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| **Submission to United Nations Special Rapporteur on Torture**  **Current Issues and Good Practice in Prisons**  **People with Disability in Australian Prisons and Forensic Places of Detention**  **An Alliance of People with Disability and Lived Experience of the Justice System and Organisations and Individuals Working in the Australian Disability and Justice Space**  **Coordinated by Patrick McGee**  **Executive Director**  **Australians for Disability and Justice**  **November 26th 2023** |

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Responses should be submitted by 27 November 2023

Email address: [sharon.critoph@un.org](mailto:sharon.critoph@un.org) and copy [hrc-sr-torture@un.org](mailto:hrc-sr-torture@un.org)

**Email subject line:**  
Call for input current issues and good practice in prison management

**File formats:**  
Word, PDF

**Accepted languages:**  
English, Spanish, French

**Postal address:**  
Office of the United Nations High Commissioner for Human Rights, United Nations Office at Geneva, CH 1211 Geneva 10, Switzerland

**Story by Taylor Budin**

**Disability and Justice Lived Experience Advocate**

**Sydney New South Wales**

**How do the prison guards treat you as a person with autism in detention – they treat you like a dog**

I was in a mental health secure unit – but I have autism.  My impact of my autism meant that I needed my food on the dinner plate separate and not touching – my peas not touching my carrots, my carrots not touching my potatoes.  However in prison my food on the dinner plate always arrived with all the food mixed up and all together.   When I asked the Senior Corrections Officer of the Mama Sher Unit (Mental Health Unit at Silverwater Maximum Security Prison) if my food could be separated due my autism, the Officer replied, “I don’t give a fuck if your peas touch your carrots you autistic dog”

Not having my food separated on the dinner plate overwhelmed me and exacerbated the symptoms of my autism.  I began to self harm.  This meant I began to hit my face with my open hand and my fist, causing massive bruisers on my cheeks.  As well I punched the walls of my cell dislocating my fingers and splitting open the skin of my knuckles.  I could not regain control of myself.

Instead of asking me what was wrong, to help me stop feeling overwhelmed and so that my autism symptoms involving self-harm, de-escalated, the prison riot squad entered my cell and forcefully physically restrained me so that I could not move and carried me to a ‘dry cell’ where I was left wearing just a hospital gown.  A 'dry cell' has no bed and no toilet and no shower.

I was detained in this ‘dry cell’ for five days.

Whilst detained in the ‘dry cell’ I continued to self-harm and would fall asleep exhausted with anxiety.  Despite the ‘dry cell’ being a part of the mental health unit at no time was I offered any support. Despite self-harming as a result of my autism I did not have access to psychological or psychiatric support during my solitary confinement in the dry cell.

Prior to my detention and as a result of living with autism and mental health issues I was prescribed Quetiapine (Seroquel) which is an anti-psychotic to manage the symptoms of autism and to help me sleep.  I had been taking this medication under medical direction for three years at the time of my imprisonment.  Upon my incarceration I was refused access to my medication and it was three weeks before I could see a psychiatrist for a prescription to resume my anti-psychotic medication.  Tis was avery difficult time for me because I was new to being in prison and I was suffering withdrawal from the antipsychotic medication leaving me unable to cope with my autism.  At the beginning of my incarceration, I was prescribed 200mg of Seroquel.  By the time of my release from prison, I was being prescribed 1000mg of Seroquel.

The impact of being prescribed such a large dose of Seroquel every day was to turn me into a zombie.  It felt like a deliberate method by the prison to keep me compliant and passive.  By the time of my release I was heavily addicted to the 1000mg of Seroquel per day.  After getting out of prison I was often unable to get out bed.  I began smoking marijuana heavily every day.  I was paranoid about leaving my house. I was unable to get a job or see my friends.  I found myself doctor shopping for Seroquel and this made me feel terrible about myself.

The thing that kept me going in prison was the support I received from my fellow prisoners.  My cell mate was one person in the prison who helped me manage my autism.  No help to manage my autism was provided by the prison whilst I was detained.  My cell mate managed to get my dinner plate before I did and would spend time separating out the food so that when I saw the dinner plate the peas weren't touching the carrots and the carrots were touching the potatoes and I could eat my dinner without getting overwhelmed.  My cell mate did this all the time for me.  I will never forget this act of kindness because it literally helped keep me sane and stands in sharp contrast to the way in which the prison dealt with my autism - with humiliation, violence and solitary confinement

**Book Chapter from Taylor Budin**

**Routledge Handbook of Penal Abolitionism**

**Edited by Michael J. Coyle and David Scott**

**The need to abolish prisons from the perspective of a person with a disability**

**Taylor Budin**

When I was locked up for the first time, I was so fearful. It was late at night. No one could come to my rescue. I cried myself to sleep. I needed my medication. I didn’t get it for the first twelve days. I told them about my disability. Did they care? No.

I spent my time in gaol in a high-dependency mental health unit for women. It was meant to be safe. You would be safer in mainstream prison. Not long after I was locked up, I was sexu­ally assaulted. I was called an “autistic dog” by a prison guard. A part of my autism means that it’s impossible for me to eat any food that has colours touching. I simply cannot do that. When I tried to explain that to a prison guard, she said, “I don’t give a fuck if your peas touch your corn or touch your carrot. I don’t give a fuck, you autistic dog”. Being unable to eat the food meant that I spent a lot of time starving in gaol.

Goal is a violent place. People get bashed all the time. You can get bashed just for look­ing at someone the wrong way. You can get bashed for taking the last spoon. Someone is always getting stabbed. People are so distressed and desperate that they would climb up the barbed wire fence to try and escape. You have drugs all around you. And you have to say no. But then you’re a bitch if you say no. Drugs are easier to get on the inside than they are on the outside.

In the gaol I was in, there were no therapeutic programmes. No education courses. No train­ing. Nothing. There were times when we would be locked in our cells for three days in a row because they were short-staffed or because the prison guards had training days. Every night our cells would be swarming with mosquitos. The gaol I was in was built on sacred Aboriginal land. How bad is that. They built a prison on sacred Aboriginal land!

I’d make it through the days just by trying to get through one little bit at a time. I’d count the time to breakfast, then to lunch, then to dinner. And I did a lot of self-harming. I’d punch the walls. My knuckles are permanently bruised and misshapen. For that I was forced to do seven days in solitary confinement with nothing but a hospital gown to wear and freezing cold air-conditioning blasting the whole time. When you self-harm in prison, you are punished even worse. You are punished for feeling distressed and desperate, for not being able to cope.

So many women self-harm in gaol. I saw some horrible things. I saw the most disturb­ing things in prison. Forensic teams were constantly coming into the unit because people had slashed up so badly. I saw one of the girls come out of her cell just dripping with blood. Blood everywhere.

I watched my cellmate, my best mate in gaol, crack her head against a door to try and get the guards to come to our cell to help me because my gallstones had flared up and I was in agony. Another time I woke up to find my cell mate all purple, gasping for air. She had tied a blanket around her neck. She was hanging from the bed. I tried to get her off, but I couldn’t. I had to press the alarm. Eventually a prison guard came and saved her.

People will do anything to get out of gaol. There were girls who would drink their shampoo and conditioner just so they would get sick and be taken to a clinic. I knew another girl who would cut herself, and then she would rub her own faeces into her cuts so that she would get an infection. She would do that just to get out of the unit and be taken to a hospital. That was the only way she knew how to feel just a tiny bit of freedom.

Most of the prison guards are shocking. They are rude. They have no respect for you. You are a piece of shit to them. You are nothing. You are nothing but a number to prison guards. Nothing but that MIN number.1 You are forever in the system as a number. They don’t even call you by your first name. They actually refer to you as your MIN number.

And if you have a disability, they definitely do not care. They don’t even understand what it is. I waited forever to speak to a psychologist. When I finally got to see her, I tried to talk to her about my issues. She spoke over me and sent me on my way. When I tried to talk to the psychiatrist about my issues, he just increased my medication. The whole time I was in there, they would just constantly increase my medication. Every time there was an issue, or a situ­ation, they would increase my meds. Now I am addicted to a really high dosage of Seroquel. All thanks to the gaol.

When I had done my time, I was forced to leave gaol with nothing. No money. No medica­tion. Nothing. After the psychiatrist had raised my medication levels so high, having to spend the first night out of gaol with no medication whatsoever was total hell. Gaol made me lose my independence. You become so vulnerable once you leave. Because you are used to it. It is so easy to become institutionalised. I was institutionalised by gaol. When I left, a part of me just wanted to run straight back inside. I was so worried about my best mate in there. I was so wor­ried that she wasn’t going to make it. I still constantly worry about her. That is the worst part. Gaol is a shocking place. Anyone who has been to gaol knows that it is horrendous. There is no rehabilitation. Nothing good comes from being incarcerated. Prison screwed me mentally. It mentally screws everyone. And it screws you for a long time after you leave.

Instead of judging us, people need to look hard at the kinds of situations that people who are in prison were in before they started breaking the law. There are reasons that people do what they do. Most of the people in gaol are not bad people. And when you hear about most of the criminal records of people in gaol, you know that they just should not be in there. Most of them have done the pettiest of things. Breach of parole conditions. Not turning up to appointments. All that kind of really petty stuff. If I do anything wrong, I will be sent straight back to gaol for at least two years. They set you up to fail. The whole justice system is a load of shit.

I don’t know what better options there are than gaol because there aren’t any other options that I have heard about. And that is the sad part. But gaols do not work. They are violent, and they are filled with drugs. How can you possibly be rehabilitated in a place like that? Even some of the prison guards would talk about how bad the system is. Gaols do not rehabilitate people. You are treated like an animal. Worse than an animal. We need to get rid of gaols altogether.

Gaols are filled with people who are so vulnerable. Almost everyone has some kind of mental illness in gaol. We need to stop treating vulnerable people like numbers or animals and abolish prisons. As a society, all of us – including people who are locked up in gaols – need to come together and start working out how we can do things better.

**Note**

1 A MIN (Master Index Number) is the number given to all prisoners in Australia when they enter a prison.

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**Rocket Bretherton**

**Justice Reform Initiative - Campaign and Advocate Coordinator**

**Darwin Northern Territory**

**Lack of physical and mental health support in prison**

My name is Rocket Bretherton a proud Noongar woman who was bought up by Wakka Wakka mob. I want to acknowledge that I am on Larrakia land and pay my respects to elders past present. I have lived experience of the justice system. I work for the Justice Reform Initiative.

Whilst I was incarcerated, I was denied access to adequate mental health care and medications that I had previously accessed on the outside which resulted in a steady decline of my mental health. because a person goes to jail should not mean that their health care is any different this includes dental care with people often forced to wait months in excruciating pain to be able to see a dental student. I have many horror stories of substandard medical, dentist, specialist care and mental health care which I won’t go into now.

You can have as many mental health diagnoses on the outside but once incarcerated these diagnosis don’t matter. The same can be said for access to mental health medication. Prisons often have limited medication options to treat mental illness. The impact of this is that people are often prescribed the wrong medication which can have significant and debilitating side effects and you are not able to access the medication you need.

In my situation I live with ADHD ad I was not able to access my ADHD medication. The impact of this was that I was not able to control my impulsivity which got me into trouble. I was often up all night leaving me fatigued during the day. I was often placed into solitary confinement because I would breach the prison rules whilst suffering from the ADHD

Because of this circumstance I spent a lot of time in high security. There were four people in my area and over the course of six months there were five attempted suicides. In an area with just four people observing repeated suicides attempts leaves you very depressed. However, if you asked for support you would be transferred to the ‘at risk’ cell. At risk cells are entirely transparent in that correctional officers and other prisoners can observe you at all times. I was made to wear dirty clothes worn by other prisoners who had been detained in the ‘at risk’ cells. There was no access to showers for five days. The prisoner in the next cell repeatedly made inappropriate sexualised comments and gestures the entire time I was detained in the ‘at risk’ cell. This constant barrage of verbal sexual assault left me feeling emotional and psychologically vulnerable and unsafe

As a result of my detention in prison I now have bladder damage leaving me vulnerable to constant kidney infections. Living with constant kidney infections means that I am regularly admitted to hospital for this health issue. On one occasion during the night whilst in prison I called the correctional officer to inform him that I was very sick and needed to see the nurse. The officer advised that there was no nurse available till the morning. By morning my illness had exacerbated and when the nurse saw me in the morning she immediately referred me to hospital. The nurse advised the corrections officers that I should be transferred to hospital via an ambulance but this was refused and instead, shackled and handcuffed I was transported in the back of a police van.

In Australia, once you are incarcerated you lose your right to free healthcare. This means that there is no funding of access to healthcare for prisoners other than the healthcare funded by the prison. Prison funded healthcare has been found to be inadequate to meet the healthcare needs of prisoners. People who are detained in Australia prisoners often exit with their physical or mental health worse than when they went in.

*Healthcare in Northern Territory Prisons*

85% of adults incarcerated in the Northern Territory are Aboriginal and 95% of our youth who are incarcerated are Aboriginal and while an Aboriginal health care provider is funded to go into youth detention up here a lot of the funding gets eaten up by medications which could be better spent on providing more cognitive assessments for young people if people incarcerated were able to access the pharmaceutical benefits scheme at least.

The other issue I want to put a spotlight on is that women have specific health needs and mental health care needs and if these are not explicitly focused on, they can be forgotten. For example, I have recently been involved in a case where the denial of reproductive justice almost had catastrophic effects on the health especially mental health of a woman and her baby. A woman was set to be forcibly induced two weeks early because of operational requirements of the prison which meant they didn’t have the staff on to facilitate the woman being transported to the hospital when she went into labour naturally. If it wasn’t for me bringing this case to the media, then she would have had the baby taken from her at birth which is exactly what happened just a few months earlier for a young Aboriginal mother in the same facility. Thanks to multiple media outlets reporting on this case the woman was allowed to give birth naturally. if I had not bought this to the media’s attention this could have had catastrophic consequences for both mother and child just as it did have for the other woman who didn’t get the media’s attention.

I have numerous stories about substandard care in prisons, but I will start with something that has stuck in my mind and is the first thought when someone mentions healthcare in prisons. An elder Aboriginal lady who I know came up to me and asked if I could help her fill out a medical form because her tooth was sore. I filled out the form and said it was urgent two weeks later the lady got to go see a doctor who said there is nothing he could do except put her on the list the see the dentist and give her antibiotics. A few days after the doctor’s visit, she came to see me her face was swollen like a balloon and she begged me to punch her in the face to loosen the tooth, later that day there was a code amber (officer needs assistance) they were responding to this elderly Aboriginal lady trying to smash her face into concrete wall to loosen her tooth. She ended up in the at-risk cells. When the lady came back to mainstream, she told me that she had managed to take her own tooth out whilst in the at-risk cells which are under 24-hour surveillance. This is just one story amongst many.

I had a sore shoulder for 15 months whilst in custody and after way too many to count medical forms put in, calls to the health ombudsman and visits to the Dr who told me I need a specialist I was eventually released from prison and I found out I had an appointment at the hospital with a specialist however the day before my appointment less than a week after being released I felt a sharp pain run down my arm and a feeling that I can not put into words except to say it felt like an elastic band had snapped inside my arm. What that was my tendon snapping completely after 15 months of pain and agony. I was told it had been left too long and there were no options available to fix it which has left me with a deformed bicep for the rest of my life.

I am an asthmatic and several times I was told by the medical staff that I was not because I had not told the nurse on reception to the jail, so I was denied my asthma medication for most of my sentence. I am also lactose intolerant and was told by the officers at the front desk that that is not a medical condition because I am not allergic.

I got sick whilst in jail and pressed the emergency intercom to see if I could see a nurse or something. I waited for hours till an officer came down to my cell to tell me there were no nurses on. I begged the officer to call me an ambulance which he said he couldn’t do. The next morning, I saw a nurse who took my temperature which was 39 degrees she immediately arranged for me to go to hospital but again an ambulance was not called instead I was put in the back of a paddy wagon in the cage in pouring rain and driven to the emergency department. Once I arrived, I was immediately admitted to a ward where I had a code blue because my blood pressure had dropped so low. After being in hospital for a few days I thought I could hear my mother’s voice, so I got out of bed (which I was handcuffed to) and tried to walk out to the hallway I saw my mother she was crying and seemed really upset I managed to yell out to her that I was ok and not to worry about a thing. At this point nobody really knew what was wrong with me, but it was important to me that my mother didn’t have to worry about me. I continuously asked if I could call my mum or have a visit with her so that I could ease her mind which was denied. I later found out the only way my mother found out I was in hospital was a friend of mine who was also in jail with me had called her mother and asked her to go to my mother’s house to tell her I was in hospital.

I had almost died yet none of my family had been informed I was even sick despite my mother being my next of kin.

Mental health care is almost non-existent unless you say the words I want to hurt myself, which corrections officers are always on the hunt for if any of us women showed a little bit of emotion it was like a game to corrections officers to get you to say those words and if you did say those words or words to that effect you were placed at risk in a clear Perspex room with no access to a shower and no privacy. Because of the angles of the Perspex, I was able to see in most of the other’s cells in one cell was an older man who was wanking and calling out to me for hours and hours on end. I was told by the corrections officers to just ignore him he does it all the time. This is the standard of mental health care in prison! By the time you get to see a psych who has the power to get you out of the at-risk cells you will say anything at all to get out of the at-risk cells. If you didn’t feel like hurting yourself before you went at risk, you certainly would after spending a little time at risk.

Rocket Bretherton

November 2023

**A Bird’s Eye View – Storytelling by Incarcerated Women in the Darwin Correctional Centre**

A Podcast Produced by Johanna Bell (www.storyProjects.com.au)

Storyteller Rocket Bretherton (and other women prisoners)

This podcast tells the stories of women detained in the Darwin Correctional Centre recorded over two years in 2018 / 2019.

Women with disability such as Rocket Bretherton were storytellers in this podcast.

Over the course of the podcast the women in detention answered three questions:

1. Who Are We Really?
2. How Did We Get Here?
3. Where to Next?

**Link to Podcast**

**birdseyeviewpodcast.net/individualstories**

Justin Walker

Mental Health and Justice Advocate

Darwin Northern Territory

**Forcibly Restrained and Injected with Antipsychotic Medication**

My name is Justin Walker and I am a Martu Man from

I would like to raise the issue of forcible injections of antipsychotic medication on people with mental illness who are detained.

When I didn’t want to take the antipsychotic medication 5 – 10 Correctional Officers came into my cell and physically restrained me so that the nurse can give me the injection. Each time this experience was humiliating and violent.

This circumstance where I was restrained by Correctional Officers in order to have a nurse inject me with an antipsychotic medication lasted for the entirety of my time in detention.

I continue to believe that I do not need this antipsychotic medication via injection however I have been compelled to accept this treatment otherwise I would not have been able to transition from detention under a Northern Territory Custodial Supervision Order in the Darwin Correctional Centre to a Non-Custodial Supervision Order in the community. I have been compelled to accept that I have schizophrenia even though I dispute this diagnosis. I also disagree with the Forensic Mental Health Treating Team that I need this antipsychotic medication to manage my symptoms of my mental illness. At no time has alternative treatment been discussed with me

Over the period of my detention where I have been required to take this antipsychotic medication there have been expert opinions provided by psychiatrists which have disagreed with the diagnosis and the treatment. This advice has not been taken into account by the Forensic Mental Health Team.

The impact of this being forced to take medication against my will is that I feel compromised. If I hadn’t participated in the version of the treatment developed by the Forensic Mental Health Team then I would not have been able to transition out of detention in a maximum security prison. So whilst I do not believe that I have a mental illness and I do not want the treatment I have had to accept the diagnosis and treatment to gain my freedom. I often feel like the Forensic Mental Health Team have been using the antipsychotic medication as a punishment rather than as a therapeutic tool to manage my mental illness

The side effects from being forcibly restrained to be injected with antipsychotic medication for the last eleven years include a lack of libido, an inability to get an erection, and a low sperm count. This leaves me feeling like I will have a relationship and a family. I feel hopeless about my future.

Other side effects resulting from being forcibly restrained and injected with antipsychotics included:

For the last two years of my detention I contracted nystagmus. Nystagmus is a vision condition in which the eyes make repetitive, uncontrolled movements. These movements often result in reduced vision and depth perception and can affect balance and coordination. Nystagmus is debilitating illness that affects your vision and your thinking and can be caused by stress. I often spent a lot of time in my cell because of this condition as I was unable to manage the external environment

I also developed Polydipsia whilst detained - Polydipsia is the medical definition of excessive thirst.. It's a reaction to fluid loss in your body. As a result of contracting this condition I lived in detention with a dry mouth (xerostomia) and the urge to pee often (frequent urination). Again because of the polydipsia I spent a lot of time in my cell.

I believe that being forcibly restrained and injected with an antipsychotic medication whilst detained constitutes cruel inhuman and degrading treatment.

Justin Walker

November 2023

Michael Heatley

Sydney New South Wales

Trapped - Indefinite Detention and Cruel Inhuman and Degrading Treatment in a New South Wales Forensic Mental Health Hospital

Australian Broadcasting Commission Four Corners Report

Monday 16th of October 2023

1. Producer – Alex McDonald
2. Journalist – Alexandra Blucher

**Trapped**

Four Corners reveals allegations of the torture and mistreatment of people living with disabilities and mental illness who are locked up indefinitely by the state.

Around Australia 700 people who have been charged, but not convicted, of crimes are being detained in the forensic system

In some of the most extreme cases, they have been locked up for years in solitary confinement with no release date

Some have been determined as too great a risk to live in the community because of their history of violence and complex behaviour.

The United Nations has condemned this treatment, and along with the Disability Royal Commission has called for an end to their indefinite detention.

Reporter Alexandra Blucher has gained unprecedented access to forensic patients and their families. In this program she enters a facility to speak to one man who has spent more than two decades in custody.

He remains indefinitely detained

The program also features another patient who’s spent more than eleven years in a high-security unit with only a caged outdoor area, sometimes pitching a tent to obscure himself from the constant CCTV surveillance.

Blucher exposes the extent of the harm that can be done by forcing them to live in these conditions – in some cases making them more dangerous

“Trapped” is an unflinching portrait of the forensic detention system and the dilemma we face in balancing the safety of the community and the basis human rights of people living with a disability

You Tube link: <https://www.youtube.com/watch?v=976Hz3hUfIM&t=44s>

**Malcolm Morton – Proud Arrente Man**

**Alice Springs Northern Territory**

**A Culturally Informed Model of Disability Support to Reduce Vulnerability to Cruel Inhuman and Degrading Treatment**

Malcolm Morton has been indefinitely detained in the Northern Territory Youth Detention, the Alice Springs Correctional Centre and the Forensic Disability Unit and since 2007.

Malcolm endured cruel inhuman and degrading treatment for the entirety of his indefinite detention. However, with the employment of Arrente men from his community by My Voice (NDIS Provider), who converse with him in Pitjantjatjara and use cultural authority and Arrente cultural protocols to support Malcolm when he is anxious and agitated, Malcolm’s risk of harm to self and others has dramatically reduced.

During Malcolm’s indefinite detention Malcolm was subjected to cruel degrading and inhuman treatment in three different closed environments:

1. In youth detention Malcolm was detained in solitary confinement for 233 days over a two-year period between 2007 and 2009
2. In the Alice Springs Correctional Centre, when Malcolm would bang is head in distress or when agitated, he would be forcibly restrained by Correctional Staff, tied down in a restraint chair and under medical supervision injected with a tranquiliser until he was unconscious upon which he would be returned to his cell unconscious. This set of circumstances occurred seventeen times between 2012 and 2015.
3. In the Alice Springs Forensic Detention Unit, Malcolm was subjected to a powerful anti-psychotic medication after it was concluded that he was suffering from Obsessive Compulsive Disorder (OCD). This conclusion by FDU staff occurred without a formal diagnosis and without consultation with guardians, family, My Voice (National Disability Insurance Scheme) Support Provider and resulted in Malcolm being subjected to chemical restraint. As a result Malcolm experienced serious side for over three months which was hidden from the guardian and the family by the FDU,including being hospitalised four times in three weeks, suffering serious epilepsy seizures, aggressive behaviour and sleeping for abnormally long periods.

The model of support that Malcolm is now receiving from My Voice seeks to take its direction from the person with a disability and use cultural safety in its operation. The model:

1. Employs Arrente men and women who speak the community language
2. Employs Arrente men and women with cultural authority
3. Employs Arrente men and women who can frame the provision of disability support using Arrente cultural protocols

In the six months since this culturally informed model of support was introduced there has been a dramatic reduction in Malcolm’s risk behaviours which in turn has seen his ability to live with dignity and free of violence

Dr Birgden Forensic Psychologist reports that in the last six months

* Overall incidents have decreased from 98 incidents to 46 incidents to 24 incidents
* There have been only 3 incidents of physical aggression (2% of all incidents)
* There have only been 2 incidents of severe head banging
* There have only been 7 incidents of severe verbal threats
* Mild verbal aggression has decreased from 20 incidents to 13 incidents to 3 incidents
* Threats to head bang reduced from 15 incidents in July 2023 to 4 incidents in August 2023

With the introduction of culturally framed disability support Malcolm became happier. He was able to converse with members of his community in his primary language using the cultural protocols with which he grew up. This was important as the Arrente men could identify earlier the no-verbal cues that Malcolm was anxious or frustrated. This allowed the Arrente disability support workers to intervene and communicate with Malcolm much earlier in the psychological and emotional process that could lead to an escalation of behaviors that may involve harm to self or others. This happier cultural dynamic becomes central to preventing cruel inhuman and degrading treatment.

Patrick McGee

Guardian for Malcolm Morton

Addressing the determinants and pathways into prison for people with disability

**Professor Emerita Eileen Baldry and Associate Professor Ruth McCausland**

**University of New South Wales**

The “social determinants of health” framework ie that social factors, such as poverty, access to education, where you live and whether you face discrimination, have a huge influence on health and life expectancy, has revolutionized the way public health policy is conceived. These determinants explain why worse health outcomes persist for some groups of people, despite advances in medical care.

McCausland & Baldry (2023) explored social determinants in relation to incarceration. They quantified what social factors increase a person’s chance of ending up in prison, and propose using that to improve policy and reduce the harms and costs of incarceration. While crime rates are decreasing and governments have committed to reducing reoffending, the incarceration rates of certain groups of people remain shamefully high. These groups include Indigenous people, those with mental and cognitive disability, and people experiencing addiction and homelessness, with the majority of people ending up in prison being across at least 3 of these groups

Studies of a linked and merged data from government agencies: NSW police, courts, corrections, and health and human services agencies such as housing and child protection containing information on 2,731 people who have been incarcerated in NSW, were analysed. The data is longitudinal, providing visibility of the contact people had with services and institutions over time from early in life, including interventions by child protection services and police, admissions to hospital and time spent in custody.

Eight factors were identified as “social determinants of justice”, with the evidence showing that a person’s chance of ending up in prison is greatly increased by:

* having been in out of home (foster) care
* receiving a poor school education
* being Indigenous
* having early contact with police
* having unsupported mental health and cognitive disability
* problematic alcohol and other drug use
* experiencing homelessness or unstable housing
* coming from or living in a disadvantaged location

Most importantly, the more of these factors a person experiences, the more likely they are to be incarcerated and reincarcerated.

There are also structural factors at play. For example, a person with cognitive disability who grew up in a middle class family with access to early support is very unlikely to go to prison, even if they are involved in offending.

They have greater access to social advantages than, say, an Aboriginal person with cognitive disability from a remote town that has many police officers but few social services. Government data provide evidence of how many people end up in youth and adult detention after child protection, education, disability and health services fail them. Broader system and policy changes are required to reduce the unacceptable social and economic costs of incarceration of Indigenous people and people with disability who are vulnerable to criminalization because they experience many or all of the negative social determinants of justice.

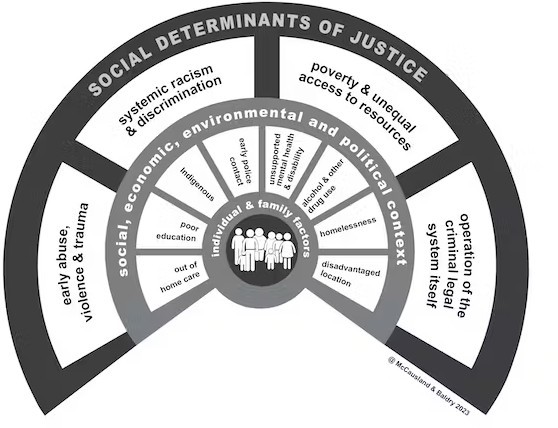
So, McCausland and Baldry further developed the concept of the social determinants of justice to identify the “causes of the causes” of who goes to prison. These are:

entrenchment of poverty and unequal access to resources in families and neighbourhoods

structural racism and discrimination, particularly as experienced by Aboriginal and Torres Strait Islander communities and people with disability

failure to adequately respond to the abuse, violence and trauma experienced by so many children and young people

the operation of the criminal legal system itself in the way that it is criminogenic; that is, it increases rather than reduces the likelihood of future incarceration.



*The social determinants of justice. McCausland & Baldry, 2023*

The social determinants of justice (the structural factors) show up in the over-surveillance of certain communities, lack of access to well-resourced legal representation, not being granted diversionary options and bail, and limited specialist services and support.

To really make a difference to one of the most pressing policy challenges in Australia, the shamefully high rates of incarceration of Indigenous people and those with disability and mental health issues, efforts and resources must focus on addressing these social determinants.

Focusing on individual behaviour and the roll out individual behaviour-change programs in prisons and on what police are doing or what happens to people in court, though important, are not going to disrupt the pathways of disadvantaged and marginalized people into prison.

Government agencies and non-government organisations must be held accountable to ensure that poor and disadvantaged people and communities are getting the services and support they need to prevent criminalisation. For example, the social determinants of justice could: inform policy to ensure police are not the frontline service for people with disability in crisis; lead to changed government procurement processes that recognise the value of Aboriginal community-controlled organisations providing culturally led support; guide a holistic case management model for people at risk of contact with the criminal legal system.; and inform a whole-of-government approach to enabling people to thrive in their communities instead of wasting lives and billions of dollars through incarceration.

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McCausland, R. & Baldry, E. 2023 Who Does Australia Lock Up? The Social Determinants of Justice. *International Journal for Crime, Justice and Social Democracy* doi: 10.5204/ijcjsd.2504 https://[www.crimejusticejournal.com/article/view/2504](http://www.crimejusticejournal.com/article/view/2504)

**Mr George Newhouse - The National Justice Project George Newhouse Principal Solicitor**

**Witness Statement to the Disability Royal Commission**

**(Parts of this Witness Statement have been redacted to protect the confidentiality of others)**

**Name:** Adjunct Professor George Newhouse

**Address:** National Justice Project University of Technology Sydney CB01.17, Building 1 Broadway NSW 2007

**Occupation:** Director and CEO of the National Justice Project

**Date:** 9th September 2022

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.
2. I make this statement on behalf of National Justice Project and I am authorised

to do so.

1. This statement is true and correct to the best of my knowledge and belief.

## Professional background

1. I am currently the Director and CEO of the National Justice Project (NJP). I cofounded the NJP in 2016 with Dan Mori and Duncan Fine.
2. I am an Adjunct Professor of Law at Macquarie University, where I lecture in law

at the NJP Social Justice Clinic and an Adjunct Professor of Law at the University of Technology, Sydney.

1. A copy of my curriculum vitae has been provided to the Royal Comission with document identification number

## National Justice Project

1. The National Justice Project is a not-for-profit human rights legal service. Our mission is to fight for justice, fairness and inclusivity by eradicating systemic discrimination.
2. Our key areas of activity include:
   * health justice, specifically for persons with disability and First Nations communities
   * challenging police misconduct
   * prisons and youth services
   * seeking justice for asylum seekers and refugees.
3. The NJP currently has 9 solicitors working on 75 active matters relating to justice settings (including correctional and policing), with 26 currently in Court.
4. My statement is informed by the clients NJP represent in prisons and youth detention facilities and the observations of myself and other staff at NJP in these settings, from evidence provided in open court or in inquiries and inquests, and from expert reports obtained on behalf of my clients regarding these settings. My team and I have worked closely with families and communities impacted by these systems over the past ten years.
5. My team and I are also involved in many partnerships, projects and alliances with advocates and sector stakeholders with whom we work collaboratively to advance much needed changes in the treatment of, and harm-minimisation for, people held in detention facilities.
6. This statement is limited to a number of key issues that have arisen in NJP cases and NJP’s observations of conditions in custody for people with disability. NJP have concerns about conditions in custody beyond these key issues, however, these are priority areas which we have chosen to focus on.

13. These issues should be viewed in context. Contrary to the recommendations of the Royal Commission into Aboriginal Deaths in Custody, we observe that police often do not attempt to divert vulnerable individuals away from the justice system. Rather, we see individuals who should be receiving a health response being funnelled into the custodial system. We attribute the criminalisation of people with disability to police culture and a lack of hospital beds, diversion programmes and disability support services.

## Acknowledgment of First Nations Peoples’ custodianship

14. The National Justice Project pays its respects to First Nations Elders past and present, and extends that respect to all First Nations peoples throughout this country. The NJP acknowledges the diversity of First Nations cultures and communities and recognises First Nations Peoples as the traditional and ongoing custodians of the lands and waters on which we work and live.

## Definitions of disability in custodial settings

15. I have observed that many custodial environments do not consider psychosocial disability as a disability. For example, Corrective Services NSW limits State-wide

Disability Services (SDS) to inmates with one or more of the following disabilities:

* intellectual disability or borderline intellectual functioning
* acquired brain injury (including traumatic brain injury and alcohol/drug related brain injury)
* autism spectrum disorder
* dementia
* sensory disability (hearing or vision impairment)
* physical disability

•frail aged. [[1]](#footnote-1)

1. NJP considers that this definition is too narrow, resulting in many prisoners with neuro-psychological disorders and psychosocial disabilities not being able to access SDS.
2. The NSW Department of Health uses the term ‘psychosocial disability’ to describe ‘a disability that may arise from a mental health issue’. They say that:

Psychosocial disability is not about a diagnosis, it is about the functional impact and barriers which may be faced by someone living with a mental health condition. A psychosocial disability arises when someone with a mental health condition interacts with a social environment that presents barriers to their equality with others.

Psychosocial disability may restrict a person’s ability to:

* + be in certain types of environments
  + concentrate
  + have enough stamina to complete tasks
  + cope with time pressures and multiple tasks
  + interact with others
  + understand constructive feedback
  + manage stress.

Someone with a psychosocial disability may require support to overcome the barriers to social inclusion they face.

Past experiences of trauma are common for people with psychosocial disability. It is important to be sensitive to the possible impacts of trauma, which may be lifelong, when providing support.[[2]](#footnote-2)

18. SDS is a multidisciplinary team within the Specific Needs cluster, Corrective Services NSW, that ‘addresses the additional support needs of offenders with disability. The SDS assists all offenders with disability whether in custody or in the community.’[[3]](#footnote-3) NJP is of the view that while psychosocial disability is excluded from its definition of disability, the SDS is not delivering on the aims of this policy. In fact, it is my belief that it does not achieve its aims for those who do fall within its remit.

## People with disability should be diverted from the criminal justice system

19. It is NJP’s experience that many people with disability end up being sentenced to imprisonment as a result of behaviours that are related to their disability and/or impairment. For example, an individual with a disordered mind is liable to be charged with disorderly conduct and criminalised by police.

## Powers which enable violence, abuse, neglect and exploitation of people with disability in custodial settings

20. NJP has observed how the legislative powers granted to prison and detention officials under the prison acts and regulations and young offender laws and regulations have the potential to, and often do lead to, abusive situations for people with disability. A particular example is confinement of children in youth detention for the ‘good government, order and security’ of a detention centre in Western Australia.

21. Often children with neuropsychological conditions, FASD, or a psychosocial disability have their particular condition or disability treated as a breach of order, or of the good governance of the centre. This issue is summarised by the

Western Australian Office of the Inspector of Custodial Services as follows:

Confinement as a consequence for a detention offence can be ordered for up to 24 hours by a Superintendent or up to 48 hours by a Visiting Justice. Under this confinement regime, a detainee is entitled to fresh air, exercise, and staff company for a minimum of 30 minutes every three hours during the unlock period. Confinement for the purposes of ensuring the good government, order and security of a detention centre can be ordered by the Superintendent for up to 24 hours. If the confinement exceeds 12 hours, the detainee is entitled to at least one hour of exercise every six hours during unlock hours. A typical day regime includes 11.25 hours of possible unlock time, which the Department claims makes an hour out of cell the minimum legislative requirement. Under both scenarios, the detainee may be confined in their sleeping quarters or to a designated room. Regulation 76 requires a room being used for confinement to be appropriate in size, well ventilated, and lit to ensure the wellbeing of the young person.

YOA and SO9a inconsistent with international treaties. The provision of one hour of exercise and fresh air for detainees in confinement or segregation is contrary to the United Nations Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules), which requires at least two hours of out of cell time in a 24-hour period (UNODC, 2015). These standards are also made applicable to youth detainees under Rule 27 of the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules) (UNODC, 1985). Rule 67 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules) also expressly prohibits cruel, inhuman or degrading disciplinary treatments including closed or solitary confinement (UNODC, 1990). While Australia supports the Mandela Rules, they have not been enshrined in legislation in Western Australia and are therefore not legally enforceable. Despite this, they provide clear moral guidelines for the treatment of prisoners and detainees in custodial settings.[[4]](#footnote-4)

1. NJP is currently representing young people who have been detained at the Banksia Hill Youth Detention Centre (**BHDC**) in Western Australia who have been subjected to the segregation regime which the *Young Offenders Act 1994* (WA) (**YOA**) and *Young Offenders Regulations 1995* (WA) (**Regulations**) provide for. NJP consider these provisions harsh and unlawful. This view has recently been confirmed in the decision of *VYZ by next friend XYZ v Chief Executive Officer of The Department of Justice* [2022] WASC 274.[[5]](#footnote-5)
2. Following the decision referred to in [22] above, the Aboriginal Legal Service of Western Australia (**ALSWA**)released a media report setting out 25 recommendations relating to this judgement. A copy of this media release is annexed hereto and marked ‘A’.[[6]](#footnote-6) NJP strongly supports the recommendations made by ALSWA.
3. ‘Safe cells’ in prisons and youth detention centres are not suitable environments for people with disabilities or for those having acute mental health episodes. They are a form of punishment. Over many years of dealing with detainees in immigration and youth detention and in prison, we have been told by clients that inmates will often attempt to hide their deteriorating mental health conditions so they won’t be put in isolation or in a CCTV cell by prison or detention centre officers. This is not a therapeutic solution. In our experience, most inmates believe that they are simply provided with sedatives and freed as soon as they no longer express suicidal or self-harming ideation.
4. As a consequence, we observe that detainees and prisoners usually leave prison or detention with worse mental health than they went in with. This causes families immense anxiety and grief. Though family members are normally good barometers of need, we have observed that they are not consulted where children are involved and often when they attempt to get help for a relative, there

are no effective pathways for the information to be passed on to clinicians, and operational staff appear to ignore them.

1. Prisons and detention centres are unsafe for people with disability. NJP represents families of people who have died in custodial settings. Appearing in these cases has informed my opinion that prisons and detention centres must be reformed to create safe places for people with disabilities.
2. People with disability in prison are vulnerable to bullying and harassment by other prisoners or prison staff. Because of the brutality of the regime used to control prisoners, prisons have a social order that sees the strongest and most violent take control over those more vulnerable than them. This involves use of bullying, harassment, psychological or emotional manipulation and violence.

## Intake and assessment

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## Rehabilitation and reintegration

1. NJP has represented clients in custodial settings across Australia, and has observed generally that these facilities have a command-and-control structure. The custodial settings we have observed tend to be understaffed and underresourced.
2. WA Corrective Services’ stated mission is to work to ensure the safety and security of detainees, prisoner and offenders, the safety of its people and the rehabilitation of those in its responsibility, including for First Nations people.[[7]](#footnote-7)
3. Corrective Services NSW website states:

Corrective Services NSW runs the state’s correctional centres, supervises offenders in the community, and delivers programs to reduce reoffending, support reintegration and build safer communities.[[8]](#footnote-8)

1. NJP has observed little evidence of the rehabilitative and reintegration functions in practice. NJP has observed that there is an extreme power imbalance between guards, prisoners and detainees which creates a risk of abuse to prisoners and children. For prisoners or children with a disability, the risks are greater, as they are vulnerable to violence and abuse from both guards and other inmates.
2. The NJP is of the view that in order to fulfil rehabilitative and reintegrative goals, prisons and detention centres must adopt a person-centred approach to services that considers and centres on the needs of the individual. We are also of the view that this cannot practically occur unless health, welfare and disability services are separate and independent of corrections. NJP considers that healthcare and disability workers cannot advocate effectively for their patients when they are part of the corrections system.
3. Meaningful change will require significant cultural change because, from my observations and issues arising in my casework, detention centres and prisons are focused on protecting the institution and those who are employed by it, not those in their care and custody.
4. On the basis of our experience in over a dozen death in custody cases where poor health care was a factor, it is clear that access to care is not equitable. Clinicians and nurses have limited time to see patients and the demand is so great that there is enormous discretion in terms of who they treat and when and how much care/therapy or treatment a detainee or prisoner receives.
5. The level of care received in carceral situations varies greatly and that means that the treatment of a detainee or prisoner does too. NJP is of the view that the bias or prejudice of individual guards and clinicians has a role to play in the inconsistent level of care received, and that this inequitable situation requires urgent attention.

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1. Health services are not provided on a first-come/first-served basis, which gives rise to the risk that more difficult personalities may be under-triaged, underserviced or refused service. In my experience, clients with psychosocial conditions are not provided with a standard of care that allows them to participate and function at a level equal to those that do not experience these conditions.
2. Sometime in 2017, representatives of the NJP met with representatives from PIAC, NSW Legal Aid and the Heath Care Complaints Commission (**HCCC**) to raise our concerns about the lack of medical care and supports provided to prisoners in NSW. During that discussion I heard that around 66% of HCCC complaints at that time came from prisoners. Although I knew about the dire circumstances of care in custodial settings, I was shocked by that figure. I believe that one of the reasons for the high reporting rate was that a direct telephone line to the HCCC was available in NSW Prisons at that time and prisoners had meaningful access to a complaint mechanism.

### ***Lack of therapeutic care and throughcare in custodial settings***

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## Access to programs, including education, for people with disability in custody

43. The NJP is aware that programs and courses for prisoners and youth detainees are often limited and have been particularly impacted by the impact of COVID-19 restrictions. The NJP has observed that for prisoners and youth detainees with disabilities, options are further limited by their lack of accessibility and the way in

which isolation and confinement regimes are regularly used to ‘manage’ people with disabilities

44. The following extract from the Aboriginal Justice Agreement raises important issues about the delivery of programmes to individuals in a custodial environment and NJP endorse it. Similar observations can be made about the programmes provided to people with disabilities:

A consistent issue raised during the consultations for the AJA is that the NT prison system does not do enough to rehabilitate Aboriginal offenders. While programs are provided in NT correctional centres, views were expressed that the programs are not culturally appropriate and do not overcome communication barriers. Many prisoners have explained that interpreters are rarely used in prison programs leading to limited comprehension and engagement, and an over-reliance on prisoners with stronger literacy skills. These barriers make it difficult to clearly identify the factors that have led to offending and reoffending, and leave the complex needs of Aboriginal offenders unaddressed.

Limited access to programs while on remand or serving short sentences, and a lack of tailored programs for Aboriginal women was raised repeatedly. The Aboriginal Justice Unit heard that vocational training programs could be better tailored to the type of employment opportunities that are available on release.

The number of all prisoners from all cultural groups has been steadily increasing in the NT. About 84 per cent of prisoners in the NT are Aboriginal. Aboriginal people are more likely to return to prison after their release than non-Aboriginal people. Between 2013–2018, about 60 per cent of Aboriginal people returned to prison within two years of their release. For non-Aboriginal people, the return rate was about 25 per cent over the same period.

Reducing recidivism by Aboriginal people requires culturally safe programs that are tailored to the needs of Aboriginal people and that prioritise the use of interpreters. The AJA has recommended that correctional programs be based on best practice

approaches and delivered by professionals and organisations with high cultural competence and demonstrated experience of working with Aboriginal Territorians.[[9]](#footnote-9)

## Recommendations

45. The NJP makes the following recommendations to improve the conditions in custody for people with disability:

### ***i. Overarching recommendations***

1. All prisons and youth detention centres adopt a definition of disability that is inclusive of psychosocial disabilities.
2. All prisoners and detainees should be able to access Medicare and the National Disability Insurance Scheme (**NDIS**) in prison.
3. Prisons and youth detention centres must create safe places for people with disability to live and have their health, social, cultural and emotional needs met. This is easy to say but harder to implement. The criteria should be specified by a panel of experts but could include the following requirements:
   1. Individuals need to be properly assessed and diverted from carceral environments wherever possible.
   2. Individuals need to be housed in an environment free from prisoner and guard violence and abuse.
   3. Individuals should have a case worker similar to the NDIS system who would coordinate their care - which must include receive one on one therapy or support (if required).
   4. Individuals should receive education and programmes to support their needs, to assist them to find work after release and to obtain parole.
4. Medical care should be provided by an Aboriginal Medical Service for First Nations prisoners and from an independent service provider who is able to advocate for their patient and whose services could be coordinated by the case worker referred to above.
5. Assessment and support for disabled prisoners should be provided by a recognised disability support service independent from the departments of corrective services who can advocate for their client/patient and whose services could be coordinated by the case worker referred to above.

### ***ii. Diversion***

49. People with disabilities, including those with psychosocial disabilities, should not be criminalised because of behaviour associated with their disability, but rather be diverted from prison. This requires investment in legal support, advocacy and disability support services.

### ***iii. Independent provision of disability support and health care, including culturally safe services***

1. Responses to medical or disability needs should not be decided by or controlled by prison guards.
2. There must be separate and independent provision of health care, welfare and disability services in prisons and youth detention settings, with a reporting structure that is separate to the custodial chain of command and whose performance should be measured by the real improvements they achieve to the health, welfare and education of those in their care.
3. Disability or health care advocates should be available to assist any prisoner or detainee to help them to secure appropriate care or support.
4. Independent disability service providers should be funded to provide services inside prisons. Ideally, the same service would provide post release support so there is consistency of care.
5. First Nations medical services and disability specialists should be able to provide care to individuals in prison or youth detention, and they should be covered by the NDIS.
6. First Nations medical services should be funded to provide all forms of health care to First Nations prisoners and detainees.

### ***iv. Disability and mental health assessments and throughcare***

1. Neuropsychological reviews of prisoners/detainees should be undertaken by independent organisations such as the Telethon Foundation, which should also create, review, and update prisoner/detainee disability or mental health plans.
2. Prisons and youth detention centres should implement ongoing and longitudinal assessments of detainee health and support needs. Care models must move away from episodic, ad hoc care and towards a throughcare ‘holistic’ model.
3. Support plans for people with disabilities and serious medical conditions must be developed, implemented in custody and regularly reviewed by an independent panel of clinicians and doctors to ensure that services and care is being provided and that progress is being made.

### ***v. Use of restrictive practices***

59. Solitary confinement, particularly of children and people with health and mental health conditions, must be limited to extreme circumstances and regulated closely to avoid unnecessary violations of rights and harmful consequences. Solitary confinement is an extreme measure that should mandate an intensive team-based response by those in control of the inmate. Instead of perpetuating a revolving door of sickness, any form of confinement for the welfare of the inmate or the good order of the centre should ring an alarm bell that demands a wellresourced response led by health professionals. That would stop the overuse of confinement without therapeutic intervention.

### ***vi. Transition planning***

1. Support plans for post-release must be developed at least 6 months prior to an individual’s release with disability and prisoner support service providers. These plans could also be provided to the Parole Board.
2. A committee made up of representatives from prisoners, prisoner advocacy groups, parole boards, the Australian Medical Association, Aboriginal medical services, disability advocacy groups and custodial centre administration should be established to set up appropriate programmes and disability supports for inmates and young people who are detained.
3. Meaningful programs must be developed, with input from prisoners and the parole board, to prepare inmates for parole and release.

### ***vii. Oversight***

1. A medical abuse and complaint hotline should be established in prisons. The hotline must not be monitored by guards and should be staffed by independent professionals.
2. The requirement for prison, health or disability complaints to be in writing must be removed.
3. There must be mandatory CCTV coverage, with audio recording, of all public areas of prisons and youth detention centres.
4. The must be mandatory body camera recordings with audio of all interactions with inmates and youth detainees.
5. There must be mandated retention of CCTV footage inside custodial settings for five years.
6. Cameras in prisons and youth detention centres should be independently checked on a monthly basis to ensure clear vision and operability.
7. Live CCTV footage feeds should be accessible to the independent oversight body and the state/territory department of justice at any time to enable independent oversight at all times.
8. Independent inspectors experienced in health care and disability should be permitted to access people detained in prisons and youth detention centres, without notice, during normal operational hours. They should report to an independent body.
9. There must be safe and accessible complaint mechanism available in places of detention to escalate issues of concern to the individual quickly without ramifications for reporting.
10. There should be a medical/disability ombudsman or independent medical/disability review panel to monitor complaints of chronic, unmet health or disability need.
11. There should be mandatory reporting of assaults, brutality and cruelty by corrections staff and third parties who attend prisons.
12. Optional Protocol to the Convention Against Torture (**OPCAT**) inspections must be permitted.
13. The recommendations of the OPCAT and of independent prison/youth detention centre inspectors must be acted on.

76. An independent medical oversight committee should be established in each jurisdiction to review the treatment of prisoners and detainees. Such a committee was recommended by the Palmer Inquiry into the immigration detention of

Cornelia Rau.[[10]](#footnote-10)

Signed:



Date: 9/9/22

**The Interaction of Capacity with Unfitness to Plead in the Context of Indefinite Detention for People with Cognitive Impairments and Mental Health Disorders**

**Submission by Trevor Moses for Australians for Disability and Justice**

**Contributions from:**

**Patrick McGee – Executive Director Australians for Disability and Justice**

**Dr Piers Gooding – Senior Research Fellow with University of Melbourne Law School**

**Associate Professor Linda Steele - Faculty of Law, University of Technology Sydney**

1. **INTRODUCTION**
2. This submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (**DRC**) is filed by Australians for Disability and Justice and is directed to issues arising during public hearings 11 and 18.
3. Australians for Disability and Justice is a national informal network advocating for the dismantling and replacing of indefinite detention of people with cognitive impairments and mental health disorders who are mentally impaired and unfit to plead.
4. The objective of this submission is to seek to persuade the DRC to make the following recommendations:
   1. That all Australian governments should immediately abolish regimes for the indefinite detention of persons who are unfit to stand trial or not guilty by reason of mental impairment.
   2. That all Australian governments should immediately move to adopt regimes for supported capacity in criminal trials.
5. **CONTEXT**
6. This submission is oriented in the following context.

**The practical realities of criminal justice for persons with disability who are found to lack capacity**

1. Persons with disability (**PWD**) are disproportionately overrepresented within the criminal justice system in Australia.[[11]](#footnote-11)
2. Indigenous Australians are also overrepresented, both within the general prisoner cohort and within the class of prisoners who are PWD.[[12]](#footnote-12)
3. Furthermore, Indigenous PWD are disproportionately overrepresented within the criminal justice system in Australia. This is a function of the greater likelihood of indigenous people having and living with a disability, and elevated indigenous incarceration rates.
4. There is a substantial body of research to the effect that the experience of custodial episodes for PWD is appreciably worse than that of the general prisoner population, and that PWD are especially vulnerable to discrimination, bullying and abuse in custody, and less likely to enjoy privileges and earned freedoms, such as employment opportunities and lower-security accommodations.[[13]](#footnote-13) This research accords with the anecdotal experience of Australians for Disability and Justice.
5. There is long-standing recognition, since at least the Royal Commission into Aboriginal Deaths in Custody, that Indigenous prisoners experience discrimination in custody and that the experience of Aboriginals in custody is often worse than that of the general prisoner population. Indigenous PWD are especially vulnerable as they fall within two classes of vulnerability.
6. Against that context, each Australian government has a modified legislative regime for dealing with PWD who are found to lack capacity:
   1. at the point of offending – not guilty by reason of mental impairment; and
   2. at the point of trial – unfitness to plead.
7. Each regime is quite different in its approach. The label ‘alternative justice regimes for PWD’ captures the essence of these regimes as an alternative or modified set of rules governing how the criminal justice systems applies in relation to PWD.

**The function of the DRC in relation to alternative justice regimes for PWD**

1. Although alternative justice regimes for PWD are not necessary,[[14]](#footnote-14) this submission proceeds from a pragmatic assessment that such regimes will be a feature of the legal landscape in Australia for the foreseeable future and, on that premise, looks to what the DRC should say to guide the terms and structure of these regimes.
2. The Governments of Australia will look to the DRC for guidance on this issue. As was noted by the DRC during the course of public hearings, the governments of Australia have stated or shown a willingness to consider legislative reform. The relatively recent commencement in New South Wales of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) and enactment of the *Criminal Law (Mental Impairment) Bill 2022* (WA) are two examples of recent reform. The NSW legislation was enacted in response to reforms recommended by the NSW Law Reform Commission. Other States and Territories will look to the DRC for its guidance as to the suitability of these laws, and their own.
3. Relatedly, what the DRC does not say may be as important and what it does say. If the DRC is silent on the content and structure of these laws that may be interpreted as endorsement of the *status quo*. Thus, the DRC has both an opportunity and an imperative to address this issue.

**System parameters v funding and practical implementation**

1. Any system of justice is only as good as its funding and practical implementation allow. Australians for Disability and Justice anticipates that much of what the DRC will comment on in this regard will concern the practical implementation of alternative justice regimes for PWD including issues around how PWD are treated in custody.
2. Historically and contemporaneously, healthcare, educational and rehabilitative components of the Australian justice system have been under-resourced.[[15]](#footnote-15) This impacts on the services available to all prisoners, but impacts especially on PWD because of their criminogenic needs, and for reasons which are developed below.
3. During public hearing 11, two indefinite detention case studies were presented under, respectively, the Northern Territory and New South Wales legislative regimes. The two case studies were used to examine, relevantly, the practical realities of the custody of PWD under those regimes by reference to standards of accommodation, treatment, care arrangements, access to services, lifestyle and relationships. Those confronting and “distressing”[[16]](#footnote-16) realities are, in the opinion of Australians for Disability and Justice, broadly indicative of the experience of many PWD in custody.
4. This submission proceeds from a pragmatic recognition that, although proper resourcing in the areas of custodial and non-custodial healthcare, education and rehabilitative services for PWD should be a top priority, this goal poses a significant challenge for all Australian governments, and accordingly legislative system design cannot assume a standard of adequate resourcing.
5. **CASE STUDY: THE ALTERNATIVE JUSTICE REGIME FOR PWD IN THE NORTHERN TERRITORY**
6. It is convenient to relate this submission to a concrete statutory context, recognising that each Australian government has adopted a different approach. This submission adopts the Northern Territory for that purpose.
7. Since 20 December 2006 in the Northern Territory PWD who are charged with serious criminal offences have been subject to the alternative justice regime in Part IIA of Sch 1 to the *Criminal Code Act 1983* (**Part IIA**). A summary of the scheme under Part IIA is as follows.
8. There is a presumption of competency and capacity. However, a person who is unable to understand the nature of the charge, unable to plead to the charge, unable to understand the nature of the trial, follow the course of the proceedings, understand the substantial effect of any evidence, or give instructions; is deemed unfit to stand trial. These statutory requirements for fitness to stand trial largely reflect the common law.[[17]](#footnote-17) They are applied in a “reasonable and common sense fashion”[[18]](#footnote-18) and in such a way that they are “not … very difficult to meet”.[[19]](#footnote-19)
9. Capacity in the context of fitness to stand trial may be raised and proved by either the prosecution or the accused. And the court on its own initiative may raise the issue. Consequently, incapacity may be alleged and established in circumstances where it is disputed by the accused.
10. Where it arises, capacity is a question of fact to be determined by the jury (in the Northern Territory there are no judge alone trials). It is to be determined on the balance of probabilities after hearing evidence and submissions. The court may call evidence on its own initiative and require an accused person submit to psychiatric examination. In practical terms, a dispute as to fitness is typically a dispute between expert witnesses opining whether or not an accused can meet the statutory requirements.
11. Where an accused is found unfit to stand trial,[[20]](#footnote-20) the court must then conduct a ‘special hearing’ to determine whether or not the accused is guilty of the offence. Assuming a finding of guilt at a special hearing, the court then has a discretion whether or not to release the defendant unconditionally or to order they become liable to supervision.
12. Separately to the question of capacity at the point of trial, there is also a defence of mental impairment which if established (and assuming the offence is otherwise proved beyond a reasonable doubt) results in a finding of not guilty because of mental impairment. This defence is determined separately from other issues in the trial.
13. The ‘defence’ may be raised and proved by either the prosecution or the accused. The court may on its own initiative raise the defence. Consequently, the defence may be alleged and proved in circumstances where it is disputed by the accused.
14. Where an accused is found not guilty by reason of mental impairment, the court then has a discretion whether or not to release the defendant unconditionally or to order they become liable to supervision.
15. A defendant who becomes liable to supervision by reason of either process may be subject to a custodial supervision order in a prison or another appropriate place, or a non-custodial order where they are supervised in the community. A custodial order must not be made unless the court is satisfied that there is no practicable alternative.
16. Once made, supervision orders, including custodial supervision orders, are indefinite but may be varied or revoked, and must be reviewed periodically. On review, a custodial supervision order is to be varied to a non-custodial supervision order unless the court is satisfied that the safety of the supervised person or the public will or is likely to be seriously at risk if the supervised person is released.
17. When a supervision order is made, the court also fixes a major review term corresponding to the notional head sentence the PWD would have received if they had been sentenced by the ordinary processes of the criminal law for the offence(s). Where that would be life imprisonment, the major review period corresponds to the non-parole period that would have been imposed. Within three to six months before expiry of the major review period the court must review whether to release the PWD from the supervision order. At a major review, unless the court is satisfied that the safety of the supervised person or the public will or is likely to be seriously at risk if the supervised person is released, the court must release the person unconditionally.
18. The principled basis on which Part IIA is to be applied is that restrictions on freedom and autonomy are to be kept to the minimum that is consistent with maintaining and protecting the safety of the community. The court cannot release a PWD from custody conditionally or otherwise or significantly reduce their supervision without obtaining and considering at least two expert reports and giving reasonable notice to victims and next of kin.
19. Two features of the regime warrant further comment in the context of this submission. *First*, when assessing fitness for trial, Part IIA does not expressly allow for modification or adjustment of the ordinary trial procedures to accommodate PWD. To give concrete examples, this means that it is unclear whether or not the court should assess capacity on the premise of a support person being available to the PWD or the court taking more frequent adjournments or whether capacity is assessed by reference to the ordinary trial procedures[[21]](#footnote-21). Arguably, as it is open to the court to control a number of aspects of its own procedure including when and where it sits and the physical layout and movement of persons within the courtroom, it is open to the Court to consider capacity by reference to reasonable accommodations, at least where they are not prohibited and within the existing powers of the Court. For Part IIA, this includes the inherent powers of a superior court.
20. This aspect of Part IIA may be contrasted with the position under the *Criminal Law (Mental Impairment) Bill 2022* (WA). Clauses 14, 29(5) and 32 of that Bill expressly authorise the adoption of reasonable adjustments and their consideration in the assessment of capacity. The position may be further contrasted with the requirement under s 44(5(a) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* for the Court to consider whether the trial process can be modified, or assistance provided, to facilitate the PWD’s understanding and effective participation in the trial.
21. There are a range of possible supports for persons with cognitive disabilities that can improve courtroom accessibility; these are available under existing law, though they appear presently to be applied in an ad hoc manner (as discussed below).[[22]](#footnote-22) For example, in Victoria, the Disability Access Bench Book recommends a range of ways judicial officers can refer to the *Evidence Act* 2008 (Vic) to improve the accessibility of court proceedings.[[23]](#footnote-23) These measures include the use of pre-recording and closed circuit television in a remote witness facility, and making adjustments for witnesses who cannot hear or speak, such as time allowances for the witness to respond to questions and physical adjustments.[[24]](#footnote-24)*Secondly*, a PWD who is found to lack capacity is exposed to indefinite detention with a nominal term corresponding to a major review period at the end of which there is a presumption, but no guarantee of unconditional release. This means that on the equivalent of sentencing, the PWD is not given the certainty of a date after which they must be released from custody if not released sooner. Part IIA is similar in this respect to the regimes in Victoria, Western Australia (currently)[[25]](#footnote-25) and Tasmania.
22. This may be contrasted with the position in New South Wales where a limiting term is fixed by reference to the best estimate of the sentence that would have ordinarily been imposed. Unless an order subsequently extending the term is made, the PWD is unconditionally released on expiry of the limiting term.
23. In practice, most PWD dealt with under Part IIA commence on custodial supervision orders. This is largely a function of a test directed at risk being applied to a person found to have committed recent criminal conduct, coupled with any relevant prior offending and compliance difficulties caused by their disability or otherwise. Most remain on custodial orders for extended periods before progressing by a step-down approach from a custodial supervision order to increasingly less restrictive terms of a non-custodial supervision order with the ultimate objective of unconditional release at the end.[[26]](#footnote-26) Not always, but not uncommonly, PWD spend longer periods of time in custody than they would if sentenced through the ordinary machinery of the criminal law, and thereafter are subject to close supervision. This is especially true for those with significant disabilities, some of whom may never transition off custodial supervision orders.
24. **INTERNATIONAL PERSPECTIVES**
25. The DRC has recognised the importance of international perspectives for its work. Australians for Disability and Justice embraces that viewpoint, recognising the intellectual and moral force of the Convention on the rights of Persons with Disabilities (**CRPD**).
26. This submission proceeds from and adopts the statement of interpretive principles articulated in the written submissions of Counsel Assisting for public hearing 18, noting in particular the following:
    1. Article 12 of the CRPD articulates an immediately realizable obligation to ensure equal recognition before the law for PWD.
    2. Article 13 of the CRPD articulates an immediately realizable obligation to ensure access to justice for PWD on an equal basis with others, including through the provision of reasonable accommodations to facilitate their participation.
    3. Article 14 of the CRPD articulates an immediately realizable obligation to ensure non-discrimination and equal process in the deprivation of liberty by process of law.
    4. Australia has ratified and committed to unqualified compliance with each of these obligations.
27. There is a view[[27]](#footnote-27) that alternative justice regimes for PWD, regardless of their terms, infringe the CRPD. Whether or not that interpretation is correct, it is tolerably clear that some aspects of these regimes are incompatible with the CRPD. That is because, while there is room for reasonable disagreement about the precise effective content of these international norms, it cannot be denied that the “overall direction of the CRPD [is] towards equality, non-discrimination, social integration, and the direct involvement of [persons with disability]”.[[28]](#footnote-28) Relevantly, for the purposes of this submission:
    1. The CRPD mandates reasonable adjustments in the evaluation of capacity, and in the trial of PWD. This is clearly within the terms of art 13 and the direction of the CRPD as a whole. The purpose of reasonable adjustments is to accommodate PWD on a level playing field with others and to optimise their participation in the trial procedure. They are necessary to maintain equality and non-discrimination for PWD.
    2. The CRPD, and international human rights law more generally, proscribes the indefinite detention of PWD. As recently as 23 November 2022, the Committee against Torture called for Australia to “[s]top committing persons with intellectual or psychosocial disabilities who are considered unfit to stand trial or not guilty due to ‘cognitive or mental health impairment’ to custody and for indefinite terms or for terms longer than those imposed in criminal convictions”. Alternative justice regimes for PWD which impose indefinite detention in circumstances in which the PWD would not be subject to such an order on sentencing in the ordinary course, even with allowance for non-custodial options and earlier release, cannot be reconciled with the objects of equality and non-discrimination against PWD at the heart of articles 12 and 14 of the CRPD.
28. **REASONABLE ADJUSTMENTS SHOULD BE MANDATORY**
29. The National Statement of Principles Relating to Persons Unfit to Plead or Fount Not Guilty by Reason of Cognitive or Mental Health Impairment (**National Principles**)[[29]](#footnote-29) provide for reasonable adjustments to be made to facilitate the effective participation of persons with disability in the criminal justice system. Other institutions, such as the Victorian Law Reform Commission, have also emphasises the importance of support measures to “optimis[e] an accused’s fitness where they might otherwise be unfit”.[[30]](#footnote-30)
30. The National Principles have been endorsed by all States and Territories except South Australia.
31. However, as identified above, some Australian governments such as the Northern Territory have not translated that endorsement into legislation. This means that:
    1. Courts are limited to adjustments within their existing powers and any discretion governing the exercise of those powers falls to be exercised in the usual way. The scheme itself provides no support for the exercise of discretion by the court.
    2. Whether the court considers the availability of reasonable adjustments depends on whether or not practitioners and judges are aware of, or turn their mind to, the issue. There is nothing in the terms of Part IIA to direct their attention and it is not an error to assess capacity without consideration of the reasonable adjustments to support capacity which might be made.
32. This is a missed opportunity to ensure that PWD are able, so far as is practicable, to participate fully and on equal terms in the criminal justice system. The reasonable adjustments to support capacity include the provision of communication assistants, support persons, as well as procedural adjustments including additional, more frequent or even longer breaks and modified courtroom language to avoid undue technicality.[[31]](#footnote-31) Consideration of these modifications should be mandatory when assessing capacity and courts should be encouraged to modify procedure for PWD to make the trial more accessible whether or not questions of fitness to plead arise.
33. **INDEFINITE DETENTION SHOULD BE PROHIBITED**
34. Indefinite detention orders for PWD offend against the equal recognition, non-discrimination and equality under articles 12 and 14 of the CRPD. They subject PWD to less favourable treatment than under the ordinary processes of the criminal law.
35. In 2016 the Senate Standing Committee on Community Affairs recommended that there should be national adoption of the principle that “indefinite detention is unacceptable and that state and territory legislation be amended in line with this principle”.[[32]](#footnote-32) That has not occurred.
36. Part of the difficulty with alternative justice regimes for PWD which impose indefinite detention is simply the lack of a certain end point. From a psychological perspective, this can create a sense of disenfranchised hopelessness and foster a sense of the inevitability of custody within an already vulnerable cohort.
37. The more pressing objection of Australians for Disability and Justice is that such laws impose what may be described as an evidentiary onus on the PWD to demonstrate that they are no longer a risk to the community in order to justify their release. This is something which other offenders do not have to do.
38. The starting point is that every person has the right to be free from arbitrary imprisonment. Persons found guilty of criminal offences and sentenced to terms of imprisonment are not deprived of their liberty arbitrarily. But the sentence imposed will only run for the minimum period required to do justice in the objective circumstances and seriousness of the offence, and their own subjective circumstance. With limited exception,[[33]](#footnote-33) they are released at the end of their sentence if not earlier regardless of the risks they present on release.
39. In contrast with that ordinary position, a PWD who is found unfit to plead or not guilty by reason of mental impairment and made subject to indefinite detention has to justify their release, or have their release justified, by reference to an acceptable degree of community safety. This creates an unjustified and inequitable evidentiary burden on the PWD. Regardless of how the statutory test is framed presumptively or who bears the legal onus, the PWD is only released where the court deems it safe to do so. And only after accepting expert evidence in relation to the risk. Other offenders, including recidivist offenders, are not similarly required to justify their release on community safety grounds.
40. This evidentiary burden is frequently made more onerous or near impossible for PWD for two reasons. First, because of the custodial environment and the experience of many PWD in that environment. Most obviously, episodes of dysregulated behaviour in custody leading to operational or disciplinary action can be used to support a case of ongoing risk of harm. Similarly, a failure to progress to a lower security classification or undertake employment or available programs can be viewed as indicating a lack of rehabilitation, and therefore an ongoing risk of harm. For many PWD, the custodial setting is where they are least able to demonstrate an absence of risk.
41. Secondly, chronic underfunding of services can lead to ‘stalemate’ situations where:
    1. a lack of services and programs available to PWD in custody can inhibit their rehabilitation or its demonstration to the court; and/or
    2. a lack of services and accommodation options outside of custody can diminish the availability of practicable options for supervised release and stall progress towards unconditional release.
42. This disjunct between how a regime might work if fully resourced and how it operates in practice has been a longstanding subject of ‘stakeholder’ submissions[[34]](#footnote-34) and reflects the experiences of Australians for Disability and Justice. It results in an alternative justice regime for PWD which marginalises and unfairly and inequitably treats some of the most vulnerable members of society. It should not continue.

Trevor Moses

26th November

2022

**Submission to the Disability Royal Commission into Violence Abuse and Exploitation and Neglect of People with Disability on Culturally Relevant and Culturally Safe Disability Support**

**Deb Frith - Chief Executive Officer My Voice, Aunty Margaret Campbell Titjikala Elder and Patrick McGee – Guardian for Malcolm Morton**

**Background**

My Voice – an NDIS Registered Provider based in Sydney - became involved in providing disability support to Malcolm Morton, a proud Arrente man, in the Forensic Disability Unit (FDU) when, as an outcome of discussions about the complexities of the provision of support coordination in Alice Springs, the CEO Deb Frith agreed to employ the then NDIS Plan Support Coordinator who was based out of Titjikala where Malcolm’s Aunty Margaret Campbell and Malcolm’s family lived.

The employment of a part time NDIS Plan Support Coordinator in 2019 initiated a process where the CEO Deb Frith began to become involved in the day to day management of providing disability support in a remote Indigenous community in central Australia. Whilst, My Voice is not an Indigenous organisation, they had a commitment to providing culturally relevant and culturally safe disability support to First Nations Australians with disability and psycho-social impairments. My Voice were also committed to employing First Nations Australians into all levels of the organisation.

The entry point for My Voice into the complexities of providing disability support in a forensic detention facility and on remote Central Australian communities came about as a result of Malcolm Morton visiting the County of his Aunty Margaret Campbell at Alice Well as par tof his community access from the FDU . Aunty Margaret Campbell, was the traditional custodian of the lands around Alice Well, an Elder of the Titjikala Community and the Senior Representative of Malcolm’s family and joint guardian for Malcom. It was organised that as often as possible, Malcolm would be supported to spend a couple of days with Aunty Margaret and family on country at Alice Well.

At that time, the joint guardians, Aunty Margaret Campbell and Patrick McGee, along with the My Voice CEO, Deb Frith and the NDIS Support Coordinator began to discuss how to provide culturally relevant and culturally safe disability support to Malcolm Morton when he visited Alice Well. In order to culturally support the staff of the Forensic Disability Unit who supported Malcolm on these visits to country the NDIS Plan Support Coordinator began to recruit Arrente men from community who expressed a willingness to work with Malcolm and whom had cultural authority and familiarity to Malcolm

When My Voice began to provide daily community access support to Malcolm in 2021, whilst he was detained in the FDU, the decision was taken to develop a disability support model that was culturally relevant and culturally safe for Malcolm and for the Arrente men who would be providing Malcolm with disability support. The decision was to in fact frame the My Voice disability support using an Arrente cultural lens.

Over the course of two years, the now My Voice Support Coordinator was able to speak with the families of people with disability and psycho-social impairments living on Titjikala community, who could see the benefits of the NDIS for Malcolm Morton, about seeking eligibility to the NDIS. And over time, people with disability and psycho-social impairments and their families on community began the process of seeking NDIS eligibility. Once eligible, and with funded NDIS Plans in place, the provision of culturally relevant and culturally safe disability support was extended to these new NDIS participants. Arrente men and women from remote Central Australian communities were employed by My Voice to provide culturally relevant and culturally safe disability support to their Arrente clients.

**Principles that guide culturally relevant and culturally safe disability support to Arrente people in detention and in the community**

1. Arrente people with disability and psycho-social impairments detained in prisons and forensic facilities have a right to the provision of culturally relevant and culturally safe funded disability support on community
2. Arrente men and women have significant technical expertise in how to provide culturally relevant and culturally safe support to Arrente people with disability and psycho-social impairments and should be employed to do so and this culturally relevant and culturally safe disability support should be extended to Arrente people with disability in prisons
3. Arrente people with disability and psycho-social impairments living on remote Indigenous communities and the Arrente men and women who support them should be able to access the NDIS like other Australians with disability and psycho-social impairments
4. The combination of Arrente cultural knowledge and expertise with disability knowledge and expertise into culturally relevant and culturally safe disability support ensures better disability support outcomes for Arrente people with disability and psycho-social impairments who are being detained in prisons and forensic facilities

**The provision of culturally relevant and culturally safe disability support relies on:**

1. Employing Arrente men and women who speak the community language
2. Employing Arrente men and women with cultural authority
3. Employing Arrente men and women who can frame the provision of disability support using Arrente cultural protocols

**Practice examples of culturally relevant and culturally safe disability support for Malcolm Morton**

*My Voice employed Arrente men to provide access to the community disability support who could speak in Malcolm’s primary language of origin Pitjantjatjara who provided culturally relevant and culturally safe disability support in a forensic detention facility.*

This resulted in:

* Malcolm being able to ask about family and community in his primary language
* Malcolm being able to understand answers with greater level of detail and complexity about his family and community – this resulted in a greater sense of connection and belonging to family and community for Malcolm

In 2022, after culturally relevant and culturally safe disability supports both at the FDU and on community access from the FDU in Malcolm’s primary language had been provided for eighteen months

* Malcolm was able to ask in his primary language why was it that these people[[35]](#footnote-35) were giving him medicine every day that made his sleepy

*My Voice employed Arrente men with cultural authority that Malcolm would recognise and respect*

When Arrente men whom Malcolm respects as ‘older brothers’ work with him using his primary language, Malcolm is more receptive and attuned to the cultural authority these Arrente men possess and thus more likely to follow their advice and direction.

This cultural authority dynamic becomes significant for Malcolm when he is experiencing an escalation of behaviours of concern. My Voice have documented that Malcolm is more likely to de-escalate behaviourally when Arrente men with cultural authority speaking with his in his primary language intervene

*My Voice employed Arrente men who could use Arrente cultural protocols with which Malcolm was familiar to frame the provision of disability support*

Arrente men who have cultural authority working with Malcolm who communicate with him in his primary language means that Malcolm is able to understand whether he is allowed to or not allowed to speak with men or women that he does not know for example. Having Arrente men with cultural authority vouch for people who Malcolm meets but does not know mean that Malcolm does not make any cultural mistakes that could lead to him feeling shame.

In not making cultural mistakes Malcolm becomes more culturally confident of his place with his family and community. In having more cultural confidence, Malcolm is less likely to feel insecure when on country with family and community. When Malcom feels confident and secure his is more able to express himself emotionally and less likely to be overwhelmed by his emotions. This then allows Malcolm to self-regulate his own behaviour.

*Summary*

The effect of this model of culturally relevant and culturally safe disability support for Malcolm has been dramatic. When the Arrente men employed by My Voice provide daily community access disability support to Malcolm there are no serious behaviours of concern that involve harm to Malcolm or others. As well the Arrente men employed by My Voice have been less likely to use chemical restraint to intervene in an escalation of behaviour that places Malcolm or others at risk.

Aunty Margaret Campbell – Titjikala Elder

Deb Frith - CEO My Voice

Patrick McGee – Exxcutive Director Australians for Disability and Justice

**Exclusion of Justice Settings from National Mental Health Planning**

**Louise Southalan / Mental Health Matters 2**

*Mental Health Matters 2 Ltd is an Australian lived experience-led charitable organisation working to embed Lived Experience Expertise into all levels of justice, mental health and drug and alcohol systems.*

In the past two decades through the national mental health reform process Australia has taken a series of major reforms in the service of having a national public health approach to mental health. State and Territory governments have worked with the Commonwealth for coordinated, population-based approaches which share evidence and act on it. Key features include a series of five year national mental health plans, a national services planning framework with associated funding models, national outcome measures, national standards and accreditation, and a suite of national institutions focused on building and acting on the evidence of what works. While there are gaps and flaws, and implementation is often far from ideal, the logic of a public health approach to mental health is now beyond question.

However mental health services in justice settings are almost entirely excluded from this national approach, and operate in a series of separate bubbles. The reason given is that under the Constitution justice settings (such as police lock ups, prisons and detention centres) are the responsibility of State and Territory governments. However this fact does not prevent national approaches being taken in many other areas. Even in mental health, where there are shared responsibilities, States and Territories have agreed that it makes more sense for many of their particular responsibilities to be coordinated as a group and to share their joint evidence. Strangely though, and despite the high prevalence of mental illness in justice settings, the provision of mental health services in justice settings is not one of those areas, and it remains largely off the radar for mental health policy makers at all levels. As a result, these services operate without the benefit of shared tools and evidence, including outcome measures, evidence of effectiveness, shared funding and staffing models, a national strategy and shared research addressing common problems, national standards for specialist justice mental health services, and many other gaps.

This lack of a public health approach is not a trivial matter. Prisons could justifiably be considered the largest mental health facilities in Australia, and manage a population with much higher complexity of mental illness than in the community.

This is not to say that there aren’t pockets of good practice taking place, and many dedicated staff working to provide quality care in these settings. However it is undeniable that this severing of prison mental health services from the national public health approach means that the framework and incentives for these services can be, and often are, redirected towards the incentives operating with the prison administration.

Anyone who has worked in a prison understands that every part of the prison is incentivised to focus on short term risks, particularly those relating to escapes, security and good order, and self-harm and/or harm to others. Prison mental health services, which are funded and function separately from the national population-based models, can often appear to function as another arm of the prison risk-management system. This means many resources are focused on acute situations, categorised as security risks, with a high reliance on medication, seclusion and restraint.

Beyond the prison gates, mental health policy makers are focused on redirecting investment away from acute services in order to have increasingly higher promotion, prevention, Lived Experience (Peer)-led and sub-acute supports. In a prison risk framework this does not fit the risk management profile which prisons are required to manage. In the absence of a shared, national approach where mental health care is the overriding framework, there are no counter-levers acting to challenge the priorities of prison mental health service funders and policy makers. One of many troubling examples of the impacts that this has on people and on health systems is the reports from many Australian jurisdictions of the huge unmet demand for people in prison assessed as needing urgent inpatient mental health treatment. Such situations fly in the face of a public health approach to mental health. An example from the Western Australian context is discussed at p34 of the 2022-23 annual report of the statutory Mental Health Advocacy Service (MHAS):

*MHAS understands that for much of the past year at least nine people have been waiting in prison on most days for a specialist inpatient mental health bed. MHAS knows at least one prisoner who has waited more than three months for admission. In most cases, prisoners waiting for a bed are held in isolation and only assessed and treated if they agree. By the time they get into a mental health bed, they are often very unwell, require more intensive treatment, and take longer to become well again.*

*Similarly, the number of people on hospital orders [where a person appearing before court is referred for immediate inpatient mental health assessment] admitted to the [Frankland Centre, the state’s only secure forensic mental health service] has diminished from 110 in 2017 to three in 2022-23. With no inpatient beds available, people on hospital orders are being diverted to prison. In-reach psychiatric services must be negotiated by the prison mental health staff for examinations, and the only treatment they receive is what they accept voluntarily. Moreover, despite having the right to an Advocate, in practical terms, they cannot access this. In a few cases, a prisoner may be admitted to a ‘civil’ bed in another authorised hospital, but MHAS is unaware of this happening in the past year.*

One of the most revealing aspects of the separation of prison mental health services from the national mental health structures and supports is their exclusion from Medicare and the Pharmaceutical Benefits Scheme. Medicare subsidises mental health services provided by GPs, psychiatrists, psychologists, occupational therapists and social workers, on the basis that that universal access to these services is an important public health and health equity policy. These services also aim to treat mental illness at an early stage, preventing more complex and acute problems from occurring. Exclusion from Medicare means that access to equivalent services for people in prison depends on each particular State or Territory choosing to fund and provide effective mechanisms for access to mental health services otherwise funded through Medicare. As noted, prisons are not incentivised to do this and nor might they consider this to be their core business. States and Territories take radically different governance approaches to provision of prison mental health care, with currently no process in place to compare effectiveness and outcomes. This problematic approach also exists in the area of youth justice, where there are often complex mental health needs due to a high prevalence of co-occurring disability (such as FASD). This is despite clear evidence showing that early intervention during childhood and adolescence is the most effective way of treating mental illness and preventing more complex issues from arising later. We are currently seeing the devastating consequences of this policy failure in our youth justice systems.

Another area where mental health services in justice settings are not taking a contemporary public health approach is their apparent neglect of the development of Lived Experience (Peer) Workforces and meaningfully drawing on Live Experience expertise. This is increasingly being built into mainstream public mental health services, reflecting its elevation through national and state/territory frameworks and commitments. There appears to be no matching of this in justice settings.

The lack of commitment to a public health approach to prison mental health is not only a human rights and health travesty with great human costs, on the individuals concerned and their families. It is also a public health and financial own goal for Australia. People moving between prison and community mental health services currently move between two radically different systems that don’t communicate well and which operate in different, disconnected universes. Nearly everyone in prison or youth detention comes out, and some people come out many times. The expensive and overloaded acute care system in the community - Emergency Departments, police and acute mental health wards - are the parts of the system bearing the burden of this public health failure. And it is ultimately individuals, families and communities who bear the greatest impact.

Louise Southalan

November 2023

**Judy Harper – Program Director Justice Advocacy Service**

**Intellectual Disability Rights Service (IDRS)**

**People with Cognitive Impairments in Prisons**

The high level overview presented below is based on the direct experience from across New South Wales of Justice Advocacy Service from the Intellectual Disability Rights Service.

**Access to physical and mental health care, especially whilst on remand**

* Lack of psychiatrists to review people in a timely manner particularly when on remand. In many instances people are on waiting lists they never get to the end of prior to their release, examples of 9 months on remand and still on a waiting list.
* Impacts with access to medication prescribed in the community. Examples where certain types of drugs are not able to be provided in gaol, even though prescribed in the community, until a person has been seen by a psychiatrist. Again, very long waitlists for psychiatrists means it never happens. Without their usual medication people’s mental health deteriorates leading to challenges for the person and also their management in gaol. The response can be to be in an isolation cell with minimal time out. This and the first point is exacerbated when people are transferred frequently between gaols, especially if they are moved to a privately run gaol.
* Limited to no access to assessment for cognitive impairment. 16% of 270 diversion clients in the past financial year had their cognitive impairment diagnosed for the first time through access to assessments with JAS as part of their Section 14 – many on remand or had been cycling through the system for years. Clearly diagnosis supports access to appropriate supports likely to reduce the likelihood of re-offending and support re-connection to the community.
* Access to physical health care. Again, demand far outweighs resources. Challenging situations where someone is diagnosed with a life threatening illness and access to the full spectrum of treatment options, information and choice. If appointments and are outside the gaol, access is often compromised by the lack of staff to enable it to happen leading to long delays.

**Access to legal and other support**

* Due to lack of facilities and lack of staff, it is very difficult to get phone calls or AVL’s with a person prior to their court appearance. This impacts JAS from the perspective of being able to support the person to know what is going on, to make informed decisions, and participate to the full extent of the legal process accessing their rights. We have seen on many occasions where legal representatives are not able to speak to their clients prior to their court appearance, and there are often additional adjournments for this reason resulting in people spending more unnecessary time in custody.
* We have staff and volunteers trained and approved to go into gaols to provide support to a person appearing via AVL. On many occasions they are denied access due to allegedly not having been approved even though there is evidence to the contrary, or made to wait in reception for 5- 6hrs and when they are finally processed are told the court matter they were there for is over. Or the gaol is in lock down due to lack of staff and therefore no one to escort people around. This is denying people with cognitive impairment access to the support they are entitled to so they can participate in their legal process
* People on remand losing their housing. Due to long court wait lists people are spending significantly more time on remand. At the moment, people are having their hearings scheduled 6 – 9 months out. This means that they are needing to relinquish their public housing after being on remand for 6 months, and one recent client lost their home of 15 years. Due to lack of capacity and resources of SAPO’s people aren’t aware of this until they are asked to sign a form to relinquish their housing. There is little to no advocacy or support for them to challenge, negotiate or do anything about it because it is too late. There is not time to make their legal representatives aware to look at any intervention options. JAS have had a number of clients who were not aware until their day of release that their home had been emptied of all their possessions to the dump and unit re-assigned, meaning they were released into homelessness with no warning. Communication is a significant issue, with housing forms not forwarded when a person goes into custody leading to issues with rent arrears etc., and then communication coming in regarding housing not getting to the person.

**Support for day of release**

* This is a problem for everyone, but the impacts for a person with cognitive impairment are increased. We recently had a client where they were due to be released from a gaol in Cessnock, but they came from Armidale. Our team had worked with others and organised support for someone to pick them up on the day at midday and all information had been communicated to all relevant people at the gaol. It required the Governor to hold the person over for one additional night so that they had someone to pick them up. Approval for these exceptional circumstances had been approved and organised. For reasons unknown, the gaol released the person the evening before and no one knew until they arrived to pick him up the following day. 4 days later no one had heard from him or knew his whereabouts.
* Gaols do not have the time/resources to organise to send a person’s property with them when they go to Court in person. If the person is then released from Court, usually late in the afternoon, they have no ID, money, clothes etc. The process to organise to retrieve their property from the gaol is long, convoluted and difficult. If they can navigate that then they have to be able to get back to the gaol. For many people it is not possible to get to the gaol and back in one day due to the distances in NSW, and if they require public transport then it is even harder. Again, people released into homelessness with no resources to help themselves.
* Protection – people with cognitive impairment either not being protected due to their vulnerability and therefore open to abuse and assault. Or the only option for protection is to spend their time in isolated protection with max of 1hr out of cell per day.
* Good example – the opportunities provided to people on remand at John Morony Correctional Centre which is 90% remand. They have access to employment opportunities, and services able to come into the goal to work with them pre-release, and plan for post release support. This makes a massive difference to people’s experience and outcomes. It is not perfect but is the only gaol in NSW where people on remand have access to this. Given the lengthening times people are spending on remand this is really important.

Judy Harper

November 2023

**Dr Astrid Birgden**

**Consultant Forensic & Clinical Psychologist / NDIS Behaviour Support Specialist**

**A proposed framework to reduce discrimination against forensic disability clients requiring access to programs in prison**

Summary of the following article (see attached file):

Birgden, A. (2016). Enabling the disabled: A proposed framework to reduce discrimination against forensic disability clients requiring access to programs in prison. *Mitchell Hamline Law Review, 42*(2), 636-696.

Note- the article was based on a thesis for the Master of Advanced Mental Disability Law, New York Law School. Therefore, it necessarily focuses on US law but is applicable to Australia, taking into consideration the principles of the National Disability Insurance Scheme (NDIS).

Here, forensic disability clients are defined as those with a cognitive disability who have engaged in behaviour that leads to contact with the CJS. It is important to highlight that there ought to be a distinction between “offending behaviour” (held accountable for their behaviour as an offender) and “behaviour of concerns” (behaviours communicating wants and needs as a person with a disability)

It is generally accepted that forensic disability clients experience discrimination and disadvantage when interacting with the criminal justice system (CJS) and, although overrepresented, are underserviced regarding access to necessary programs. The law can be a barrier to required programs and services upon contact with the court, within corrections and human services, and in the community upon re-entry.

The focus of this article is on how to support the forensic disability client as a person with a disability (through habilitation) *and* as an offender (through rehabilitation) in order to reduce the likelihood of returning to the CJS.

The table below summarises the journal article by considering person-centred values, person-centred assessment, and person-centred programs that ought to be delivered in correctional and human service systems.

To understand the table below the following definitions are provided regarding supporting theories:

* Habilitation - learning new skills that do not presently exist or offence-related programs;
* Rehabilitation- relearning old skills or offence-specific programs;
* Positive Behaviour Support (PBS)- a philosophy of practice that aims to improve the well-being of a person with a disability and reduce behaviours of concern, that determines what human needs are being met through behaviours of concern and replaces maladaptive behaviours with adaptive behaviours;
* Good Lives Model (GLM)- an offender rehabilitation model that determines what human needs are being met through offending and replaces anti-social behaviour with pro-social behaviour. GLM balances offender needs against community needs. In my view, GLM is an extension of PBS into the correctional system;
* Risk-Need-Responsivity (RNR)- another offender rehabilitation model that focuses on risk management for community protection;
* Desistance- an offender may experience a positive or negative event that triggers readiness to change and then receives support to reconstruct the self (habilitation) or re-establish a previously adaptive self (rehabilitation) and then desists from re-offending for a long period of time; and
* Old Me-New Me- an offender rehabilitation model for offenders with disability to identify anti-social characteristics and behaviours (Old Me) and replace them with pro-social characteristics and behaviours (New Me).

Table: Principles to reduce the likelihood of discrimination against forensic disability clients

|  |  |  |  |
| --- | --- | --- | --- |
| Supporting Theories | *Person with a Disability* | *Person as an Offender* | Supporting Theories |
| *Person-Centred Values* | | | |
| Human Rights | Positive rights: access to programs, services, and activities. | Negative rights: freedom from unlawful restrictive practices. Any restrictions are proportional and tailored to the person’s circumstances; apply for the  shortest time possible; and are reviewable by a competent, independent, and impartial authority or judicial body. | Human Rights |
| Human Rights  GLM | Consider the client as rights-holder and duty-bearer able to pursue their own goals. | Consider the client as rights-violator and duty-bearer with obligations toward others. | Human Rights  RNR  GLM |
| Human Rights  PBS  GLM | Support the person in exercising and experiencing their rights, will, and preferences. | Support the client in exercising and experiencing their responsibilities, for themselves and toward others. | Human Rights  PBS |
| PBS  GLM | Understand the context of the person’s relationships, the people who matter to the person and the people who know and love the person. | Understand the context of the person’s relationships, the people who matter to the person, and the role of ex-offenders who “make good” and assist the offender. | Desistance  GLM |
| Human Rights  PBS  GLM | Provide full information about treatment options, risks, and expected outcomes; support participation in treatment planning and decision-making regarding program participation with free and informed consent. | | Human Rights  PBS  GLM |
| PBS  GLM  Old Me-New Me | Understand that change is a balance between the person and the broader social system and that behaviour is a process of adaption between the person and their environment. | | PBS  GLM  Old Me-New Me |
| Human Rights  PBS  GLM  Old Me-New Me | Preserve and enhance personal autonomy and self-efficacy. | | Human Rights  PBS  GLM  Old Me-New Me |
| Human Rights  PBS | Establish practices, policies, and procedures that address discrimination in general and enhance access to programs in particular. | | Human Rights  PBS |
| *Person-Centred Assessment* | | | |
| PBS  GLM  Old Me-New Me | Determine deficits and strengths in adaptive behaviour and non-criminogenic needs. | Determine dynamic risk factors and protective factors linked to the offending behaviour to be targeted for treatment. | RNR  GLM  Old Me-New Me |
| PBS  GLM  Old Me-New Me | With the person, determine their life goals and definition of a good life or an improved quality of life. | | PBS  GLM  Old Me-New Me |
| PBS  GLM | Develop a clinical case formulation to determine the functions of the offending behaviour and hypothesize what life goals the person is trying to meet through the offending behaviour. | | PBS  GLM |
| *Person-Centred Treatment Planning* | | | |
| PBS  RNR  GLM  Desistance  Old Me-New Me | Develop a treatment plan that guides adaptive behaviours to replace behaviours of concern (habilitation). | Develop a treatment plan that guides pro-social behaviours to replace dynamic risk factors (rehabilitation). | GLM Desistance  Old Me-New Me |
| PBS  GLM  Desistance  Old Me-New Me | Plan for human capital (internal capacity) and social capital (external supports). | | PBS  GLM  Desistance  Old Me-New Me |
| Human Rights  PBS  GLM  Desistance  Old Me-New Me | Individualise the treatment plan, including positive self-identity narratives. | | Human Rights  PBS  GLM  Desistance  Old Me-New Me |
| RNR  GLM  Old Me-New Me | Include avoidance goals (community interest) in the treatment plan. | | GLM  Old Me-New Me |
| GLM  Old Me-New Me | Include approach goals (client interest) in the treatment plan. | | GLM  Old Me-New Me |
| *Person-Centred Programs* | | | |
| Human Rights  PBS  GLM | Provide programs in the least restrictive and most integrated environment. | | Human Rights  PBS  GLM |
| PBS  GLM  Desistance | Apply a therapeutic style that imparts motivation and hope and acknowledge and celebrate achievements and positive potential for development and redemption. | | PBS GLM  Desistance |
| Human Rights | Provide access to  habilitation programs that  are equivalent to those  available to disability clients  in the community. | Provide access to  rehabilitation programs that  are equivalent to those  available to offenders in the  community. | Human Rights |
| PBS | Provide habilitation programs that utilise task analysis of the individual to identify skill-building needs. | Provide rehabilitation programs that supply the correct dose and intensity to manage risk of re-offending. | RNR |
| PBS  GLM | Improve quality of life for person interest. | Reduce the likelihood of reoffending for community iinterest. | PBS  GLM |
| Human rights  PBS | Consult specialized organizations. Provide one-to-one support, a qualified person to assist, or a transfer to an appropriate setting. | | Human rights  PBS |
| PBS | Provide habilitation programs that utilize task analysis of the individual to identify skill-building needs. | Provide rehabilitation programs that supply the correct dose and intensity to manage risk of re-offending. | RNR |
| PBS  GLM | Improve quality of life for client interest. | Reduce the likelihood of reoffending for community interest. | RNR  GLM |
| Work with, not on, forensic disability clients.  Reintegrate a non-offending citizen with full rights and responsibilities who  contributes to the community. | | | |

**Dr Astrid Birgden**

**Forensic and Clinical Psychologist**

**Dana Leviit**

**Associate Levitt Robinson Solicitors**

**Juvenile detention in Western Australia as example of worst practice in detention setting.**

**Juvenile detention in Western Australia**

Banksia Hill Detention Centre and Unit 18, the stand-alone unit situated inside Casuarina maximum-security adult prison gazetted in July 2022, are West Australia’s (WA) only juvenile detention facilities with a capacity of approximately 120 and 20 detainees respectively.

# Profile of juvenile detainees in WA

The complex needs of juvenile detainees are multifactorial: the product of social disfunction, disengagement, disadvantage, and high rates of disability.[1](#_bookmark0) Most juveniles in detention are First Nations children – on an average night in 2022, 80% of juveniles in detention in Western Australia were indigenous – which outstrips the national average by 19%.[2](#_bookmark1)

# Detention devoid of rehabilitative potential

The failure to implement a dedicated policy for the diagnosis, treatment, and support of disability;[3](#_bookmark2) and/or culturally adapted, trauma informed and/or therapeutic models of care, has resulted in juvenile detention in WA being fundamentally ‘not fit for purpose’[4](#_bookmark3).

Deskilling and industry segmentation among custodial staff has resulted in lower pay, worse conditions, high levels of staff turnover, the combined effect of which is to leave juvenile detention centres poorly resourced and understaffed, and the widespread use of the following practices, the combined effect of which is to render juvenile detention devoid of any rehabilitative potential:

* the wide discretion afforded to custodial staff to sanction detainees for ‘misconduct’, which is often a manifestation of their disability,
* the unhealthy separation between custodial management and professional services[5](#_bookmark4);
* limited access to programmes and services including education[6](#_bookmark5);
* the routine use of solitary confinement for operational reasons and/or for behavioural management – which both singularly and in combination, amounts to psychological subjugation, and torture[7](#_bookmark6).

1 89% have at least one form of severe brain impairment, 65% had at least three forms of severe brain impairment, 23% had five or more forms of severe brain impairment, and 36% have foetal alcohol spectrum disorder (FASD).

2 [Australian Institute of Health and Welfare, youth detention population in Australia 2022,](https://www.aihw.gov.au/reports/youth-justice/youth-detention-population-in-australia-2022/contents/summary) Supplementary Tables S4 and S14.

3 [Paragraph 49 of Statement of then Superintendent of Banksia Hill Detention Centre,](https://disability.royalcommission.gov.au/system/files/2022-10/Transcript%20Day%205%20-%20Public%20hearing%2027%2C%20Perth.pdf) Wade Reid.

4 [Office of Inspector of Custodial Services (OICS) Western Australia, 2021 *Inspection of the Intensive Support*](https://www.oics.wa.gov.au/wp-content/uploads/2022/03/Banksia-Report-141.pdf)[*Unit at Banksia Hill Detention Centre,* Report 151,](https://www.oics.wa.gov.au/wp-content/uploads/2022/03/Banksia-Report-141.pdf) March 2022, p iv.

5 Judge D.J. Reynolds, President of the Children’s Court of WA, Speech at National Youth Health Conference (2013) on Children in Detention and Mental Health.

6 Western Australia is the only state in which the Department of Justice (DOJ) rather than the Department of Education, is responsible for the provision of education in juvenile detention, which has consistently failed to meet community expectations – [Office of the Inspector of Custodial Services Inspection of Banskia Hill](https://www.oics.wa.gov.au/wp-content/uploads/2018/04/Banksia-Hill-Report-116-FINAL.pdf) [Detention Centre, 2017,](https://www.oics.wa.gov.au/wp-content/uploads/2018/04/Banksia-Hill-Report-116-FINAL.pdf) pvi

In May 2023, 57 letters of complaint were tabled in parliament, detailing serious allegations of neglect and abuse. Some examples are provided below:

* “Two male YCOs … picked up chairs and hit [the child] on the left and right sides of her head at the same time with the two chairs. She had lumps on her head as a result. She was then placed in handcuffs and her legs were folded up behind her into a ‘hog tie’ or ‘folding up’ position. She was then dragged along the floor whilst restrained.”
* “During her most recent admission in BHDC, [the child] asked [officer] to open her cell door. He moaned inappropriately (sexually) at her which made her scared. If [the child] screams, [officer] will often say things such as ‘I love it when you scream.'”
* “The recreation YCO … stares at [the child] and the other girls which makes them feel uncomfortable. When they are playing sports [child’s name redacted] has seen him looking at their buttocks. Approximately two weeks ago [the officer] was present at the gym when the girls were playing cricket. [The child] saw M\*\*\*\* looking at another girls’ buttocks when she was ‘batting.’ [The child] has witnessed YCO M\*\*\*\* touch his ‘front part’ or ‘crotch’ area as he is looking at the girls. This makes [the child] feel scared.”
* “[The child] threatened to hurt himself and YCOs ripped his clothes off and left him naked in the cell with a rip proof gown, which in his distress [the child] did not put on … [The child] was left naked in the cell from about 2:30pm on 30 January 2023 until his visit with [his lawyer] the following morning … His mattress was covered in OC Spray and was ‘itchy’. As such, he slept in the shower and he had only a rip proof pillow and no bedding. He was very cold all night.”
* “[The child] is often left in the same clothes for days without being provided fresh ones.
* In around mid-January 2023, [the child] spent two weeks in the same clothes, being denied fresh clothing by the staff.”

# Routine use of solitary confinement as cruel and unusual punishment

In August 2022, Justice Tottle of the Supreme Court of Western Australia[8](#_bookmark7) found that ‘rolling lockdowns’ in excess of 11 hours and 15 minutes, were unlawful, acknowledging the capacity to cause an acute and severe decline in detainees’ mental and physical health, as manifested in high rates of self-harm and/or attempted suicide. The practice continues, with Director General of Custodial Service, Adam Tomison, being caught admitting as such, off microphone, during a recent Parliamentary Committee Hearing on November 15 2021.[9](#_bookmark8)

# Banksia Hill Detention Centre’s Intensive Support Unit (ISU)

Juvenile detainees housed in the euphemistically named Intensive Support Unit are confined to their cells under regression management regimes, which pose a serious threat to their welfare, as manifested in uptake in critical incidents, including serious self-harm and/or attempted suicide.[10](#_bookmark9)

7 Styles A., “WA’s treatment of children in prison is tantamount to torture, but we are the ones who should be scared?” [WAtoday (11 February 2022).](https://www.watoday.com.au/national/western-australia/wa-streatment-of-children-in-prison-is-tantamount-to-torture-but-we-are-the-ones-who-should-be-scared-20220210-)

8 *VYZ by Next Friend XYZ v the Chief Executive Officer of the Department of Justice* [2022] WASC 274 delivered on 25 August 2022.

9 <https://7plus.com.au/seven-news-perth?episode-id=7NNP23-319&autoplay=true>

10 [OICS 2021, Inspection of the Intensive Support Unit Banksia Hill Detention Centre, Report 151,](https://www.oics.wa.gov.au/wp-content/uploads/2022/04/Inspection-of-Banksia-Hill-Detention-Centre-ISU-CORRECTED.pdf) March 2022, p 19.

# Unit 18

Unit 18, located inside Casuarina maximum-security adult prison, presented as a temporary solution to house Banksia Hill Detention Centre’s most ‘disruptive’ detainees when it opened in late July 2022, has resulted in detainees being subject to *even more* punitive treatment than they were at ISU.

Between July 20 and August 8, 2023, there were 13 incidents of self-harm and three attempted suicides, culminating in the State’s first juvenile death in custody of the late Cleveland Dodd on 19 October 2023.

Cleveland Dodd was 16 years old when he was found unresponsive in his cell after two calls for help over his cell-call button went unanswered as custodial staff relaxed, watched movies, and even slept while on duty. A coronial inquest into Cleveland’s death will be held, and a Corruption and Crime Commission (CCC) investigation into alleged ‘serious misconduct’ by custodial staff is already underway.

# Conclusion

The treatment of children in detention in WA, including those with disability, contravenes the State’s own legislation, as outlined in section 6 and 7 of the YOA, together with the standards set out in the *Convention on the Rights of Persons with Disabilities*, the *Convention on the Rights of the Child*, the *International Convention on Civil and Political Rights*, including the standards which Australia supports for juvenile detention in the *Rules for the Protection of Juveniles Deprived of their Liberty.*

**Dana Levitt, Associate**

**Levitt Robinson Solicitors**

**Apprendix**

**Reports and Recommendations from the Disability Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability on the Criminal Justice System and People with Disability**

Please find attached as a file:

* Disability Royal Commission in Violence Abuse, Exploitation and Neglect of People with Disability Issues Paper Criminal Justice System Issues Paper

January 2020

* Disability Royal Commission in Violence Abuse, Exploitation and Neglect of People with Disability Final Report Volume 8: The Criminal Justice System and People with Disability October 2023
* Disability Royal Commission in Violence Abuse, Exploitation and Neglect of People with Disability Final Report Volume 9: First Nations People with Disability Page 139 – 147

October 2023

See attached links from relevant Disability Royal Commission Public Hearings into people with disability in the criminal justice system with a focus on people with disability in detention in mainstream goals and forensic detention facilities:

* Public Hearing 6 – Psychotropic Medication, Behaviour Support and Behaviours of Concern September 2020

disability.royalcommission.gov.au/public-hearings/public-hearing-6

* Public Hearing 11 – The Experiences of People with Cognitive Disability in the Criminal Justice System February 2021

disability.royalcommission.gov.au/public-hearings/public-hearing-11

* Public Hearing 15 – People with Cognitive Disability and the Criminal Justice System: The NDIS (National Disability Insurance Scheme) Interface Brisbane August 2021

disability.royalcommission.gov.au/public-hearings/public-hearing-15

* Public Hearing 27 – Conditions in Detention in the Criminal Justice System September 2022

disability.royalcommission.gov.au/public-hearings/public-hearing-27-conditions-detention-criminal-justice-system

**Excerpts from the Statement by Mr George Newhouse - The National Justice Project**

**George Newhouse Principal Solicitor (complete transcript in the appendix)**

**Disability Royal Commission Public Hearing 27: Conditions in Detention in the Criminal Justice System**

**The Need to Deinstitutionalise Detention Centres**

**MR NEWHOUSE (page 216):** Look, colonisation of this land began as a convict settlement, and when you look at Banksia Hill, not much has changed in philosophy since then. And when you look at the current philosophy, it's brutal, it's cruel and it's just punishment. There is ‑ I have had a lot of experience with children in Banksia Hill and in prisons in Western Australia, and there's nothing but punishment provided to any of those individuals.

But when you look at philosophy, I would like to pick up Ms Kilroy's points, and I accept them and adopt them all. But I think some of the principles should be ‑ and I think I'm reframing some of what she is saying, that the institution should be focused on the detainee or the prisoner and improving their health, their educational outcomes and preparing them for life outside of the youth detention centre or prison. That's not what's happening at the moment.

And the centre should be transparent. Bringing in independent people will shine a light on the awful deeds that are being done in prisons. These are total institutions. If you look at the Royal Commission into Child Sexual Abuse, the same principles applied to children who were abused in the Catholic Church or orphanages or institutions. Those organisations protect themselves, and it's exactly the same in prisons. They run for themselves.

But the principle of philosophy should also be culturally safe, allow independent organisations to come in and provide services, not simply contractors of the departments who have to toady to them. They should be respectful of difference and have, as a measurable goal, improvement in the lives of their charges, the people that are within the prisons. At the moment, we don't measure any of that. We don't measure the improvement in the lives of those who remain within the prison or youth detention system.

**The Lack of Employment Pathways When Exiting Detention**

**MR NEWHOUSE (page 217):** I was involved in a death in custody of a 19-year-old boy in the Western Australian system, and his mother told me ‑ and this is not related to his death ‑ but he was looking forward to leaving the custodial system and joining a group called Yeehaa. And I asked her about Yeehaa, and it was an organisation that ran ‑ that taught young men and boys to be stockmen or ‑ I don't know if there were women involved in this group, but this mother told me that her son was looking forward to going there.

They taught them these skills during the day, and at night they learnt ‑ they did schooling. And she told me that every one of the boys that graduated from that course became valuable citizens with families and jobs today. And I said to her, "What happened to that institution?" Because I wanted to use it as a model. She told me that the Western Australian government defunded it. So, I don't know of any other institution that's doing anything like that, but that seemed to be a success to me.

**Better Access to Healthcare in Prisons**

**MR NEWHOUSE (pages 220 / 221):** Alright. Before I do, I would like to take Ms Sharma's point about the Department of Health a step further. It's my experience in New South Wales, for example, that the Department of Health does get involved and there is a prison ‑ sorry a hospital inside Long Bay prison. But there are some conflicts there and the health workers become subservient to the guards for their safety and also because of the militaristic style structure of a prison.

But I strongly advocate for Aboriginal Medical Services to be allowed in, independent disability services to be allowed in, for every disabled prisoner to have an NDIS case worker, leaving aside funding, to advocate for that prisoner to provide appropriate services. So, I accept and adopt the suggestion of the Department of Health, but I would go even further. The more independent organisations and community‑based organisations that are allowed into prisons to see the horrors of what's going on it creates transparency and openness and they can actually advocate, whereas state organisations often feel like they are vassals to the organisation.

**Better Access to Healthcare in Prisons**

**MR NEWHOUSE (page 221):** Western Australia is one ‑ is one of the worst systems in the provision of healthcare in ‑ in detention or in prisons. That's because it's the Department of Corrective Services that actually provides that care, not an independent department. The standard of healthcare is abysmal. We see suicide after suicide. I'm involved in six deaths in custody at the moment and, in my view, a lack of appropriate care is a major contributor to those deaths.

The death I mentioned earlier of the boy who was looking forward to going to Yeehaa, 19‑year‑old boy with rheumatic heart disease, they lost his file. He was waiting to see a cardiologist who could have saved his life, and he died waiting because the Department changed service providers and they lost his file. This is what's going on in Western Australia. It's scandalous. And, in my view, Aboriginal Medical Services should go in immediately and provide those services to Aboriginal prisoners, and independent disability organisations should be providing services to all prisoners and detainees with a disability.

**Need for Oversight**

**MR NEWHOUSE (page 223):** You go. Well, very quickly. I acted for Cornelia Rau in 2005. One of the recommendations of the Palmer Report, because she was incarcerated with a serious mental illness ‑ and I'm not revealing anything that isn't in the report ‑ the recommendation there was for an independent medical and health oversight committee separate from the Department of Immigration, and that was a very effective mechanism for holding them accountable. And I strongly recommend that.

**Diversion from Detention**

**MR NEWHOUSE (page 224):** Yes. And the Koori Court in Victoria. These are mechanisms that have been used on the east coast very successfully to involve the community, to ensure that there is a rehabilitative approach and yet hold young people accountable in some ways for what they have done. So ‑ and some of the courts are involved with adults as well, but I strongly recommend those processes, and they're something that should be looked at across the nation.

**Access to Culturally Safe Education in Prisons for Indigenous Young People**

**MR NEWHOUSE (page 226):** Just to add to that, there are young men in youth detention in WA today who speak an Aboriginal dialect that no one in Perth understands. Certainly no one in Banksia Hill. How are you going to assess them? And the assessments are complex. They need to be culturally safe, no matter what group they come from. But also I think it's really important to look at education as well. We shouldn't just be assessing people's disabilities. It's a critical issue, but so is their education.

Most of the prisoners and detainees that I see are illiterate. They are ‑ they are not given any educational opportunities. There is no assessment of their baseline. There is no assessment of what they need in detention or in prison. In youth detention, they get thrown a scrapbook and told colour in or work on this yourself. Half of them can't even read and no one has assessed them. So, this assessment process needs to be with occupational therapists, teachers, psychologists and culturally safe practitioners.

**The Need for Transparency in Australia’s Places of Detention**

**MR NEWHOUSE (page 228):** Alright. I agree with you, Commissioner. You can't train prejudice and culture out of people in a day. It will take time. I think there needs to be law reform. If you look at the recent case in WA where the Supreme Court declared ‑ made a declaration that holding children in solitary confinement was unlawful, that would be a good start. The Inspector of ‑

MR GRIFFIN: Custodial Services.

**MR NEWHOUSE (page 228 / 229)**: Custodial Services in WA has been saying this for years. It is in his reports, and he does a great job, but this government is not listening, and they need to act. So, law reform is necessary to outlaw the form of solitary confinement that Ms Kilroy has been talking about. People can't complain in prison. If they do complain, they get punished by guards. So, there needs to be a secret mechanism or one that's holistic amongst the whole cohort so that punitive action and victimisation and retribution cannot be meted out to prisoners and inmates who complain.

Spit hoods must be banned; strip searches outlawed. If you have been sexually assaulted, can you ‑ particularly as a child, can you imagine the impact that strip searching has on you? Transparency is essential, Commissioner. Every time we go to take action on a complaint, guess what, there is no video evidence. In Western Australia, they will tell you, "We ‑ we record over it every 30 days." Right. That's the ‑ that's the situation. Guards cover up cameras whenever they are about to assault someone.

There needs to be CCTV footage running in all public areas 24 hours a day with live streaming into the Inspector's offices, and the video footage ‑ you can laugh ‑ you can laugh ‑ and that footage needs to be kept for five years so that these young, vulnerable people can actually have some accountability. When guards go into cells they need body cams and there should be audio as well. And you can laugh but this is a very serious point.

NDIS and Medicare end at the gates of prisons and youth detention centres. They need ‑ those ‑ both those services need to be funded. And I agree with you, Commissioner, having a ‑ a case worker, an NDIS case worker who can actually advocate for you would have helped the witness yesterday, I believe, and would help all prisoners and detainees with a disability.

Can I raise another issue. It's quite controversial. Coroners in many states have been charged with investigating deaths in custody for 30 years, since the Royal Commission into Aboriginal Deaths in Custody, and many are not doing their job. Ms Kilroy and I discuss this regularly. There are coroners who will only look at the immediate cause of death of an individual. Quite often, it's related to a lack of medical service or racism or discrimination. They refuse in many states ‑ in particular, I will name Queensland and Western Australia ‑ some in Queensland, but Western Australia is particularly bad. They refuse to look at the systemic problems within prisons and carceral areas.

And you should not be doing this job. We should not be having to expose this kind of problem at a once in a generation Royal Commission. Coroners should be doing this job every time they have to look at a death in custody. And I come back to my point earlier, that the focus of prisons and youth detention centres should be the individual. At the moment, they run around the institution. If you start setting key performance indicators based on the plans that the individuals receive when they go in, the assessments, let's measure the improvement in those ‑ the individual throughout their journey. If you are not measuring it, it's not happening. So, I've spoken ‑

**Access to Medicare in Prisons**

**MR NEWHOUSE (page 231):** I think there's an opportunity that might come out of this Royal Commission for the Federal Government to get involved. If we are talking about having NDIS and Medicare access to prisoners, that's money and that's something that the Federal Government could do to bring the states and territories together. There is no effective coordination. Everyone in every state gets to make their ‑ the leaders of government in each state make their own ‑ and territory ‑ make their own decisions. I think the Federal Government has a role to play in improving the lot of disabled people in detention and in prisons.

**Accountability Through Law Reform in Prisons**

**MR NEWHOUSE (page 232):** Can I answer that. Both Ms Kilroy and I work with a critical race theorist, Chelsea Watego, Professor Chelsea Watego in Queensland. She's of the view ‑ training is important, and I'm not dismissing anything that Ms Sharma said, but you can't train away racism and prejudice against people with disability. You need accountability and transparency; right? Without that ‑ and ‑ if you don't hold people accountable for their abuses ‑ which is why I suggested CCTV, because that's the only defence that some of these people have against the abuses of their guards ‑ you will not see change.

You need law reform to ban solitary confinement for the good order of the ‑ of the institution. I have seen boys locked up in solitary for 300 days or more for the good order of the youth detention centre. Now, unless that's outlawed legislatively, unless people are held accountable, the people that did that got promoted or moved to other sections of the public service. Until that happens, you won't see cultural change, in my view.

**Justice Health Partnerships**

**MR NEWHOUSE (page 234):** Can I add to that and then I will go. I think you have raised a really good point. All those departments have a role to play in assisting the individual, but they need to be coordinated by an independent case worker. You see this model ‑ I know it's working in New South Wales; I think it's national now ‑ in the Health Justice partnerships. So, a lawyer is allocated to a hospital emergency ward. Homeless people arrive in a hospital ward, and they receive a coordinated response from the Department of Housing, from a medical aspect, from their legal aspects, and that's the kind of coordinated response that the individual needs in prison or youth detention.

And it's a great suggestion that all these departments need to be involved. It's not that they are compromised by being organs of the state, but they need to be harnessed together, otherwise you do get the silos that Ms Kilroy is talking about.

**National Justice Project Position Statements**

**First Nations Over-Incarceration and Deaths in Custody**

**justice.org.au/wp-content/uploads/2022.07.12-NJP-Position-Statement-on-First-Nations-Overincarceration.pdf**

**Health Justice**

**www.justice.org.au/wp-content/uploads/2022.07.12\_NJP-Position-Statement-on-Health-Justice.pdf**

1. ‘Services for inmates with a disability’, Corrective Services NSW, webpage

   [https://correctiveservices.dcj.nsw.gov.au/csnsw-home/reducing-re-offending/initiatives-to-supportoffenders/specialist-support/services-for-inmates-with-a-disability.html#>](https://correctiveservices.dcj.nsw.gov.au/csnsw-home/reducing-re-offending/initiatives-to-support-offenders/specialist-support/services-for-inmates-with-a-disability.html). [↑](#footnote-ref-1)
2. ‘What is psychosocial disability?’, Corrective Services NSW, webpage

   [https://www.health.nsw.gov.au/mentalhealth/psychosocial/foundations/Pages/psychosocialwhatis.aspx>](https://www.health.nsw.gov.au/mentalhealth/psychosocial/foundations/Pages/psychosocial-whatis.aspx). [↑](#footnote-ref-2)
3. ‘Services for inmates with a disability’, Corrective Services NSW, webpage

   [https://correctiveservices.dcj.nsw.gov.au/csnsw-home/reducing-re-offending/initiatives-to-supportoffenders/specialist-support/services-for-inmates-with-a-disability.html#>](https://correctiveservices.dcj.nsw.gov.au/csnsw-home/reducing-re-offending/initiatives-to-support-offenders/specialist-support/services-for-inmates-with-a-disability.html). [↑](#footnote-ref-3)
4. Office of the Inspector of Custodial Services, *Inspection of the Intensive Support Unit at Banksia Hill Detention Centre*, Report no. 141, March 2022, 10-11. [↑](#footnote-ref-4)
5. *VYZ by next friend XYZ v Chief Executive Officer of The Department of Justice* [2022] WASC 274. [↑](#footnote-ref-5)
6. Aboriginal Legal Service of Western Australia, *Supreme Court declares lockdowns at Banksia Hill unlawful - Aboriginal Legal Service*, media release, 25 August 2022. [↑](#footnote-ref-6)
7. ‘Corrective Services’, WA Government, website <[https://www.wa.gov.au/organisation/departmentof-justice/corrective-services>](https://www.wa.gov.au/organisation/department-of-justice/corrective-services). [↑](#footnote-ref-7)
8. ‘Corrective services NSW’, NSW Government, website [<https://correctiveservices.dcj.nsw.gov.au/>](https://correctiveservices.dcj.nsw.gov.au/). [↑](#footnote-ref-8)
9. ‘Common myths about the Aboriginal Justice Agreement’, Northern Territory Government, Department of the Attorney-General and Justice, website <[https://justice.nt.gov.au/attorneygeneral-and-justice/northern-territory-aboriginal-justice-agreement/common-myths-about-theaboriginal-justice-agreement>](https://justice.nt.gov.au/attorney-general-and-justice/northern-territory-aboriginal-justice-agreement/common-myths-about-the-aboriginal-justice-agreement). [↑](#footnote-ref-9)
10. Mick Palmer AO APM, *Inquiry into the circumstances of the Immigration detention of Cornelia Rau*, Report, July 2005. [↑](#footnote-ref-10)
11. Key indicators are referred to in B McSherry et al, *Unfitness to Plead and Indefinite Detention of Persons with Cognitive Disabilities* (2017) at 13-14. See also C Brolan and D Harley, ‘Indigenous Australians, Intellectual Disability and Incarceration: A Confluence of Rights Violations’ (2018) *Laws* 7(7) (**Brolan 2018**) at 6. [↑](#footnote-ref-11)
12. Brolan 2018 at 6. [↑](#footnote-ref-12)
13. See, eg, Brolan 2018 at 7-8; Senate Standing Committee on Community Affairs, ‘Indefinite detention of people with cognitive and psychiatric impairment in Australia’ (2016) at [4.6]-[4.31]. [↑](#footnote-ref-13)
14. P Gooding and T Bennet, ‘The Abolition of the Insanity Defense in Sweden and the United Nations Convention on the Rights of Persons with Disabilities: Human Rights Brinkmanship or Evidence it won’t work?’ (2018) *New Criminal Law Review* 21(1) at 141; [↑](#footnote-ref-14)
15. Concluding Observations from the Review of Australia’s Compliance with the Convention Against Torture at [31]; B McSherry et al, *Unfitness to Plead and Indefinite Detention of Persons with Cognitive Disabilities* (2017) at 20. [↑](#footnote-ref-15)
16. Opening Address Counsel Assisting – Public hearing 11, Brisbane at [118]. [↑](#footnote-ref-16)
17. See, eg, *R v Presser* [1958] VR 45 at 48. [↑](#footnote-ref-17)
18. Ibid. [↑](#footnote-ref-18)
19. *Eastman v The Queen* (2000) 203 CLR 1 at [298]. [↑](#footnote-ref-19)
20. And assuming the Judge determines that it is not likely that the accused will become fit to stand trial within 12 months. Otherwise, the process is adjourned for reassessment. [↑](#footnote-ref-20)
21. B McSherry et al, Unfitness to Plead and Indefinite Detention of Persons with Cognitive Disabilities (2017) pp. 51-52. [↑](#footnote-ref-21)
22. Piers Gooding et al, ‘Supporting Accused Persons with Cognitive Disabilities to Participate in Criminal Proceedings in Australia: Avoiding the Pitfalls of Unfitness to Stand Trial Laws’ (2017) 35(2) *Law in Context. A Socio-legal Journal* 64. [↑](#footnote-ref-22)
23. Judicial College of Victoria, Disability Access Bench Book (2016) ss3.3, 5.6.1, 5.7, 5.9, 5.10, 5.19, 5.20.1, 5.20.2, 5.21. [↑](#footnote-ref-23)
24. Ibid ss 5.13, 5.10. [↑](#footnote-ref-24)
25. Until the *Criminal Law (Mental Impairment) Bill 2022* (WA) comes into force. [↑](#footnote-ref-25)
26. See the discussion in *R v KMD (No 5)* [2022] NTSC 69 at [149]. [↑](#footnote-ref-26)
27. See, eg, Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities*. [↑](#footnote-ref-27)
28. P Bartlett, ‘Benefitting from Hindsight: What the Mental Capacity Act and its Implementation can Teach us about CRPD Implementation’ (forthcoming publication). [↑](#footnote-ref-28)
29. Chair Opening Address – Public hearing 11, Brisbane at 13-14. [↑](#footnote-ref-29)
30. Victorian Law Reform Commission, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)*, Report No 28 (2014) at [3.124]-[3.125]. [↑](#footnote-ref-30)
31. B McSherry et al, *Unfitness to Plead and Indefinite Detention of Persons with Cognitive Disabilities* (2017) at 26-28; P Gooding et al, ‘Supporting Accused Persons with Cognitive Disabilities to Participate in Criminal Proceedings in Australia: Avoiding the Pitfalls of Unfitness to Stand Trial Laws’ (2017). [↑](#footnote-ref-31)
32. Senate – Community Affairs References Committee, Indefinite detention of people with cognitive and psychiatric impairment in Australia (November 2016) at 176. [↑](#footnote-ref-32)
33. Preventative detention laws are an exception to this. The difference is that they apply directly by reference to categories of serious offending or antisocial behavior rather than by reference to the arbitrary (from a safety point of view) factum of capacity at trial or at the time of the offence. [↑](#footnote-ref-33)
34. Senate – Community Affairs References Committee, Indefinite detention of people with cognitive and psychiatric impairment in Australia (November 2016) at [2.110]. [↑](#footnote-ref-34)
35. Staff of the Forensic Disability Unit [↑](#footnote-ref-35)