressing the possibility that individuals diagnosed with cognitive disability are ordered into the mental health system because of misperceptions that cognitive disability is a mental health disorder. It should also examine the institutional and social dynamics in the use of section 32 that systematically channel people diagnosed with cognitive disability into the civil mental health system (and specifically into the civil mental health system as a way *out of* the criminal justice system and *in lieu of* a coercive civil legal framework specific to people diagnosed with cognitive disability).

Ultimately, the report invites further critical reflection by scholars, policy makers and disability rights advocates on the possibilities and limitations of section 32 in acknowledging and addressing the long term social marginalisation and criminalisation of people diagnosed with cognitive disability and mental health disorders in the criminal justice system.

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