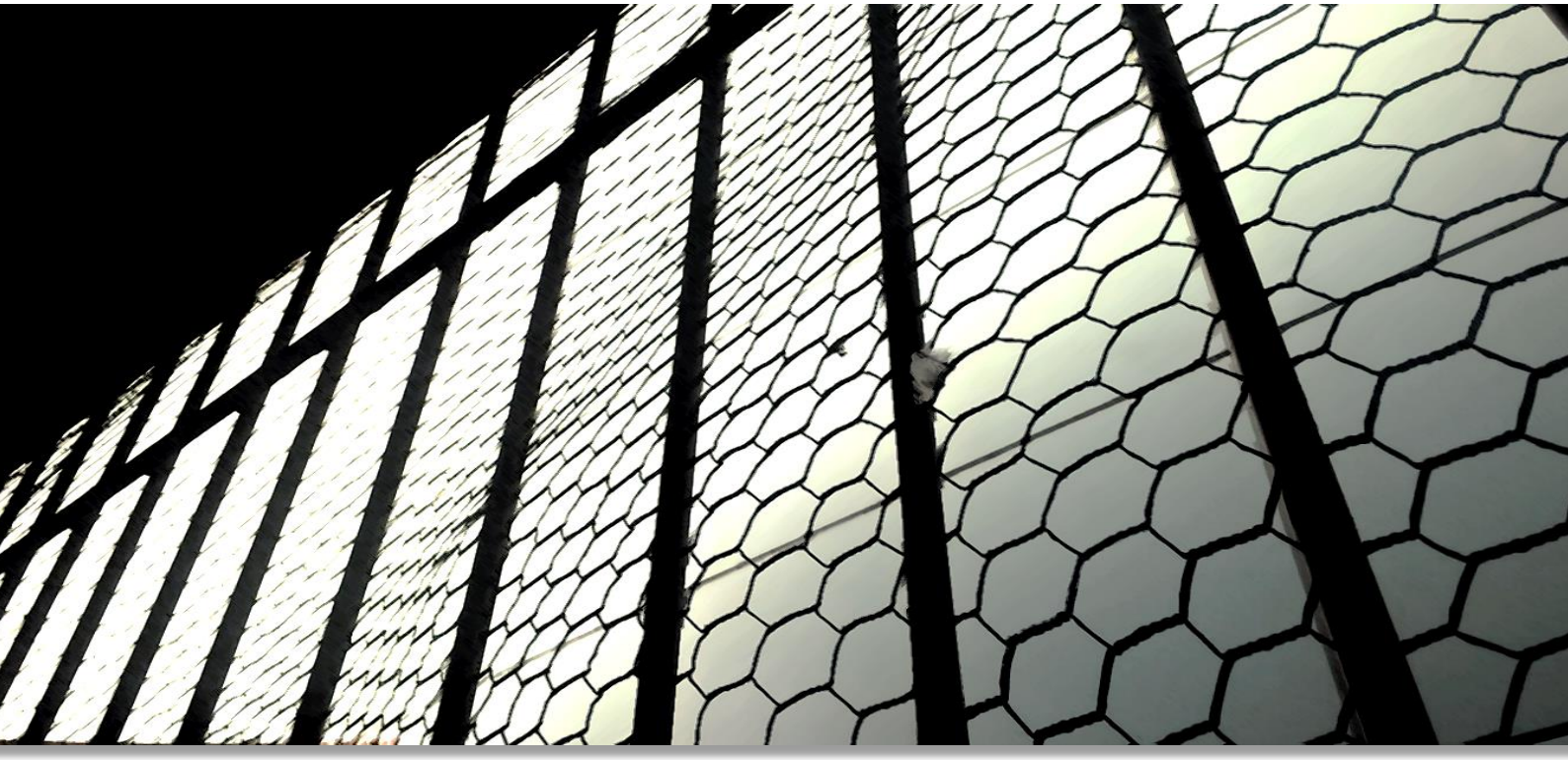

SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

INDEFINITE DETENTION OF PEOPLE WITH COGNITIVE OR PSYCHIATRIC IMPAIRMENT IN AUSTRALIA

APRIL 2016

DACSSA
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VICTIM SUPPORT SERVICE

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Dignity for Disability

BARRIERS TO JUSTICE

Barriers to Justice (B2J) is comprised of representatives from the Disability Advocacy and Complaints Service of South Australia (DACSSA), Victim Support Service (VSS) and Dignity for Disability (D4D). We work in partnership to advocate for law and policy reform to improve access to justice for people with disability.

DISABILITY ADVOCACY AND COMPLAINTS SERVICE OF SOUTH AUSTRALIA

DACSSA provides support, information and advocacy for all people with disability, their families, friends and carers. DACSSA is a not for profit organisation funded by the Australian Government, dedicated to providing the most effective, respectful and culturally competent individual advocacy service for people with disability.

DACSSA advocates are highly experienced and qualified and understand the importance of adopting a person-centred philosophy when working with family, friends, professionals and organisations to help make changes happen.

DACSSA promotes individual rights to freedom of expression, self-determination and decision-making and actively prevents abuse, harm, neglect and violence in accordance with the National Standards for Disability Services.

For more information go to www.dacssa.org.au.

VICTIM SUPPORT SERVICE

Victim Support Service (VSS) is a statewide, community based not-for-profit organisation in South Australia that provides practical and therapeutic support to more than 40,000 victims and witnesses of crime each year in South Australia. Our services include information and advocacy, counselling, practical assistance and support for victims of family and domestic violence.

VSS is recognised as an authoritative body which speaks on behalf of South Australian crime victims, and is a representative voice about victims' issues at many forums, including on the Parole Board of South Australia and the Department for Correctional Services' (DCS) Serious Offenders Committee.

For more information go to www.victimsa.org.

DIGNITY FOR DISABILITY

Dignity for Disability (D4D) is a South Australian registered political party represented by Hon Kelly Vincent MLC in the Legislative Council of the Parliament of South Australia. D4D passionately advocate for people with disabilities and mental illness or experiencing social disadvantage, and their family carers and supporters. D4D seeks to promote the United Nations Convention of the Rights of People with Disabilities in the Australian context, and advance the human rights of all people with disabilities or facing social disadvantage. This is achieved through individual and systemic advocacy and policy and legislative change, and communicated via media and political forums.

For more information go to www.d4d.org.

INTRODUCTION

B2J welcomes the opportunity to provide comment to the Senate Community Affairs References Committee regarding the Inquiry into the Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia.

This submission responds to the following Terms of Reference for the Inquiry:

- the experiences of individuals with cognitive and psychiatric impairment who are imprisoned or detained indefinitely, and
- access to justice for people with cognitive and psychiatric impairment, including the availability of assistance and advocacy support for defendants.

Approximately one in five Australians identify as having a disability.[i] Many people with cognitive and psychiatric impairment come into contact with the criminal justice system as victims or witnesses of crime, accused persons, defendants, or offenders, and face significant barriers to accessing justice, whether in a police station, in court, or in the prison system.

The number of forensic patients and prisoners with a mental illness in Australia is increasing.[ii] It is our understanding that as of July 2015, eight forensic mental health patients are being held in South Australian prisons.[iii]

B2J supports the human rights-based approach to improving access to justice for people with disability outlined in the Australian Human Rights Commission's 2014 report, '*Equal Before the Law: Towards Disability Justice Strategies*'.[iv]

We acknowledge and commend the work of the South Australian Government through the *Disability Justice Plan 2014-17* to address the systemic failures of the criminal justice system in South Australia to adequately meet the needs of people with disability.

There is a clear human rights and public interest in addressing and preventing the indefinite detention of people with cognitive and psychiatric impairment. Without immediate preventative action, people with cognitive and psychiatric impairment will be forced to continue to endure the long-term psychological, financial and social impacts of imprisonment or indefinite detention.

Moving forward, legal and policy responses to protecting and upholding the human rights of people with disability must be informed by their voices. We have included several case studies in our submission to demonstrate the harm caused by the indefinite detention of people with cognitive and psychiatric impairment within the criminal justice system.

LIST OF RECOMMENDATIONS

RECOMMENDATION 1

That correctional services staff and volunteers in all Australian States and Territories receive regular and adequate training on the human-rights based approach to the treatment and care of people with cognitive and psychiatric impairment within the criminal justice system.

RECOMMENDATION 2

That the National Statement of Principles for Forensic Mental Health are implemented through legislative reform and cross-border arrangements in all Australian States and Territories.

RECOMMENDATION 3

That appropriate services and places of detention for people with cognitive impairment are developed in all Australian States and Territories.

RECOMMENDATION 4

Whenever forensic patients need to reside in a prison setting, the responsibility for all rehabilitation programmes should rest with the forensic mental health service, and programmes should be aligned to a forensic mental health program, not a corrections regime.

RECOMMENDATION 5

The National Disability Insurance Agency (NDIA) and state-based corrections services develop ongoing dialogue about the planning processes and management of prisoners and those detained in forensic mental health facilities that are eligible for NDIS support.

COGNITIVE AND PSYCHIATRIC IMPAIRMENT

In 2013, the New South Wales Law Reform Commission (NSWLRC) completed a review of the criminal law and procedures relevant to people with cognitive and psychiatric impairments in the criminal justice system.

WHAT IS COGNITIVE IMPAIRMENT?

The NSWLRC defines 'cognitive impairment' as an ongoing impairment in comprehension, reason, adaptive functioning, judgement, learning or memory that is the result of any damage to, dysfunction, developmental delay, or deterioration of the brain or mind. Such cognitive impairment may arise from, but is not limited to, the following:

- Intellectual disability
- Borderline intellectual functioning
- Dementias;
- Acquired brain injury (ABI)
- Drug or alcohol related brain damage (including Fetal Alcohol Spectrum Disorder, FASD)
- Autism spectrum disorders.

WHAT IS PSYCHIATRIC IMPAIRMENT?

The term 'psychiatric impairment', also known as 'mental health impairment', refers to 'temporary or continuing disturbance of thought, mood, volition, perception, or memory that impairs emotional wellbeing, judgement or behaviour, so as to affect functioning in daily life to a material extent'.[v] Psychiatric impairment may arise from, but is not limited to, the following:

- Anxiety disorders;
- Affective disorders;
- Psychoses; and
- Substance induced mental disorders[1].

WHO IS A FORESIC PATIENT?

A forensic patient is a person who the Court has:

- Found unfit to be tried for an offence and ordered to be detained in a correctional centre, mental health facility or other place;
- Found not guilty by reason of mental illness or nominated a limiting term and ordered to be detained in a prison, hospital or other place
- Found not guilty by reason of mental illness and released into the community subject to conditions.

[1] 'Substance induced mental disorders' include ongoing mental health impairments such as drug-induced psychoses, but do not include substance abuse disorders such as addiction to substances or the temporary effects of ingesting substances.

SENTENCING LAW

Section 269C of the *Criminal Consolidation Act 1935* (SA) provides that a person is mentally incompetent to commit an offence if, at the time of the offence, the person had a 'mental impairment' and did not know the nature or quality of the conduct, or that the conduct was wrong, or was unable to control the conduct.

Section 269A of the *Criminal Consolidation Act 1935* (SA) defines 'mental impairment' as mental illness, intellectual disability, or impairment of cognitive function due to senility.

If the Court finds that the accused person is mentally incompetent, there are several possible outcomes of such a finding. These include:

- the unconditional release of the defendant[vi]
- a supervision order that releases the defendant into the community for a specified period of time under strict conditions[vii]
- a supervision order that commits the defendant to detention for a specified period of time in secure psychiatric care.[viii]

The defendant can apply to the Court for release from detention on conditions of licence at any time during the term of the supervision order.[ix] If the above outcomes are not feasible due to a lack of capacity, such as a shortage of beds available at James Nash House (JNH), the Minister for Correctional Services may direct that the defendant be kept in prison.[x] These individuals are referred to as 'forensic patients'.[xi]

The support and treatment needs of people with cognitive and psychiatric impairments within the criminal justice system differ from other inmates:

> *The nature of the care, containment and support that intellectually disabled people require…is very different to that of the mentally ill. While they require psychological and psychiatric understanding and appropriate structured care, to define such processes as treatment is to miss the difference between the onset of an illness, which is largely treatable and reversible in the case of a major mental illness, and a condition which is simply managed by training, allowance of maturation and caring support in the case of an intellectual deficit. This difference rightly requires different legal mechanisms for each group.*[xii]

RESPONSE TO THE INQUIRY TERMS OF REFERENCE

THE EXPERIENCES OF INDIVIDUALS WITH COGNITIVE AND PSYCHIATRIC IMPAIRMENT WHO ARE IMPRISONED OR DETAINED INDEFINITELY

Research shows that access to adequate mental health care in prisons continues to be one of the biggest challenges faced by the criminal justice system.[xiii] B2J understands that, in lieu of access to adequate mental health care facilities, prisoners with cognitive and psychiatric impairment are often 'managed' by segregation from other prisoners. This can result in an prisoner with a cognitive or psychiatric impairment being subject to solitary confinement. Research shows that segregation and solitary confinement can cause significant psychological harm[xiv], and in the case of Scott Simpson (refer Case Study 1), death.

CASE STUDY 1: SCOTT SIMPSON

Scott Simpson was arrested and taken to the Silverwater remand centre in March 2001 after assaulting a friend during a psychotic episode. Despite his psychosis and long history of violent crime, he was placed in a cell with a juvenile sex offender, Andrew Parfitt, who had requested protective custody. Mr Simpson kicked Parfitt to death within 15 minutes and was later charged with murder.[xv]

Over the next three years, Mr Simpson, who had previously attempted suicide in prison, was kept in segregation cells at various jails. During this time he suffered severe psychotic symptoms (auditory hallucinations, suicidal urges and a belief his mind was under control of the Australian Security Intelligence Organisation (ASIO)), for which he received no hospital treatment. In letters from jail, Mr Simpson said he felt he was being slowly tortured to death. Mr Simpson's clinical notes show that psychiatrists and nursing staff at Goulburn jail repeatedly requested his transfer to Long Bay jail hospital. One nurse wrote personally to a senior bureaucrat in the Health Department to express his concern. Instead, Mr Simpson was isolated to a cell in the jail's high-risk-management unit in early 2003. A departmental letter to his family claimed that the transfer would help manage his condition.[xvi]

At a court hearing three months later, psychiatrist Dr Bruce Westmore testified that the impact of Mr Simpson's schizophrenia had a detrimental impact on his wellbeing. Two other psychiatrists disagreed with each other over Mr Simpson's mental state; one said Mr Simpson's psychotic symptoms had dissolved completely because of medication, the other said he was only in minor remission and required long term care.[xvii]

In March 2004, Mr Simpson was found not guilty of murder by reason of mental illness. It was recommended he be placed under supervision of the Mental Health Review Tribunal. Nine weeks later, Mr Simpson was found hanging in his segregation cell in the main jail at Long Bay. At the time of his death, Mr Simpson was still on the waiting list for the hospital. The correction officers who discovered Mr Simpson hanging from the bars of his cell did not immediately attend to him, or attempt resuscitation, as they feared that Mr Simpson had faked his own hanging and helping him would put their safety at risk.[xviii]

Mr Simpson had sent his last letter to his mother Terri Simpson three weeks before he died. He ended the letter with a scrawled: 'HELP ME'.[xix]

During the inquest into the death of Mr Simpson, submissions made by the Human Rights and Equal Opportunity Commission (HREOC)[xx] pursuant to its functions relating to human rights under s 11(1) of the *Human Rights and Equal Opportunity Act 1986* (Cth) (HREOC Act) outlined the human rights issues regarding the incarceration and death of Mr Simpson.[xxi]

In 2006, the NSW Deputy State Coroner was also highly critical of the prison conditions that led to the suicide of Mr Simpson.[xxii] Her Honour recommended, in line with international

human rights law, that inmates suffering from mental illness should be held in solitary confinement, only as a last resort, and for a limited period.

The rights of people with a mental illness in the criminal justice system are prescribed in several international treaties and human rights instruments, including the *International Covenant on Civil and Political Rights* (ICCPR), the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, the *Body of Principles for the Protection of All Persons under any Form of Detention or Imprisonment*, the *Standard Minimum Rules for the Treatment of Prisoners,* and the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.

Article 9 of the International Covenant on Civil and Political Rights stipulates that no one shall be subject to arbitrary detention. To meet this standard, the United Nations Human Rights Committee (UNHRC) advises that 'any deprivation of liberty must be necessary and proportionate … applied only as a measure of last resort … for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law'.

According to the European Court, and other bodies such as the UNHRC, it is incumbent on the State to 'organise its penitentiary system in such a way that ensures respect for the dignity of detainees, regardless of financial or logistical difficulties'.[xxiii]

THE DEPARTMENT FOR CORRECTIONAL SERVICES (SA)

In South Australia, the Chief Executive (CE) of the Department for Correctional Services (DCS) may direct that a prisoner be kept separately and apart from all other prisoners in the correctional institution.[xxiv] The reasons it may be deemed desirable to do so include:

- the interests of the safety or welfare of the prisoners,[xxv]
- the interests of protecting other prisoners,[xxvi] or
- the interests of security or good order within the correctional institution.[xxvii]

The DCS CE has a non-delegable duty to a prisoner, in the sense that it is a duty that cannot be passed down to individual officers, to whom the CE makes delegations of power. The CE is responsible for ensuring his officers observe the duty of care, and are making appropriate decisions as it is his duty to ensure reasonable steps are taken to uphold the safety of prisoners.[xxviii] We argue, therefore, that the duty of care to a prisoner includes a duty to provide prison officers who are properly trained, and receive ongoing training, in disability and mental health.[xxix]

CASE STUDY 2: PATIENT X

Patient X was found not guilty of an offence by reason of mental incompetence and sentenced to a limiting term of 13 years. After spending seven months of his sentence at the main forensic facility, James Nash House, Patient X was transferred to Yatala Labour Prison where he was incarcerated for seven years.

In Yatala, almost all of Patient X's time was spent in solitary confinement. Solitary confinement, officially known as 'segregated custody', is when a prisoner is detained in isolation from all other prisoner in a segregated cell for all or nearly all of the day, with minimal environmental stimulation.

For the first two and a half years of his sentence, Patient X did not have access to psychiatric support. At one stage, he was placed in a very small dark cell, known by prisoners as the 'fridge'. Patient X was kept on handcuff regime in the cell, where he slept on a concrete slab.

Patient X in this period also requested time out of G Division, to have time with others in B division. He also wanted to have time in the gym to work out, a privilege that is usually available to forensic patients (and can be available to prisoners.)

Patient X was a forensic patient and should have had access to a clinical program available to any person who is in the custody, supervision and care of the Minister for Mental Health, whether he was in G Division at Yatala or any other location.

It is worthy of note that in the *2011 United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Juan Méndez stated that there should be a world-wide ban on the practice of prolonged solitary confinement except in very exceptional circumstances and for as short a time as possible, *with an absolute prohibition in the case of juveniles and people with mental health issues.*[xxx]

The Community Visitor, Mr Maurice Corcoran, has the jurisdiction to visit forensic patients at James Nash House (JNH), however he has no right to enter and access prisons, so cannot visit or meet people with cognitive and psychiatric impairment who may be improperly detained. B2J has no information indicating that the Forensic Mental Health Service (FMHS) fulfils its obligations to forensic patients who are being denied psychological treatment, or subject to solitary confinement and handcuff regime. If FMHS fails to prevent these occurrences, or fails to intervene when a forensic patient in prison has been subject to inadequate care, correctional officers are likely to treat these patients presuming they have capacity and mental health. This means a DCS response may involve punishment of the patient for poor behaviour, instead of treating their condition, and failure to recognise their status as forensic mental health patients rather than prisoners.

According to Patient X's mother, there is a clear need for adequate training to be provided to all DCS staff about what it means to implement a human-rights based approach to the treatment of forensic patients in South Australia's criminal justice system:

> *In speaking with a veteran officer, with many years of service at South Australia's Yatala Labour Prison, whom I have come to know fairly well, I expressed my dismay that a forensic patient would be held in solitary confinement in prison for so many years. His reaction was, "What is 'forensic'?" I explained that it was someone who had been found not guilty by reason of mental impairment and he asked, "If he's not guilty what is he doing here?" Unfortunately, his reaction was far from unusual. Many of the officers do not have any knowledge of what forensic means. And if some do know, I found out that the daily notes given to officers about the various prisoners never even stated that he (Patient X) was forensic. This explained why he was treated exactly as though he had been found guilty with no tolerance or understanding shown for his mental condition, (Antisocial and Narcissistic Personality Disorder with Psychopathy) including his*

> *Obsessive Compulsive Disorder, which caused him to ask for cleaning products and bin lines (often denied) because he had to have his cell spotless.*[xxxi]

RECOMMENDATION 1

That correctional services staff and volunteers in all Australian States and Territories receive regular and adequate training on the human-rights based approach to the treatment and care of people with cognitive and psychiatric impairment within the criminal justice system.

ACCESS TO JUSTICE FOR PEOPLE WITH COGNITIVE AND PSYCHIATRIC IMPAIRMENT, INCLUDING THE AVAILABILITY OF ASSISTANCE AND ADVOCACY SUPPORT FOR DEFENDANTS

THE NATIONAL STATEMENT OF PRINCIPLES FOR FORENSIC MENTAL HEALTH

The National Statement of Principles for Forensic Mental Health (the National Statement) provides a framework of nationally agreed principles that aims to provide cohesion and credibility so that optimal diagnosis, treatment and rehabilitation can be provided to clients of forensic metal health services.[xxxii] The Principles apply to adults and young people in the criminal justice system.

The National Statement acknowledges that there are inherent challenges in providing a mental health service within a correctional facility.[xxxiii] Generally, correctional facilities focus on the secure containment of the person, whereas mental health services tend to focus more on appropriate diagnosis, treatment and rehabilitation of the person.

> *The relationship between the treatment and rehabilitation culture of forensic mental health services and the custodial culture of correctional agencies is often problematic. Similarly, the police, courts, corrections and forensic mental health have different foci and sets of expectations, which can, at times, be difficult to reconcile.*[xxxiv]

It is unclear whether the National Principles have been applied to provide cohesion and credibility so that clients of forensic mental health services receive optimal diagnosis, treatment and rehabilitation. It is also unclear whether the National Principles have been reviewed since they were developed by the Australian Health Ministers' Advisory Council in 2006.

RECOMMENDATION 2

That the National Statement of Principles for Forensic Mental Health are implemented through legislative reform and cross-border arrangements in all Australian States and Territories.

FORENSIC PATIENTS IN PRISON

Forensic patients have complex psychiatric, medical and social needs that cannot be adequately addressed in a prison environment. Correctional officers have not received appropriate or ongoing training to be able to provide this level of mental health support. A lack of awareness among correctional staff on how to treat forensic patients has resulted in negative attitudes, and patients being subjected to extreme punishment, which can exacerbate negative health outcomes for these individuals.

The high prevalence of mental illness in prison, combined with insufficient mental health care, means it is very common for mentally ill prisoners showing acute and disturbing psychiatric symptoms to be 'managed' by segregation.[xxxv] This placement is often not a mental health decision, but one made by correctional administrators, where there is no alternative accommodation, to guarantee their safety.[xxxvi] Treated as a disciplinary matter,

there is no consideration given to whether the management of the prisoner will exacerbate his or her condition.

Holding forensic patients in the unsuitable prison environment causes their condition to deteriorate. Those placed in the general prison population are also at risk of both physical and sexual assault. [xxxvii] According to Dr John Brayley:

> 'People in prison on the James Nash waiting list can exhibit a combination of distress and bewilderment. Their situation is reminiscent of historical descriptions of 19th century mental hospitals before modern treatments developed.' [xxxviii]

RECOMMENDATION 3

That appropriate services and places of detention for people with cognitive impairment are developed in all Australian States and Territories.

RECOMMENDATION 4

Whenever forensic patients need to reside in a prison setting, the responsibility for all rehabilitation programmes should rest with the forensic mental health service, and programmes should be aligned to a forensic mental health program, not a corrections regime.

ACCESS TO ADEQUATE MENTAL HEALTH CARE

B2J understands that there are currently 60 beds available to forensic patients in James Nash House. It is important to note that the lack of capacity in forensic mental health to meet the needs of forensic patients has long been debated and negotiated. As the incidence of mental illness continues to increase, the continued question of forensic mental health capacity in the South Australian jurisdiction will require constant monitoring.[xxxix]

Furthermore, JNH is not able to provide high-level care, which can be delivered in forensic systems in other states. This means high-risk patients, who, in other states would be managed in hospital, are transferred to prison.

Dr Margaret Tobin first highlighted the insufficient design of JNH over ten years ago. She was concerned about the welfare of women and younger patients living in this environment. She said:

> *James Nash House has been operating since the mid-1980s and resembles a prison more than a health facility, it is now out-dated and the facilities are not in line with modern treatment principles. In recent years the design of modern forensic health facilities interstate and overseas has seen a move away from the correctional and custodial type facilities to a secure health campus facility with a specific focus on mental health recovery.*[xl]

Aldgate and Birdwood wards both have a prison-like design. This means, it is neither a modern forensic hospital environment that aims to minimise harmful behaviour nor a particularly effective 'prison environment' for containing difficult behaviours when they do occur.[xli]

A patient occasionally being transferred to prison is just one consequence of the limitations of JNH. At times, the unit will continue to manage high-risk patients. However, to ensure safety, these patients are secluded in their 'cell' for long periods of time. This in itself is anti-therapeutic.[xlii]

THE NEED FOR A FORENSIC DISABILITY SERVICE IN SOUTH AUSTRALIA

In South Australia, the Minister for Mental Health generally handles issues concerning individuals with mental illness, while the Minister for Disabilities is responsible for issues concerning individuals with intellectual disability or brain injuries.[xliii]

Even though a significant portion of people who successfully raise the defence of mental incompetence have an intellectual disability or ABI, the Minister for Disabilities does not have any supervisory responsibilities in relation to supervisions orders. Instead, forensic patents with a disability are placed in the custody of the Minister for Health, who may give directions as to the appropriate custody, supervision and care of the defendant. In most cases, individuals are detained at the forensic mental health facility, JNH.

The requirement for people on forensic orders to be detained in JNH is not appropriate for people with a sole diagnosis of intellectual disability or ABI. Mental health services are designed to provide treatment for people with mental illness. As a result, they do not usually have the facilities or expertise to provide appropriate care for people with a disability, some of whom may present with particularly difficult behaviour and require 'long-term intensive support and secure care'.[xliv]

Another issue is that people with a disability are more likely to wait in prison for a bed at JNH, as people presenting with an acute psychiatric illness are often given priority. People with a disability can be at risk both in prison and in a psychiatric ward- 'often by unwisely approaching other prisoners, and being assaulted'. [xlv]

There is a clear need for a dedicated secure facility for people with cognitive impairments who are found not guilty due to mental incompetence, or who are unfit to stand trial. In the absence of a purpose built facility however, there needs to be a specialised forensic disability program for people who have an intellectual disability, brain injury, autism spectrum disorder or other disability affecting their behaviour. The program should include tailored options for housing and support. [xlvi]

This would ensure people with cognitive impairment are not admitted to a psychiatric facility, such as JNH.

HESITATION TO USE THE DEFENCE OF MENTAL INCOMPETENCE

It is not unknown for people found not guilty by reason of mental incompetence to serve a longer period of incarceration in a mental hospital, than they would have served with a determinate prison sentence.[xlvii]

As a result, some criminal defence lawyers avoid using the defence of mental incompetence, opting instead to simply have their client's mental illness taken into account as a mitigating factor in sentencing. [xlviii] B2J has been told that some lawyers see this tactic as a way to ensure the best possible outcome for their client.

It may be argued that because criminal lawyers believe they can attain a better outcome for their client by avoiding the use of the mental incompetence defence, the system is fine as is. However, this fails to highlight the flaws in the current system and does not reflect the true quantum of people with mental health issues that are in the prison system.

However, as outlined in case studies three, four and five of this submission, many cases are not even reaching the courts in the first instance for the defence of mental incompetence to be considered, nor tendered. Lengthy stays in remand are an Australia-wide feature in the justice system, however for people with cognitive or psychiatric disability where no access to advocacy, health or other support service is provided, disadvantage is further compounded.

CASE STUDY 3: PRISONER A

In March 2016, Hon Kelly Vincent MLC was made aware of the case of a middle-aged man with an intellectual disability detained in a South Australian prison. The case was brought to Ms Vincent's attention as it was believed the man was in prison because no suitable accommodation could be found for him.

It was believed that the due to the individual's intellectual disability, he did not fully understand his circumstances. He seemed to have difficulty with his memory and therefore may not have been able to easily recall the events that resulted in his imprisonment. The individual who made contact with Ms Vincent's office was concerned the prisoner had no form of advocacy or support from family and friends. It was unknown whether he had legal representation to assist him in court.

The individual had been in prison for approximately one month. During this time he had been sexually propositioned by other prisoners. Although it is understood no abuse occurred, those with an intellectual disability in prison are likely to be at a higher risk of assault due to their increased vulnerability. It is also believed the individual may have been showing more extreme behaviours due to his reaction to the prison environment and his treatment by other prisoners.

Prior to imprisonment, this individual was employed through a disability employment provider. The employer was made aware of this situation and it was their understanding that the individual was only in prison because his housing had fallen through and he had been detained until accommodation could be found for him. The employer was informed by Disability SA that it would take approximately one month to find suitable housing for the man.

It is understood that accommodation was found for the prisoner on the day of his court appearance and as a result he has now left prison.

CASE STUDY 4: PRISONER B

In April 2016, Ms Vincent was made aware of the case of a 19-year-old Aboriginal male who was kept in prison past his release date due to a lack of disability support at the recommended post-release accommodation arranged for him.

The individual has Fetal Alcohol Spectrum Disorder (FASD). He experiences memory loss, disorientation, and a range of other issues that, according to reports, make functioning in a 'normal environment' impossible. He also has an acquired brain injury (ABI) resulting in further cognitive difficulties, paranoia, limited understanding, and hearing voices. He has a history of self-harm. The individual was placed in foster care at the age of five when he was found to have untreated broken bones. During his foster placement he was sexually abused. He was under the Guardianship of the Minister for Child Protection until age 18 and is now under the Public Trustee's oversight. The individual does not identify as having a disability.

In July 2015, Disability SA was aware that the individual was homeless and in need of supported accommodation. Two weeks later his support worker advised him that they would not be able to support him, as he has stated he does not have a disability. Since July 2015, it is unknown where the individual is living.

The individual is understood to have committed his first offence at the age of 13 and has since been charged with non-compliance breaches. Late last year, the individual was released on parole. He was given reporting instructions, however due to his disability was not capable of reading or remembering this information or of understanding the steps he would need to take to get to the reporting location etc. He was then charged for breach of parole and was imprisoned.

It was planned that the individual would be released from prison in early April 2016. Accommodation had been arranged for the individual prior to his release at a supported facility. It was also arranged through Disability SA that the individual would receive funding for eight hours a day for staff assistance. However, at the last minute Disability SA declined to fund his application until they had more information about his parole conditions. As a result the individual was held in prison until his application was accepted. This was despite the fact that Disability SA had been aware of the man's imprisonment and need for support after his release from December 2015.

It is understood that the individual has since been released from prison and is living at the accommodation that was previously arranged for him, however the disability support he needs to stay there is only funded until 30 June 2016.

CASE STUDY 5: PRISONER C

In April 2016, Ms Vincent's office was contacted by a mother concerned about her son who has drug induced mental health issues and is currently detained on remand in a police station.

The individual has a long history of drug abuse. He started using cannabis at the age of 14 and in the last few years has been using ice (methamphetamines). He has had episodes of severe psychosis. This has resulted in a breakdown of family support and contact. This was exacerbated by the fact that his mother was deemed to be a trigger for his psychosis and therefore had to stop contact for some time.

The individual has attempted to seek entry to drug rehabilitation in the past but was unable to get assistance. In the past he has presented to hospital, for help with his drug problem on his own, with his mother and under police intervention. He was never taken into a drug rehabilitation program.

The individual was charged with a serious violent crime and since early March 2016, has been detained at a police station until a place becomes available for him in prison. It is questionable as to whether prison (or, in this case a cell in a police station) is an appropriate environment considering his extreme mental health issues.

His mother does not know if he was given the correct treatment when he was first taken to prison as she has been unable to get this information.

If he does not receive appropriate assistance for his drug and mental health issues, this cycle is likely to repeat. It is clear that intervention is needed to ensure that he does not commit another offence and is given assistance to stop his drug use.

THE NATIONAL DISABILITY INSURANCE SCHEME INTERACTION WITH STATE-BASED CORRECTIONS, HEALTH AND DISABILITY DEPARTMENTS

While B2J appreciates that this is specifically in the terms of reference for the Committee's current inquiry, we would like to draw attention to the current disability reforms occurring with the rollout of the National Disability Insurance Scheme (NDIS) by the National Disability Insurance Agency (NDIA) at Commonwealth level.

As demonstrated by the case studies provided throughout this submission, it is already a struggle ensuring health, disability and corrections systems work together to ensure people with cognitive and psychiatric disabilities receive adequate and fair treatment and support within the justice system.

While corrections will continue to be state based, disability services will be coordinated at Commonwealth level by the NDIA across Australia (except for WA) from 2018. There are many people currently within the corrections system that will be eligible for NDIS support, but how that will be managed across national-state borders remains to be seen.

RECOMMENDATION 5

The National Disability Insurance Agency (NDIA) and state-based corrections services develop ongoing dialogue about the planning processes and management of prisoners and those detained in forensic mental health facilities that are eligible for NDIS support.

[i] Australian Human Rights Commission, *About Disability Rights* (2016) <https://www.humanrights.gov.au/our-work/disability-rights/about-disability-rights>.

[ii] Human Rights Law Centre, *Australia's Treatment of Prisoners and Prison Conditions* (2015) <hrlc.org.au>

[iii] ABC News, *Forensic mental health patients being held in mainstream prisons, SA public advocate says* (13 July 2015) < http://www.abc.net.au/news/2015-07-13/forensic-mental-health-patients-being-held-in-sa-prisons/6616696>.

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