The NDIS and access for Aboriginal and/or Torres Strait Islander people interfacing with the criminal justice system

FINAL REPORT

This Report is part of the Providing Support to Aboriginal people in custody, to access, plan and receive NDIS services project, undertaken by UnitingCare West and Wungening Aboriginal Corporation and funded by the WA Department of Communities Disability Services.

This project is a NDIS Information, Linkages and Capacity Building (ILC) initiative.

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Aboriginal and Torres Strait Islander prisoners

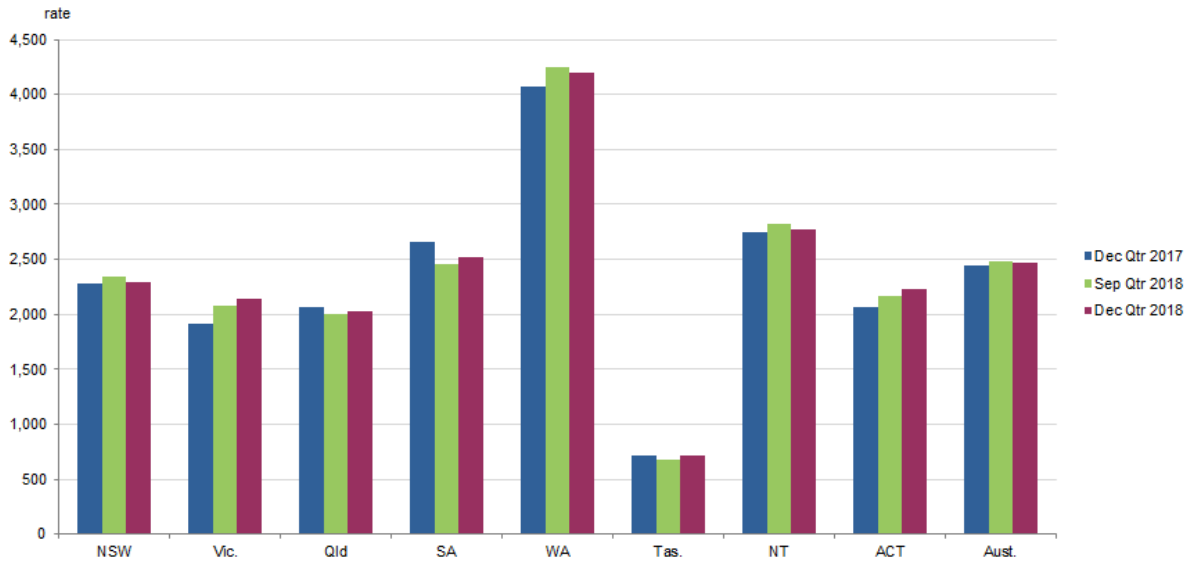
"The average daily number of Aboriginal and Torres Strait Islander prisoners during the December quarter 2018 was 11,776 persons. This represented a slight decrease of less than 1% (66 persons) since the September quarter 2018 and an increase of 4% (438 persons) since the December quarter 2017.

Aboriginal and Torres Strait Islander prisoners represented 28% of the total full-time adult prisoner population during the December quarter 2018.

Three states continue to account for nearly three-quarters of the total Aboriginal and Torres Strait Islander prisoner population:

- New South Wales (28% or 3,304 persons);
- Queensland (24% or 2,771 persons); and
- Western Australia (23% or 2,676 persons)- as shown at Figure 1 below.

Figure 1: Aboriginal and Torres Strait Islander Imprisonment rate(a), By states and territories, Dec 2017, Sep 2018 and Dec 2018



Footnote(s): *(a) Rate is the number of prisoners per 100,000 adult Aboriginal and Torres Strait Islander population. Based on average daily number. © Commonwealth of Australia 2019"*

Australian Bureau of Statistics (2019). Summary of Findings, Persons in Corrective Services. Viewed 19 May 2019, https://www.abs.gov.au/ausstats/abs@.nsf/mf/4512.0

Aboriginal and Torres Strait Islander peoples with disabilities in prison

Aboriginal and Torres Strait Islander people are significantly overrepresented amongst those in prison with complex disability support needs. They are also significantly more likely to be very poor, come from places of high socio-economic disadvantage, have low levels of education, be unemployed, have experienced violence and abuse and have earlier and more police and criminal justice events as both victims and offenders.

Aboriginal and Torres Strait Islander people with a cognitive impairment are also overrepresented amongst people held in indefinite detention as reported in the Senate Community Affairs Committee report *Indefinite detention of people with cognitive and psychiatric impairment in Australia,* which suggested that as many as 50 per cent of the people currently detained indefinitely without charge in prison are Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander women are the fastest growing prison population in Australia. A significant proportion of these women have cognitive disabilities as well as an undiagnosed mental health condition, with one of the reasons cited for this overrepresentation being the lack of appropriate early diagnosis and culturally responsive support available for Aboriginal and Torres Strait Islander children and young people with cognitive impairment.

The first time many Aboriginal and Torres Strait Islander people with cognitive impairment are diagnosed is upon entering the criminal justice system and without access to holistic disability support, Aboriginal and Torres Strait Islander people with cognitive impairment are at a much greater risk of entering a cycle of offending and imprisonment.

Glossary

DSC- Disability Justice Service and Disability Justice Coordinator: The Disability Justice Service supports people with disability who are interfacing with the justice system, including people in custody (e.g. sentenced, on remand or 'mentally impaired accused') and people living in the community, such as people progressing through the Courts or who have transitioned out of a custodial environment.

Justice Coordinators facilitate joint planning, management and support for people with disability who are interfacing with the justice system, providing advice and resource consultancy for staff in services funded and/or provided by the Department of Communities (Disability Services) that are responsible for developing support and diversion options for people with disability, including mentally impaired accused persons. The Disability Justice Coordinator contributes to the identification of training needs and the development and implementation of specific training programs for key internal and external stakeholders, including Prison staff.

Aboriginal: Refers to peoples who are considered as the original inhabitants of mainland Australia. There are significant differences in social, cultural and linguistic customs between various Aboriginal groups in Australia and the distinction between Aboriginal people and Torres Strait Islander peoples is important in recognition of the diversity and distinct cultural history of Torres Strait Islander peoples from that of Aboriginal Australians (refer to definition of Torres Strait Islander). Please refer also to the definition of "Indigenous Australians."

The Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) has developed the map below of Aboriginal and Torres Strait Islander Australia, showing the many and diverse language and social groups – see Figure 2 below.

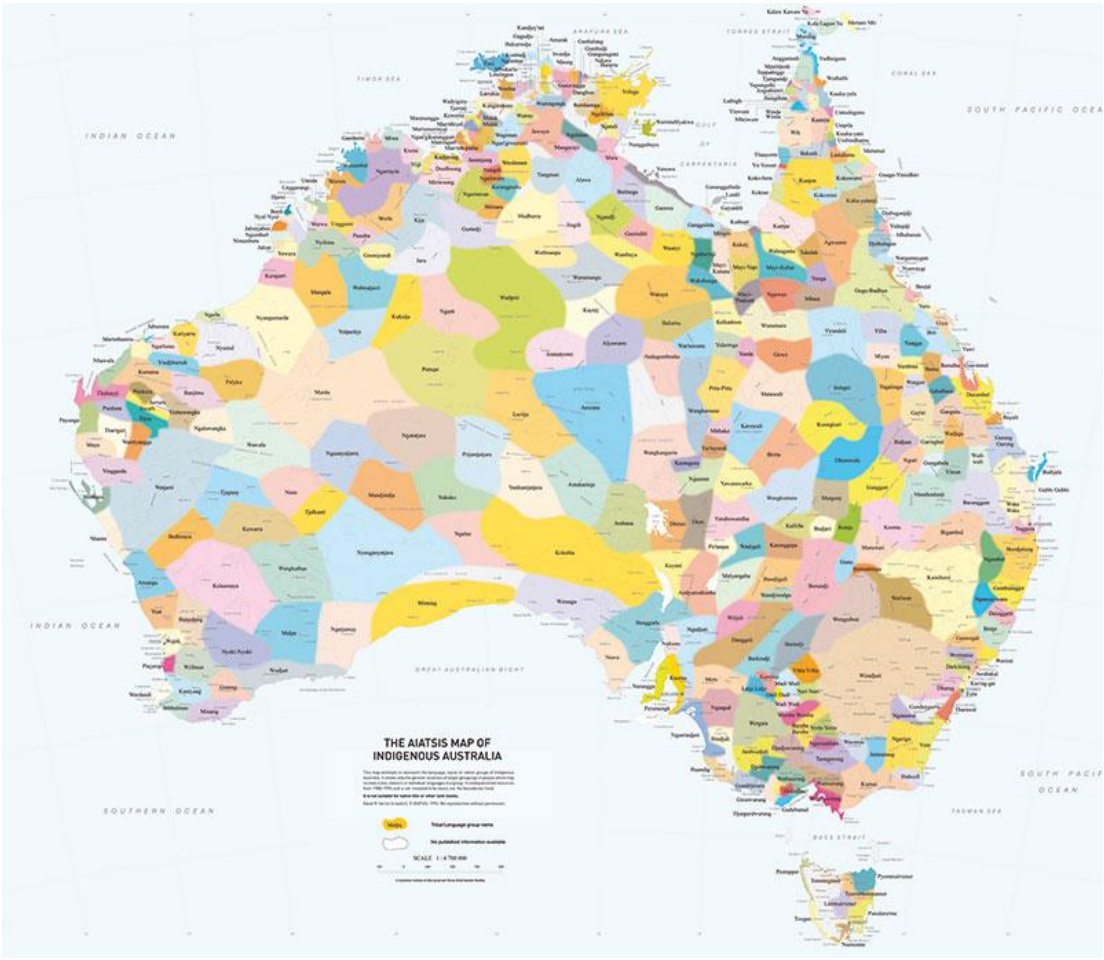


Figure 2: Aboriginal Language Map
Source: https://aiatsis.gov.au/explore/articles/aiatsis-map-indigenous-australia

"Aboriginal and Torres Strait Islander groups were included on the map based on the published resources available between 1988 and 1994 which determine the cultural, language and trade boundaries and relationships between groups. Regions were determined using the watershed basis as a template.

Aboriginal English

Many Aboriginal people still speak varieties of English, based on a combination of standard English and their Traditional language; this distinct dialect of English spoken in Australia known as Aboriginal English. Understanding and respecting the importance of Aboriginal English is fundamental to understanding the lived experiences of Aboriginal peoples, highlights the diversity amongst Aboriginal peoples, and speaks to the strength and resilience of many peoples who were forbidden to speak their Traditional languages, particularly those impacted through the Stolen Generations. Aboriginal English is not 'bad English', and by recognising it as it ought to be recognised it is an important part of identity formation for Aboriginal peoples which is significant in terms of mental health and resilience. Another way of looking at or defining Aboriginal English is to refer to it as 'Aboriginal ways' of using English. Given the hundreds of dialects across Australia, these 'Aboriginal ways' of using and speaking English can be highly variable and is unique from group to group.

"The extent to which the lives of Aboriginal defendants are characterised by often extreme disadvantage, including illiteracy, alcohol abuse and violence, is often central to the judicial consideration of Aboriginality in sentencing. But there is no inherent connection between these negative (and distressing) living conditions experienced by many Aboriginal people and their language variety — in southern Australia, their Aboriginal use of English. Yet in cases in which communication with Aboriginal English speakers is central (for example with prosecution witnesses in a murder case), a focus on problems experienced by Aboriginal people can sometimes connect to a deficit view of Aboriginal identity and social practice. This can result in a situation in which the court may be prevented from engaging in effective intercultural communication." (Eades, D:2016)

Aboriginal Mental Health: Refers to the understanding that for Aboriginal people, assessment, treatment and intervention must cover additional components that may be risk or causative factors for diagnosis. This should include genetic, biological, environmental, cultural, spiritual and specific generational, trauma based components of risk. This includes issues of identity, inter-generational trauma and historical impacts of removal policies. It is vital that through and rigorous assessment incorporate factors are that unique to Indigenous people in terms of both accounting for risk for disorder as well as the focus of sustained treatment and intervention.

Aboriginal and Torres Strait Islander Social and Emotional Wellbeing: Aboriginal and/or Torres Strait Islander Social and Emotions Wellbeing (SEWB) refers to a broad and holistic concept that reflects the Aboriginal and Torres Strait Islander holistic understanding of life and health. It includes mental health, but also considers other factors such as cultural, spiritual and social wellbeing. It encompasses not just the wellbeing of the individual, but also the wellbeing of their family and community. The definition of SEWB is that it ensures the accurate assessment of Aboriginal people who are experiencing mental ill health by ensuring that all contributors to mental ill health are understood and explored for their relevance.

Assessment: The process of gathering information from and about the client in order to develop an understanding of their drug and alcohol, health and welfare needs and to determine suitable intervention options and treatment planning. Client assessment is usually undertaken after intake, though may be done at the same client contact.

Avoidance language: Traditionally refers to the use of language as a sign of respect or as a result of 'power' or hierarchy differences. For instance, referring to a deceased person by name directly after their death as a mark of respect and to ensure that, spiritually they are not 'called back' before grieving

has occurred in its finality. Today the practice continues in many communities, but has also come to encompass avoiding the publication or dissemination of photography or film footage of the deceased person as well (for example, many Australian television programs include a title card warning Aboriginal and Torres Strait Islanders to 'use caution viewing this film, as it may contain images or voices of dead persons,' out of respect for the cultural beliefs of said viewers).

Behaviour support: The NDIS Quality and Safeguarding Framework (2016) defines the requirements for the delivery of behaviour support. Note that the term includes positive behaviour support as an evidence-based method of intervention, and that the term "positive behaviour support" is applied on occasions in NDIS policy. (NDIS Quality and Safeguarding Framework 2018).

Behaviours of concern: Defined as "behaviours of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of, or result in, the person being denied access to ordinary community facilities' (NDIS Quality and Safeguarding Framework, 2016, p. 98). Importantly, these behaviours can be a barrier to the person participating in and contributing to their community, they can undermine directly or indirectly a person's rights, dignity or quality of life, and can take the form of both active and passive behaviours (McVilly, 2012). Note that NDIS legislation and policy will also describe behaviours of concern as "challenging behaviours". (NDIS Quality and Safeguarding Framework 2018).

Black Identity Formation: Black racial identity development (BRID) theory explains the processes by which Black people (the term Black is used here, rather than Aboriginal people, to reflect the terminology in models of identity development) develop a healthy sense of themselves as racial beings and of their Blackness in a toxic socio-political environment in which 'blackness' is the minority position and worldview. Black racial identity development has often been conceptualised in models that describe linear stages through which Black individuals move from a negative to a positive self-identity in the context of their racial group membership.

Case Management: "Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's holistic needs through communication and available resources to promote quality cost-effective outcomes" (Case Management Society of Australia Limited: 2013).

Case Review: A process whereby a Caseworker's active cases are reviewed in the supervision context to determine how effectively the case plan is working, and what steps need to be undertaken to ensure high quality client services. It is a supportive process and is designed to assist workers to achieve goals and outcomes for clients.

Case Review Meetings: A process whereby select active cases are reviewed by the worker, supervisor and peers in a meeting context. This allows the worker to access differing opinions, skills and abilities to determine how effectively the case plan is working and what steps need to be undertaken to ensure high quality client services. It is a supportive process and is designed to assist workers to achieve goals and outcomes for clients.

Client Confidentiality: Service providers only need to know as much personal information about your client as will directly help them deliver their particular service. It would not be necessary, for instance, to reveal personal details about your client's family history to the worker helping them with job training skills.

Clinical competence: Refers to the skill levels possessed by the individual to deal with the presentation of clinical issues in mental health to ensure the client obtains the best possible outcome.

Conflict of interest: A conflict of interest occurs when a risk that professional judgement or actions regarding a primary interest (work) will be influenced by a secondary interest (personal), and occurs

where a personal interest conflicts with a responsibility to act in the best interests of the organisation. A conflict of interest may be actual, potential or perceived and can be financial or non-financial.

Criminogenic needs: are characteristics, traits, problems, or issues of an individual that directly relate to the individual's likelihood to re-offend and commit another crime. Criminogenic needs are broken down into static and dynamic factors, as per below:

- **Dynamic criminogenic factors-** Dynamic factors could be lack of respect for authority, anti-social behaviour, lack of literacy or job skills, or other expressed nonconformist behaviours, values, and attitudes that are correlated with criminal activity. These factors can be addressed by therapy, training, education, and/or targeted programming and subsequently altered to result in more law-abiding behaviour.
- **Static criminogenic factors-** Static factors cannot be changed or addressed by any sort of program or therapy in the prevention of future crimes. Examples of static factors include age at the time of first arrest, criminal history, residing in a single-parent home, and so forth. Generally, these are structural elements of a person's life that personally led them to commit crime.

Cultural accountability: The ability to be open, transparent and accountable in all of our interactions and consultations with the Aboriginal community. This means that practitioners should be fully conscious of the need to culturally validate (refer to definition in this Glossary) information obtained from the community to ensure that it is culturally accurate as well as appropriate to use in written or other forms to external parties as part of the practice of quality assurance.

Cultural Competence: The ability to identify and challenge one's own cultural assumptions, values and beliefs. It encompasses and extends elements of cultural respect, cultural awareness, cultural security and cultural safety. It is about developing empathy and connected knowledge, the ability to see the world through another's eyes, or at the very least to recognise that others may view the world through a different cultural lens. At an operational level it will mean staff/practitioners are able to understand and respond effectively to the cultural needs of Aboriginal clients and appreciate how culture-specific illnesses can manifest themselves emotionally, physically, mentally or spiritually for Aboriginal clients and understanding that this differs from mainstream constructs of mental ill health. Cultural competence must be shown at the levels of; (1) identification; (2) culturally valid assessment, and (3) culturally appropriate intervention through evidence based models of traditional and westernised treatments from which the Aboriginal client is able to select.

Cultural Confidentiality: Refers to the fact that there is a different interpretation of what is 'confidential information' when working with Aboriginal people. This is largely due to the cultural sensitivity of certain topics as well as the sacrosanct nature of many topics within the Aboriginal culture. This requires that firstly, the service provider must be fully aware of the sensitivities that exist in the Aboriginal community in which they are working (this is also an important aspect of cultural competence) and then to make the patient aware that you are cognisant of the sensitivities. Following this, the service provider must then seek permission to proceed with the topic which is of sensitivity. This should normally occur through a process of Informed Cultural Consent (see definition in this Glossary).

Cultural Consultant: An Aboriginal person who can act as a guide to Aboriginal culture to the staff member/practitioner/clinician for the client. They can be:

a) personal friends to the client;

b) professionals within an organisation;

c) integrated network of cultural consultants within a region, including elders, healers etc, and;

d) formalised cultural consultant / co-therapist relationship.

The cultural consultant provides culturally relevant information, to primarily non-Aboriginal workers, however may also be used in situations where there is a gender difference between the counsellor and the client (e.g. Aboriginal males talking with Aboriginal females can often use a Aboriginal female cultural consultant to minimise impact of gender differences). There are a number of ethical dilemmas involved in engaging cultural consultants and the process of engaging cultural consultants can be fraught with difficulty. A process that addresses all potential ethical, legal and cultural dilemmas involved in the engagement of cultural consultants needs to be outlined in organisations policies and procedures.

Cultural Governance: Refers to structures that are developed within service delivery models that allow for the Aboriginal community to have an ongoing role in the development, refinement and evaluation of service delivery models into their communities. For models to be effective in terms of cultural governance it is essential that those involved in the governance structure are;

a) representative of the target population in which services are being delivered;
b) continue to live within the community in which the services are being delivered;
c) vouched for from within that community as holding appropriate regard; and
d) clearly aligned with the values and philosophies of the organisation.

Cultural safety: Involves understanding, learning, respecting the diversity that exists between different Aboriginal groups and not assuming absolute knowledge based on a common cultural background or interactions with select Indigenous groups. For practitioners to operate in a culturally safe manner they must have a full understanding of and ability to apply cultural validation and respect the need for cultural accountability. It is also essential that practitioners attain cultural competency in practice to ensure their cultural safety in practice. The process of "vouching" is also a key element in ensuring cultural safety and security. Additionally, it involves appreciating that information that may be relevant to referral, treatment and assessment may be also culturally taboo. The clinician therefore needs to be sufficiently culturally competent to ensure that cultural transgressions do not occur and therefore potentially put the client at risk within their community. Cultural safety can only occur when differences in culture are recognised and respected and these differences are incorporated into health service delivery. Cultural safety importantly requires the health practitioner to explore their own cultural make up.

Cultural Security: When the respect of cultural rights, beliefs, values and expectations of Aboriginal peoples is upheld.

Cultural supervision: Is a formal relationship between members of the same culture or different cultures for ensuring that the supervisee is practicing according to the values, beliefs, protocols and practices of that particular culture. Cultural supervision focuses on cultural accountability and safety and must occur specific to the area in which the supervisee is providing services. This is due to the extreme differences within the Aboriginal culture. Cultural supervision does not replace clinical supervision.

Elders: Elders are highly respected Aboriginal people held in the highest regard by the Aboriginal community for their wisdom, cultural knowledge and commitment to community. Elders are responsible for making important community decisions and are the traditional custodians of knowledge and Lore/Law (see definition below). Elders hold the knowledge and beliefs of their tribal group and have permission to disclose their traditional Aboriginal knowledge and beliefs in circumstances only they are aware of. In some communities, older people refer to themselves as Elders, however it is important to acknowledge the difference that *may* exist between a traditional Elder and an Elder based on age.

Eligibility: Refers to characteristics that people must possess and/or situations which people must experience to receive services from the NDIS, specifically:

To gain access to NDIS the individual needs to satisfy the following access criteria :

- Age Requirements (NDIS Act 2013, Section 22, page 31)
- Residential Requirements (NDIS Act 2013, Section 23, Page 32)
- Disability Requirements (NDIS Act 2013, Section 24, Page 33).

Note: The definition of disability must be understood within the cultural realities of Guiding Cultural Principles around the limitations of cognitive testing with Aboriginal people as well as the clinical interaction (practitioner error) associated with clinical assessments (Westerman, 2003).

Family Violence: The Human Rights and Equal Opportunity Commission defines **'family violence'** as:

> "Any use of force, be it physical or non-physical, which is aimed at controlling another family member or community member and which undermines that person's well-being. It can be directed towards an individual, family, community or a group. Family violence is not limited to physical forms of abuse and includes cultural and spiritual abuse. There are interconnecting and trans-generational experiences of violence within Indigenous communities."[1]

"Like domestic violence, family violence is about control and power. It may involve:

- Physical violence
- Controlling who you see or what you do
- Emotional abuse such as insults, manipulation and threats
- Financial abuse, such as controlling access to money
- Stalking or other kinds of harassment
- Spiritual or cultural violence, such as denigrating your religious, cultural or spiritual beliefs or preventing you from practising those beliefs
- Sexual violence, including coercion; and other forms of behaviour that are used to control you, make you afraid, or to diminish your sense of self-worth."[2]

Functional behavioural assessment: The process for determining and understanding the function or purpose behind a participant's behaviour, and may involve the collection of data, observations, and information to develop an understanding of the relationship of events and circumstances that trigger and maintain the behaviour. The subsequent behavioural hypotheses can only be confirmed following the implementation of specific strategies and the analysis of data relating to changes in behaviour. (NDIS Quality and Safeguarding Framework 2018). This must be understood within the established bias in the clinical assessment of Aboriginal clients as per Westerman (2003).

Gratuitous concurrence: Refers to the situation where a person appears to assent (say yes) to every proposition put to them even when they do not agree. For many Aboriginal people, using gratuitous concurrence during a conversation is a cultural phenomenon, and is used to build or define the

[1] Aboriginal and Torres Strait Islander Social Justice Commissioner, 'Ending family violence and abuse in Aboriginal and Torres Strait Islander Communities, Australian Human Rights Commission, Canberra, 2006
[2] Ibid

relationship between the people who are speaking. Gratuitous concurrence is also referred to as the 'yes syndrome'.

Informed cultural consent: Refers to the need for practitioners to be aware that for Aboriginal people there is a strong aspect of the culture that requires that information is kept secret or sacred and is therefore not able to be discussed openly. The practitioner must therefore be able to undertake a process of informed cultural consent to ensure that Aboriginal clients are not unwittingly asked to provide information to a third party that they are not culturally allowed to provide.

Intellectual Disability Diversion Program Court (the IDDP Court):
The IDDP Court seeks to address the overrepresentation of people with an intellectual disability ("ID"), cognitive disability ("CD") or autism spectrum disorder ("ASD") within the criminal justice system by addressing their offending behaviour and support arrangements.

Intervention: Refers to any activity whose aim is to address an identified problem or issue. This may be clinical in nature (i.e., a treatment program) or it may be more purely management oriented as in the case of behaviour management in the classroom or juvenile justice context.

Justice Reinvestment: There is no single accepted definition of the term 'justice reinvestment', however it is generally understood to represent a form of economic modelling where resources are redirected from punitive and deficit responses to crime (custodial settings, etc.) into preventative strategies and early diversion away from the criminal justice system in areas with high crime rates. According to the report, *Aboriginal and Torres Strait Islander Experience of Law Enforcement and Justice Services*:

> "justice reinvestment essentially refers to a policy approach to criminal justice spending, whereby funds ordinarily spent on keeping individuals incarcerated, are diverted to the development of programs and services that aim to address the underlying causes of criminal behaviour in communities that have high levels of incarceration"

Limited confidentiality: All shared information will be held in confidentiality (not shared), however limitations to confidentiality exist for both victims and perpetrators. In general, the following principles are a starting point:

- As part of the informed consent procedure clients should be advised that if they disclose something that gives cause for concern workers have a duty to act but will talk with the client first about what to do.
- In exceptional circumstances – if someone is at risk it may be necessary for the worker/agency to breach confidentiality without first talking to the participant.

This means that when seeking consent, the limits of confidentiality must be explained to clients, and included on all consent forms and information sheets.

Local Area Coordinators (LAC): Assist people with disability to plan, organise and access supports and services which enhance their participation in and contribution to their local community. In addition, LACs work with family members and others involved in supporting people with disability so that they are strengthened and supported in their caring role, as well as to make local communities more inclusive and welcoming through education, advocacy and development of partnerships with local community members and organisations, government agencies and businesses.

LAC is available to people with intellectual, physical, sensory, neurological and/or cognitive disability who are under the age of 65 at the time they apply for support. Each Coordinator works with between 50 and 65 people with disability, providing personalised, flexible and responsive support, however they do not appear to provide services to participants in Prison.

In Western Australia, the partners who will deliver LAC services are:

- APM in the North Metro, Central South Metro, South Metro, South West, Great Southern and Inner Wheatbelt Services Areas.
- Mission Australia in the Central North Metro, South East Metro and North East Metro Service Areas.

NDIA: The **National Disability Insurance Agency** (**NDIA**) is an independent statutory agency, whose role is to implement the **National Disability Insurance Scheme** (**NDIS**).

NDIS - What does it mean?

- **National:** The NDIS is being introduced progressively across all states and territories.
- **Disability:** The NDIS provides support to eligible people with intellectual, physical, sensory, cognitive and psychosocial disability. Early intervention supports can also be provided for eligible people with disability or children with developmental delay.
- **Insurance:** The NDIS gives all Australians peace of mind if they, their child or loved one is born with or acquires a permanent and significant disability, they will get the support they need.
- **Scheme:** The NDIS is not a welfare system. The NDIS is designed to help people get the support they need so their skills and independence improve over time.

NDIS key words

- **Permanent and significant disability:** A permanent disability means your disability is likely to be lifelong. A significant disability has a substantial impact on your ability to complete everyday activities.
- **Supports and services:** Assistance or products that help a person in their daily life and help them participate in the community and reach their goals.
- **Early intervention:** Providing support to a person, either a child or an adult, as early as possible to reduce the impacts of disability or developmental delay and to build their skills and independence.

NDIS Participant: A person with a disability who has been assessed by the NDIA as meeting the eligibility criteria to become a participant in the NDIS. Note that NDIS legislation and policy will also describe the participant as a “person” or “person/people with disability”. (NDIS Quality and Safeguarding Framework 2018).

NDIS Support Coordinator: A person who works with NDIS participants to plan their individual development goals and how they want to achieve them. NDIS support coordinators do things such as: Assess funding and services available for a participant, including mainstream, community, informal and provider options.

Regional Intensive Support Coordinator RIS C: This position is responsible for the provision of coordination, support and advice regarding individuals with complex needs and/or interfaces with multiple government and other agencies within a region.

The Regional Intensive Support Coordinator provides a key interface between local stakeholders and the Local Coordination team, gathering and sharing information to provide enhanced access to supports and services for individuals with complex needs.
The position provides consultation, coordination, support and advice to Area Managers and Local Coordinators to ensure quality supports and services to people with disability and their family and carers in complex situations.

Specialist behaviour support provider: A registered NDIS provider (registration group 110) whose registration includes the provision of specialist behaviour support services. (NDIS Quality and Safeguarding Framework 2018).

Specialist behaviour support practitioner: Either as the provider or engaged by a provider, is a person the Commissioner considers is suitable to undertake behaviour support assessments (including functional behavioural assessments) and to develop behaviour support plans that may contain the use of restrictive practices (NDIS Quality and Safeguarding Framework 2018).

Start Court: The "Start Court is a partnership between the Mental Health Commission.
In line with progressive mental health practice, the expertise of people with a lived experience of mental health issues and criminal justice involvement, and their families and supporters, informs the processes and practices of Start Court.

Start Court is a solution focused court, adopting principles of therapeutic jurisprudence, for people who are experiencing a mental health issue.

Through the Start Court Program ('the Program'), it seeks to address the overrepresentation of people with mental illness in the criminal justice system by addressing their offending behaviour as well as their mental health and psychosocial needs" (Start Court Guidelines).

Supervision: A formal, ongoing and collaborative learning process involving a supervisor and supervisee. It usually involves a number of sessions over a period of time to assist the worker in developing their skills in working with clients with varying presentations. It should be conducted by an appropriately trained worker(s) with expertise in the same field. The desired outcomes of supervision for the supervisee are increased autonomy, independence, knowledge and skills, development of professional values and the development of an integrated professional approach to the counselling, advocacy and support services they provide.

- **Clinical supervision** is defined as providing supervision in the *clinical* perspective of mental health issues, social, emotional and behavioural factors.
- **Cultural supervision** is defined as the process of being provided with supervision specific to the cultural manifestations of mental illness. Cultural supervision is able to make sense of the complex relationship between cultural and mental illness across assessment, counselling, testing and intervention services.

Therapy: is a treatment procedure that is based on classic therapeutic models and may be short- or long-term and needs to be valid and reliable way of working for the Aboriginal population. The aim of therapy is to empower the client make alterations to their personal defenses and develop adequate coping strategies to survive and thrive in their environment. Usually treatment continues until the problem(s) resolve or become appropriately manageable.

Torres Strait Islander: Refers to those peoples who are Indigenous to the Torres Strait Islands. The eastern Torres Strait Islanders are related to the Papuan peoples of New Guinea and speak a Papuan language. The Torres Strait Islanders possess a heritage and cultural history distinct from Aboriginal traditions. Accordingly, they are not generally included under the designation "Aboriginal Australians." This has been another factor in the promotion of the more inclusive term "Indigenous Australians". Six percent of Indigenous Australians identify themselves fully as Torres Strait Islanders, with four percent identifying as having both Torres Strait Islander and Aboriginal heritage. The Torres Strait

Islands comprise over 100 islands. Many Indigenous organisations incorporate the phrase "Aboriginal and Torres Strait Islander" to highlight the distinctiveness and importance of Torres Strait Islanders in Australia's Indigenous population.

Transition Managers (TM): Transition Managers are located at each WA State prison to coordinate services that will help prisoners re-enter the community. Services include:

- ***Re-entry link program*** is a voluntary program to help prisoners improve their life skills, prepare for release, find somewhere to live and link up with job network providers, family and community support services. Prisoners are eligible
    - for support 3 months before they are released and for 6 months after they get out. This service operates in every prison across the State.
- ***Transport options program*** is a program that provides transport for prisoners
- ***Transport Options Program (TOP)*** provides transport to prisoners from remote locations who have difficulty returning to their homes when they are released from prison or a work camp. The TOP operates in the Pilbara, East Kimberley, West Kimberley, Murchison, Gascoyne and Goldfields regions. A TOP policy is in place to make sure prisoners are fit to travel and all vehicle and safety requirements are met.
- ***Supported accommodation services*** provide support for people who have just got out of prison and other ex-offenders who are at risk of committing crime if they don't have somewhere stable to live, including:
    - short-term and emergency accommodation - for newly released offenders for up to 3 months
    - transitional accommodation and support services - accessible via the relevant prison's transitional manager to prisoners for up to 9 months post-release, including mothers and babies
    - long-term accommodation for single people for up to 18 months.

  After they are released, prisoners can get help with:
    - organising Centrelink payments
    - keeping a place to live
    - linking back in with family and friends
    - finding a job
    - finding somewhere permanent to live
    - life skills.

- ***Parenting and Support Services (PASS)*** provide support, education and advice to parents at Bandyup Women's Prison and in the community after prisoners are released.
- ***Family Support Service Centres (FSSC)*** provide information, support and referral services to prisoners' families, friends and other visitors to the prison.
- ***Chaplain services*** are provided for the spiritual welfare of prisoners. The Department funds five religions that service all prisons and detention centres.
- ***Specialist Re-entry and Support Services*** provide support and accommodation services to life and indeterminate sentenced prisoners and sex offenders before and after they are released. The service encourages offenders to live a law-abiding lifestyle and successfully re-enter the community by providing:
    - pre-release support and visits
    - somewhere to live in both the short and medium term
    - support to find somewhere permanent to live
    - help to set up community networks and re-connect with family
    - help with referrals to other welfare agencies.

While the Department provides some funding for this program, the majority of services are provided by volunteers.

Guiding Cultural Principles

Guiding Cultural Principles are a set of Principles developed for an organisation or program that lay down the "Cultural Foundation Principles". They are developed as standalone organisational policies and procedures that are able to sit across all program areas and guide staff irrespective of their professional and cultural backgrounds.

Examples of commonly required cultural foundation principles include:

a) Statement of Cultural Security which specifies the focus on the betterment of the life circumstances and outcomes of Aboriginal children in care

b) Protocols and process to ensure effective Engagement with Aboriginal clients and communities

c) Undertaking Culturally Competent Assessment

d) Informed Cultural Consent with Clients

e) Cultural Confidentiality when working with Aboriginal clients

f) Guidelines for the valid use of psychological tests with Aboriginal clients

g) Delivering Culturally Competent Behaviour Management Programs and many more

Cultural Guiding Principles, when fully understood and applied, assist in:

a) the development of new policies, procedures and guidelines across an organisation

b) the identification of any absence of essential, culturally specific procedures and guidelines which are essential for appropriate levels of quality assurance and duty of care in assessment

c) the review of and changes that need to be made to existing policies, procedures and guidelines to ensure their cultural specificity

d) changes to existing data base management system or development of data base system capable of capturing research data from new and adapted tools. This will ultimately allow for the development of evidence based practice with Aboriginal clients

e) the identification of new Assessment Protocols if necessary based upon a review of best practice assessment tools in existence

Risk assessment tools in use to assess the offending / reoffending of high-risk Indigenous offenders

Many mainstream assessments and psychological tests that are used with Aboriginal people fail to recognise the role of culture in client presentation (Okazaki, 1998; Hunter, 1994; Westerman, 2010; Westerman & Sheldon in preparation). A number of confines have been shown to *significantly* bias psychological tests in favour of western, middle-class, schooled individuals. However, the Australian literature has focused primarily on the issue of test bias in the cognitive assessment of Aboriginal people.

In addition to this, the literature on personality assessment has been conducted primarily within indigenous cultures internationally. Factors impacting on test bias with Aboriginal and other minority populations include:

(a) the normative populations for the thousands of psychological tests in existence are predominantly Caucasian Americans – in many instances college students, men and/or middle class (Jones, 1991; Williams, 1991). As a result these tests are "emic psychometric derivatives of a Eurocentric worldview" (Dana, 2000). Therefore, when minority populations are assessed using these norms, questions are raised regarding whether these norms are relevant for indigenous people. Concerns are therefore raised regarding the possibility of misdiagnosis (Epstein, March, Conners & Jackson, 1998).

(b) the validity of diagnoses, which are conducted by a tester who is operating from a perspective diametrically opposed to that of the testee (in this case, the Aboriginal client (Kearins, 1981). This is referred to as interpretation bias, and this affects the validity of assessments in psychometric testing as well as clinical assessment.

(c) the testee's emotional, spiritual and behavioural presentation is driven by a cultural context, which is often not incorporated in the construction of psychometric tests (DeShon, Smith & Chan, 1998; Cuellar, 1998).

(d) the representativeness of a test performance to everyday life knowledge and ability, particularly in terms of cultural value are of primary concern (Cross, 1995).

(e) the fact that instruments has not been translated for indigenous people who often have English as a second language, or dual language. Translation of tests provides construct equivalence or validity of constructs through valid language, format and content (Dana, 2000; 1998).

(f) the suspiciousness held by Aboriginal Australians of the (mental) tests (Davidson, 1996). This factor alone is considered to contribute to the test outcomes i.e. extraneous factors.

The measures which have been used, such as the Minnesota Multiphasic Personality Inventories (MMPI and MMPI-2), have been developed within, and standardised on, predominantly white, middle-class populations, therefore having questionable diagnostic reliability with Aboriginal youth. It is the case that when researchers utilise these standard measures with Aboriginal clients they have chosen to ignore the fact that these tests are known to provide bias assessments of Aboriginal clients. Unfortunately, the result is that the prevalence rates reported within this research will always be questionable (Velazquez et al., 2000).

Another example was The Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) used in detention centres for Indigenous youth. While evidence suggests high levels of alcohol and drug use, depression, anxiety and suicidal ideation in both adolescent boys and girls in this cohort, with higher rates were reported in females, the study failed to demonstrate differences in mental health problems between Indigenous and non-Indigenous youth. The authors suggest this might be due to MAYSI-2 not being culturally appropriate for Indigenous adolescents and therefore had reservations in recommending it as a valid screening tool in this population group (Stathis et al., 2008).

Attempts to improve an obvious lack of reliable data on the prevalence and distribution of mental health problems amongst Aboriginal people of Australia (Swan & Raphael, 1995) are reflected in the Western Australian Aboriginal Child Health Survey (WAACHS) mentioned earlier which identified mental health as part of the concept of social and emotional wellbeing where poor mental health referred to problems and diagnoses that impacted on an individual's social and emotional wellbeing and that of their community.

Social and emotional wellbeing reflected a holistic Aboriginal definition of health that included emotional, psychological and spiritual wellbeing (De Maio et al., 2005). Survey data from the initial WACHS has now been compared to that from the WAACHS which was collected between May 2000 and June 2002 (Blair, Zubrick, & Cox, 2005). The WAACHS used adapted scales (mostly the Strengths & Difficulties Questionnaire) to measure the prevalence of mental disorder in Aboriginal children and youth where statistical analyses tested the concurrent validity and scale reliability of the SDQ subscales and Total Score. Results from single-level congeneric models are generally satisfactory and internal reliabilities for four subscales (Emotional symptoms, conduct problems, hyperactivity and prosocial skills) were good (exceeding 0.70). Further analysis that allowed the unobservable mental health dimensions to correlate with each showed three hypothesised models provided a good fit to the underlying data. This suggests that observed indicators are capturing the unobservable dimensions of mental health they claim to measure (Zubrick et al., 2006).

The temptation to categorise people on the basis of deficits generally overrides concerns regarding cultural bias within psychological testing (I. Cuellar, 1998; Dana, 2000). The perception is that psychometric testing still remains as the only tangible component in the decision-making process (Rowe, 1991). There has also been a conspicuous lack of viable options with regard to alternative means of providing culturally valid tests of indigenous people. However, Thomas et al (Thomas, Cairney, Gunthorpe, Paradies, & Sayers, 2010) developed the 'Strong Souls' as a screening tool to measure Social and Emotional Wellbeing (SEWB) in Indigenous young people that was culturally appropriate and demonstrated validity and reliability. The authors tested the abridged version of the Kessler Psychological Distress Scale (K6+) and WASC-Y both of which had demonstrated reliability in young Indigenous populations. The K6+, WASC-Y and Strong Souls tools were pilot tested with school students under 17 to see if they made sense. Strong Souls showed strong construct validity, reliability and appropriateness for Indigenous youth in the Northern Territory. This re-states Sheldon's (2010) premise of the need for tools to be locally adaptable across jurisdictions and raises again the question of the efficacy of standardised, monocultural models. The development of the WASC-Y and the accompanying Clinical Guidelines were, and are, of such vital importance in assessing Indigenous Australians.

Assessing the reliability and validity of tests

When talking of using tests with minority groups, such as Australian-Aboriginals, the question of test reliability and validity must be addressed. Although a test can be reliable without being valid, the opposite is not true: a test can only be valid if it has first achieved an adequate level of reliability (Groth-Marnat, 1997). Reliability is simply about how accurate a test is, and this is assessed via two primary methods (Groth-Marnat, 1995); test-retest reliability and internal consistency reliability.

Test-retest reliability is measured by administering a test to the same subject on two occasions (Kline, 2000). The two scores are then correlated, with a minimum correlation of 0.7 considered acceptable. However, test-retest reliability is not always a perfect indicator of the reliability of a test, particularly in those instances in which real changes in behaviour may have occurred (Kline, 2000). Obviously, as the WASC-Y research was concerned with the assessment of mental ill health, test-retest is an inappropriate evaluation of the psychometric properties of such tests, as the nature of mental ill health is that there exists function fluctuation in symptoms over time (Cohen, 1987). It is for this reason that test reliability is often best determined statistically through the use of internal reliability via the computation of alpha coefficients, which is interpreted as if it were a correlation (Cronbach,

1975). The internal consistency reliability reflects the extent to which each test item is measuring the same variable (Kline, 2000). Therefore, in the current situation, if we have a test which measures depression, we should expect each item to be measuring depression and not some other dimension. The more this is the case, the higher the internal consistency reliability of the test. Confirmatory Factor Analysis (CFA) is currently the most powerful approach to determining the internal consistency or factor structure of tests (Tabachnick & Fidell, 1996).

The validity of a test is more complex, as there are many different components involved which affect how valid a test can be. It is in fact true that a test may be found to have high validity, but it does not necessarily follow that it will also be valid within a specific situation with a specific client (Groth-Marnat, 1998). A test can never be valid in an absolute sense because, in practice, numerous variables might affect test performance (such as cultural differences). The primary concerns regarding test validity (and indeed, the theoretical development of the WASC-Y) within the indigenous mental health literature have been concerned with issues of face, predictive and construct validity. These issues will now be explored.

Firstly, face (ecological, functional) validity refers to the extent to which the test makes sense, to the person taking it, and is most often concerned with the appearance of the test (Munro, 2001). Face validity is often lacking in psychological tests, which have been constructed for use in a culture different to that of the testee. For Aboriginal clients, psychological tests may not make functional sense due to the cultural variations in language or constructs that often exist in the interpretation of test items (Dana, 1998). The way in which items are interpreted are subject to individual differences, however, in addition to this, for indigenous people responses may also be dependent upon having contact with a western style of education or information. For instance, taking the construction of a test for depression, as an example, an item may say "I am quite often sad" can be interpreted in a number of different ways; "often" can mean different things to different people. In addition to this, culturally, is the concept or term 'sad' appropriate for a range of different indigenous individuals, and tribal (language) groups? The fact that there are currently no tests which have been developed from within the Aboriginal culture, makes the likelihood of tests having face validity less likely (Davidson, 1995).

Criterion validity (also known as predictive or concurrent validity) is also an important consideration in psychometric testing of Australian-Aboriginals. Criterion validity is determined by comparing test scores with some sort of performance on an outside measure. The distinction between concurrent and predictive validity has been described by Groth-Marnat (1995). He argues that concurrent validity assesses a person's current status (i.e. are they depressed?), whereas predictive validity is concerned with predicting the client's status at a time in the future (are they likely to become depressed?). Within mental health, the obvious concern is the extent to which outcome measures is a valid predictor of a person's functioning across different situations, and in the case of Aboriginal people, within their cultural context. For example, if you have a client who is presenting as depressed within a mainstream context, to what extent does this equate with how they are viewed within their culture of origin, both currently (concurrent), or at some stage in the future (predictive). Given that there are no acceptable 'outside' criteria upon which to compare test performance against for Aboriginal people, issues of criterion validity are always going to be lacking in mainstream psychometric tests.

Finally, the issue of construct validity was developed primarily due to the concerns with criterion validity. Construct validity is concerned with whether or not the test is a good measure of a particular construct or psychological concept, such as depression, anxiety and so on (Aiken, 1994). When considering the fact that most psychometric tests are constructed within mainstream cultures, it is difficult to assess the extent to which mainstream constructs have validity within an indigenous worldview (Dana, 2000).

The WASC-Y research was therefore concerned with addressing these existing concerns with validity and reliability in the construction of the psychological tests, and assessment protocols with minority populations. The initial validity study demonstrated that the WASC-Y was able to obtain good to

excellent factor structure and reliability outcomes. The current manual provides updated information on the validity of the scale and provides additional prevalence data on Aboriginal youth age.

As argued, the benefits of psychometric testing are firmly established within mainstream populations through their ability to provide specific information on which to base diagnostic formulations and to guide more appropriate treatments (Gutterman, O'Brien, & Young, 1987). However, the greatest value in the existence of psychometrically derived tests lies in their value of placing respondents upon a continuum of normality through the standardisation process. The problem inherent in standardised tests however is in their potential for misuse by placing individuals upon such a continuum without consideration of the merits of this standardisation process. In the case of Aboriginal clients, not only have tests been developed from outside of their cultural context, but they have also been standardised on populations, which have no Aboriginal representation (Davidson, 1995; Kearins, 1981). Questions therefore arise regarding how representative these tests are of the worldview of Aboriginal clients, but also the relevance of a normality continuum constructed for mainstream populations. In short, this is concerned with how valid information is which is derived from mainstream tests in terms of diagnosis of pathology? Unfortunately, the temptation to classify and to have a label upon which to validate a client's behavioural manifestation has become an issue, which faces all mental health clinicians in their day-to-day practice.

The evidence of test bias in mainstream psychological tests with indigenous/minority groups

These dimensions all represent aspects of test reliability and validity already discussed. They also mirror the extensive documentation within the psychological and psychiatric literature of the pervasive influence of culture on the presentation of mental ill health (Lopez, 1989; Marsella & Yamada, 2000). This research has pointed to test bias in both cognitive and personality assessments of African American populations, (DeShon et al, 1998; (Lindsey, 1998); Epstein et al, 1998), Asian Americans (Okazaki, 1998), Hispanics (Cuellar, 1998) and American Indian populations (Allen, 1998). Primarily, research into bias in personality assessments with cultural minority groups has been conducted using the Minnesota Multiphasic Personality Inventory (MMPI-2). This is due to the fact that it is accepted as the most widely used personality inventory with indigenous populations internationally (see Velasquez et al, 2000). However, controversy remains regarding the potential for bias in its use with ethnic minorities (Okazaki, 1995). Unless culture-specific symptoms are recognised and decoded by clinicians, unnecessary diagnostic procedures and inappropriate treatment may result. This requires clinicians to understand symptoms not simply in the context of disease or disorder, but related to the language of distress that evokes interpersonal and social meanings (Kirmayer, 2001).

A number of trends have become apparent that distinguish cultural minority groups from their white counterparts. Firstly, there is a tendency for Asian Americans to score significantly more items in the pathological direction in 9 out of 13 clinical and validity scales (S. Sue, Keefe, Enomoto, Durvasula, & Chao, 1996). A similar pattern was found with American Indian people (Butcher, Dahlstrom, Graham, Tellegen & Kaemmer, 1989; Forey, 1996) with this population scoring higher than European Americans. Finally, some African American population studies have also scored significantly higher than European Americans on the clinical scales F, 8 and 9 measuring schizophrenia and hypomania respectively (Green & Kelley, 1988); Pritchard & Rosenblatt, 1980).

In addition to the research trends demonstrated with the MMPI/MMPI-2, research with the Beck Depression Inventory (BDI: Beck, Rush, Shaw & Emery, 1979) and the Center for Epidemiological Studies Depression (CES-D) scale (Radloff, 1977) show a significantly elevated pattern of reported symptomatology among Asian Americans (Greenberger & Chen, 1996) and Asian Canadians (Okazaki, 1997) compared to white Americans.

The fact that there are clear group differences, or trends in the way that ethnic minority groups respond on personality inventories therefore appears to be established within the literature (Cuellar, 1998). While psychiatric diagnosis is often located in individual psychopathology, cognitive social

psychology and clinical ethnography demonstrate that experiences of symptoms and meanings attributed to them are culturally informed (Kirmayer, 2005). Despite this it is of note, and with some level of confusion, that the prevailing hypothesis about cultural differences still remains within the literature as the null hypothesis; i.e., that there is no difference between ethnic groups until sufficient empirical evidence is gathered to enable its nullification (Allen, 1998). The result has been that whilst the literature and DSM-IV acknowledge the potential influences of culture on the manifestation of psychological problems, researchers have continued to use these measures unchallenged. The primary reason for this, as argued by Cole (1996) is that culture remains distal rather than central to psychological training, practice and research. Other researchers have argued that culture must be considered as a primary component in the assessment of minority populations, including Aboriginal people (Cuellar & Paniagua, 2000; Davidson, 1991; 1995).

Related to the notion that culture is distal rather than central is the fact that the research has also failed to address the many methodological factors, which affect the validity of the diagnostic data that is generated. Firstly, the issue of assuming that performance on a single test, without any accompanying clinical or cultural validation of these reported mental health problems is a primary concern. Secondly, the extent to which test performance is affected by the tester being from a different cultural background to that of the testee, particularly when using structured interviews and clinical assessment are used. Given that most of the available research has been conducted from the perspective of non-indigenous researchers, the absence of research into the effect of this interaction is concerning. Despite this, it has been cited prominently in the available research as contributing to misdiagnosis of behaviours as pathological, without consideration of the appropriateness of such behaviours within their cultural context (J. Cawte, 1965); (Collard & Garvey, 1994). However, the extent of this bias still remains unclear. This is unfortunate, as many of the existing studies provide interesting insights into the mental health of Indigenous Australians. The fact that much of this research has been minimised at best, or discounted at worst, indicates that the most obvious and overriding current issue is the development of culturally valid identification tools and processes for indigenous people.

However, research has also continued to support the need for diagnosis of psychiatric disorders to follow a holistic assessment process, which includes clinical interview, direct observation (which should be environmentally valid), lists of diagnostic criteria as well as an appropriate psychometric test (Dana, 1998). Dingwall and Cairney (2010) described several ways to assess cognitive function and mental health in Indigenous Australian adults and underscored the limitations of mainstream methods where few culturally appropriate approaches were internally validated, requiring further development and evaluation of their effectiveness. Unfortunately, the use of psychometric tests as the sole basis for resulting diagnoses in epidemiological studies is an issue, which has been of concern to those opponents of such psychometric tests (Dyck, 1996). Certainly an even greater issue lies in the use of these tests as diagnostic tools rather than as one aspect of an assessment, which should include direct observation, clinical interviews as well as information regarding behavioural presentation from a variety of sources known to the client.

The use of a range of measures to assess the existence of mental health problems

There has been a range of different psychometric measures used both within and between studies to diagnose a range of mental health problems. Such measurement devices have included self-report (Clayer & Czechowicz, 1991), clinical interview (McKendrick, Cutter, Mackenzie, & Chui, 1992), as well as a range of different informants (Morice, 1979, 1988) to inform diagnoses. More importantly, the use of a range of different measures has also precluded any comparison between studies which may contribute to a more conceptually sound volume of research.

Indigenous views of disorders

There has also been healthy debate within the literature regarding the need to explore the extent of relevance for Aboriginal people of mainstream conceptualisations of mental health problems (Allen,

1998; Garvey, 2000; Hunter, 1993, 1997). For instance, Manson (1994, cited in Allen, 1998) interviewed 160 Pacific Northwest tribe and 150 middle class European American adult outpatients, and asked them to sort symptoms of anxiety and depression symptoms using the Q-sort procedure. He found significant differences between these groups in terms of symptoms, and attributed this to the variations in explanations and experience of illness by indigenous groups. The Cultural Influences on Mental Health (CIMH) framework (Hwang, Myers, Abe-Kim, & Ting, 2008) was developed in the US for broad application aimed at identifying specific mental health domains that were influenced by culture. The paper highlighted the challenges and tensions culturally diverse clients face when at the 'cultural interface' (Nakata, 2007) with the dominant white Anglo-American culture and the impact of both cultures on clients' lived experience and psychopathology. The authors identified that culture influenced mental health domains including disease aetiology, lived experience of distress, diagnosis and assessment, ways of coping and seeking help and treatment and intervention issues. It moved beyond binary conceptualisations of mental health to understanding the complexity of inter-cultural health service provision at systemic and inter-personal levels that required practitioners to know enough about the cultural background of clients to identify whether symptoms and behaviours were culturally normative or pathological (Hwang et al., 2008).

Indeed, there is a consistent view within the literature that the Native worldview tends not to distinguish between mind and body in mental ill health (Roe, 2000). Such findings of symptom variation within syndromes for indigenous cultures have called into question whether the conceptualisation of mental health problems is equivalent across cultures (Okazaki & Sue, 1995; (Okazaki, 2000). Whilst it has been argued that, from a purely symptom-based perspective, there are unlikely to be huge differences, other research suggests the need to develop a comprehensive nosology that includes culture and context, including regional differences, to avoid a reductionist view of symptoms that ignores the role of culture in people's lived experiences (Kirmayer, 2005; Sheldon, 2010). This has led to renewed calls for the inclusion of more socio-cultural data into psychiatric nosology and diagnostic practice in the upcoming DSM-V manual due for publication in the next couple of years (Alarco´n et al., 2009).

There has been some resistance to explore this as an issue, as the concept of having a different set of diagnostic criteria for the same disorders is fraught with methodological problems (Allen, 1998). For instance, it precludes the possibility of being able to accumulate a strong research base of epidemiological data through being able to compare across studies or cultures. Kowal et al (Kowal, Gunthorpe, & Bailie, 2007) argue that progress to reduce health disparities will be slow unless methods of measurement, are standardised and interventions evaluated for their effectiveness so a comparable body of literature can be developed that deepens understanding of ESWB in an Indigenous context.

Ewert versus Canada and Implications

On June 13, 2018, the Supreme Court of Canada (SCC) issued its decision in *Ewert v Canada* (*Ewert* SCC), in which the majority held that the Correctional Service of Canada (CSC) breached its statutory duty to Jeffrey G Ewert, a Métis inmate, when it used five actuarial risk assessment tests that were not proven to be accurate when applied to Indigenous offenders. CSC uses these tests to assess inmates' risk of recidivism, and the test results can impact liberty-related processes such as security classification, parole hearings, and eligibility for escorted temporary absences (ETAs). Mr. Ewert had rather slim positive evidence for the presence of cultural bias in the tests; his argument was, instead, that his and others' legitimate concerns about the possibility of bias should require CSC to produce research confirming the tests' validity. He was initially successful at the Federal Court in 2015, overturned at the Federal Court of Appeal in 2016, and ultimately prevailed at the Supreme Court of Canada.

The subject matter of Mr. Ewert's 18-year undertaking was five actuarial psychological assessment tools used by CSC to assess the likelihood that an inmate will reoffend violently or sexually if released. They are:

- the Hare Psychopathy Checklist Revised, which measures personality factors and past behaviours to assess psychopathy and recidivism risk (*Ewert v Canada*, 2015 FC 1093 (CanLII) (*Ewert* FC 2015) at paras 13-19);
- the Violence Risk Appraisal Guide and Sex Offender Risk Appraisal Guide, which assess percentage of risk "that an offender will commit a new violent offence or sex offence within a specific period of community access" (*Ewert* FC 2015 at paras 20-21);
- the Static 99, which assesses long-term risk of "sexual and violent recidivism among adult males who have been convicted of at least one sexual offence" (*Ewert* FC 2015 at para 22);
- the Violence Risk Scale, Sexual Offender version, which measures probability of sexual recidivism following sex offender treatment (*Ewert* FC 2015 at para 23).

Ewert argued that all of these tests lacked predictive value for Indigenous offenders due to cultural bias. The implications of this decision for the Australian context is yet to be fully realised, although has obvious considerations.

Gladue and Implications

Section 718.2(e) of the *Criminal Code*, of Canada as well as the Supreme Court of Canada in R. v. Gladue, [1999] 1 S.C.R. 688 have stated that Judges should account for Aboriginal specific criminogenic considerations when making sentencing decisions.

Gladue asks judges to apply a method of analysis that recognises the adverse background cultural impact factors that many Aboriginal people face. In a *Gladue* analysis these factors, if present in their personal history, work to mitigate or reduce the culpability of offenders. Judges are then asked to consider all reasonable alternatives to jail in light of this. Such an analysis, then, is more likely to lead to a restorative justice remedy being used either in place of a jail sentence or combined with a reduced term.

Gladue effectively means that it you are being charged with a crime and are an Aboriginal person, there are special cultural considerations that the Court must take into account in assessing your case. This applies to all Aboriginal peoples of Canada, including those with a status and non-status Indian, Inuit, and Métis and whether living on or off Reserve.

What this means is that, as an Aboriginal offender, a restorative justice process may be more appropriate. Such processes focus on healing those affected by the criminal act, including the offender, and so are more in line with traditional Aboriginal justice. Also, a restorative justice approach will often allow for a solution with no jail time, which helps reduce the drastic over-representation of Aboriginals in Canadian jails.

In Australia, there have been some interesting responses to *Gladue* and the most specific response to this appears to be that of the ACT Government who is developing a trial of a new style of report (modelled on Canadian *'Gladue* reports' to be called 'Ngattai reports') that would give the sentencing court further information about culturally appropriate rehabilitation options available in the community for Aboriginal offenders.

Cultural Competency and clinical, cultural guidelines

The development and application of Guiding Cultural Principles is vital to safeguard around practitioner 'error' and the cultural accuracy of assessments with Aboriginal offenders. Guiding Cultural Principles will also assist organisations to embed a strong cultural aspect or lens into and across all policy and governance aspects of the agency.

Westerman (2003) has developed a number of cultural competency 'profiles' or tests to determine levels of cultural competence and as a method of targeting and improving essential cultural competencies The scales developed and determined psychometrically are as follows:

a. The Aboriginal Mental Health Cultural Competency Profile (CCP): is unique to Australia in that it is the only tool that has been both culturally and psychometrically validated as a measure of Aboriginal mental health cultural competence (see Westerman, 2003; Bright, 2012; Westerman & Sheridan, 2019 in preparation).

b. The General Cultural Competency Profile (GCCP) is based upon the CCP and is a test of cultural competence for those in the non-mental health workforce. It is currently undergoing psychometric validation (Westerman & Sheridan, in preparation).

c. The Cultural Competency Profile – Child Protection (CCP-CP). This tool which has determined the cultural competencies of those in the child protection workforce has just completed validation (Westerman & Littern, 2019, in preparation)

d. The Cultural Needs Scale (CNS) is a test for Aboriginal staff regarding the types of cultural and personal barriers that exist in workforce participation. Once completed each individual is provided with a personal development profile which can be used as a supervision plan or as a pre-test prior to a personal development workshop provided by IPS. It is currently undergoing psychometric validation (Westerman & Sheridan, 2019, in preparation)

The Workforce

IPS has been delivering Aboriginal General and Mental Health Cultural Competency Programs for many years. These programs result in dramatic improvements in worker cultural competence and demonstrate that it is possible to achieve substantial improvements in measurable/definable cultural competence. This has significant implications for people working in areas where Aboriginal people are often overrepresented, like the criminal justice system. A standard cultural competency improvement program involves the below main activities:

a) Determination of baseline cultural competencies via administration of the Aboriginal Mental Health Cultural Competency Profile (CCP) or the Aboriginal General Cultural Competency Profile (GCCP). This includes testing of cultural competencies, analysis and individual feedback

b) Development and delivery of a targeted three day training intervention program specific to the organisational analysis of cultural competencies as determined by the CCP or CCP-G

c) Re-evaluation of the cultural competencies at post-training intervention

d) Full report with pre and post cultural competency analysis, training workshop evaluation and general recommendations for the organisational strategic benchmarking of the development of cultural competencies over time

Taking such an approach will enable the determination of staff baseline Aboriginal Cultural Competencies which can be re-evaluated over time. IPS have developed the only known objective and culturally validated measure of Aboriginal Mental Health Cultural Competency (CCP: Westerman, 2003).

Systemic factors

There are several existing mechanisms within the justice system that could be linked more explicitly to supporting the capacity of the WA service system to support Aboriginal and/or Torres Strait Islander people to access, plan, and receive NDIS services. As per recommendation 1 IPS recommends that a central coordinator could play a role in ensuring this access and linkage of systems to enhance the life outcomes of current NDIS participants, or future, as yet accepted, participants.

It is noted by IPS that very few of these existing programs utilise culturally informed and psychometrically validated assessments in order to better support Aboriginal and/or Torres Strait Islander people- this is addressed through recommendations 5 and 11.

Some of these existing systems are described below:

1. <u>Intellectual Disability Diversion Program (IDDP) Court:</u>

"IDDP Court adopts the core therapeutic values and practices of:

- Self-determination which recognises that if an individual chooses action personally meaningful to them they are likely to have a greater motivation to achieve it. Promotion of procedural fairness by:
- The IDDP Court Magistrate acting independently with compassion and empathy.
- Giving the individual the opportunity to be heard, especially when a decision affects them.
- Acknowledging that the individual's own views about their life are important.
- Treating everyone in IDDP Court with dignity and respect acknowledging that individuals who are more satisfied with the process and believe they have been treated fairly are more likely to comply with orders and have respect for the court.

The target participants for IDDP Court may have one or more of the following three diagnoses:

1. Intellectual Disability
2. Cognitive Disability
3. Autism Spectrum Disorder.

Where appropriate, implementing evidence-based processes and strategies to promote compliance with the Program, engaging individuals in goal-setting and supporting them through the change process.

An accused person will be considered eligible for IDDP Court if:

- They have been diagnosed with an ID, CD or ASD by a suitably qualified person or they are likely to be so diagnosed if assessed by a suitably qualified person
- They have entered or are likely to enter a plea/pleas of guilty to at least a significant proportion of their charges
- They are suitable for conditional bail
- They consent to participate in the IDDP Court Program.

Participants are not eligible to be referred or considered for suitability if:

- Their primary issue is a mental health issue; or
- There is no prospect of them being sentenced other than to an immediate term
- of imprisonment.
- An accused person may be referred more than once to IDDP Court." (IDDP Guidelines)

2. <u>The Start Court:</u>

As outlined in the Glossary, the Start Court "is a solution focused court, adopting principles of therapeutic jurisprudence, for people who are experiencing a mental health issue.

An accused person can be referred to the Start Court in Perth Magistrate's Court by a Magistrate in any metropolitan court (including Northam and Mandurah in some cases).

Referral can be made upon the request of the accused person, their lawyer, the prosecutor, a Community Corrections officer, a medical or mental health practitioner, supporting agency, carer or family member or upon the instigation of the Magistrate if:

- The accused person consents to the matter being referred to Start Court;
- The Magistrate is satisfied there is information before the court to suggest the eligibility criteria at Part 8(a)(ii) are likely to be fulfilled; and
- The Magistrate is satisfied there is not another less restrictive option open to the court in dealing with the accused person.
    - The accused person should be remanded to a Tuesday at 10am at Perth Magistrates Court for application for Start Court.

An accused person will be considered eligible for Start Court if:

- They are experiencing a mental health issue or issues which they wish

- to address;
- They have entered or are likely to enter a plea/pleas of guilty to at least
- a significant proportion of their charges;
- They are suitable for conditional bail; and
- They consent to participate in the Start Court Program.

Participants are not eligible to be referred or considered for suitability if:

- Their primary issue is an intellectual disability;
- Their primary issue is alcohol and other drug misuse;
- They are remanded in custody; or
- There is no prospect of them being sentenced other than to an immediate term of imprisonment.

An accused person may be referred more than once to the Start Court.

There is no list of prescribed offences for which an accused person can be referred to Start Court (subject to the criteria for eligibility for referral set out at Part 8(a)(i) and (ii)) and it adopts the following methods in accordance with the principles of therapeutic jurisprudence and solution focused judging:

- Development of Individual Start Court Plans with active engagement of the individual;
- Supervision and support by appropriately trained professionals with access to coordinated and comprehensive treatment services;
- Monitoring by a judicial officer using techniques to encourage accountability, behavioural change and compliance; and
- A less-adversarial court setting with emphasis on self-determination, dignity, respect and voice.

The Start Court Program, seeks to address the overrepresentation of people with mental illness in the criminal justice system by addressing their offending behaviour as well as their mental health and psychosocial needs" (Start Court Guidelines).

The expression mental health issue as it relates to the Start Court is inclusive of the categories of "mental and behavioural disorders" as defined in Chapter V, ICD-10 Classification System but is not restricted to that classification and includes individuals who are likely to have a diagnosis in one or more of the categories listed:

- Organic (including symptomatic) mental disorders;
- Mental and behavioural disorders due to psychoactive substance use;
- Schizophrenia, schizotypal and delusional disorders;
- Mood (affective) disorders;
- Neurotic, stress-related and somatoform disorders;
- Behavioural syndromes associated with physiological disturbances and
- physical factors;
- Disorders of adult personality and behaviour;
- Disorders of psychological development;

- Behavioural and emotional disorders with onset usually occurring in childhood and adolescence; and
- Unspecified mental disorder.

The Start Court provides an option for Aboriginal clients who may be registered with the NDIS as having a recognised functional impairment, and provides an option for them to receive additional therapeutic support, including (and not limited to):

- **Clinical Psychologist:** 4 hours per week to psychological consultation to participants through the State Forensic Mental Health Service.
- **Community Corrections Officers:** Case management or co-case management; pre and post sentence reports.
- **Drug and Alcohol Diversion Officer:** Assesses and facilitates access to Presentence Opportunity Program (POP) and Supervised Treatment Intervention Regime (STIR) where they can access Alcohol and Other Drug (AOD) counselling.

3. <u>Personal Helpers and Mentors service (PHaMs):</u>

PHaMs provides practical assistance for people aged 16 years and over whose lives are severely affected by mental illness. PHaMs helps people overcome social isolation and increase connections with their community.

People are supported through a recovery focused and strengths based approach that recognises recovery as a personal journey driven by the participant. Potential participants undertake a functionally based assessment with a PHaMs service provider to determine their eligibility for services.

PHaMs clients will need to test their NDIS eligibility to be able to access continuity of support and those eligible for the NDIS will access supports through their NDIS plan. Supports provided under the NDIS are holistic and are designed to give people more choice and control over the services and supports they need. Clients will continue to receive supports through PHaMs until their plan is finalised.

From 1 January 2019, new clients with severe mental illness can be referred to the appropriate NDIS Local Area Coordinator or Primary Health Network in their region to determine access to appropriate psychosocial supports.

4. <u>Local Coordinators:</u>

Local Coordinators (LCs) can help people access disability supports. APM and Mission Australia have been selected to deliver NDIS Partners in the Community (PITC) LC Services in Western Australia. LCs help people with disability, NDIS participants, families and carers to identify and access the support they need.

This includes help to realise individual goals and aspirations by connecting individuals eligible to community and mainstream services. LCs also work with these services and organisations to be more inclusive and supportive of people with disability.

Access to the NDIS, including barriers

This section of the Report draws heavily on the Joint Standing Committee on the National Disability Insurance Scheme, which can be accessed at:

https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MentalHealth/Report/c05

Access to the NDIS

There is often confusion and/or uncertainty around supports the NDIA can provide to NDIS participants in custody. It is also unclear as to whether there are any, or many, individuals within the WA Prison system that are actively receiving support through the NDIS.

The NDIS (Supports for Participants) Rules 2013 state that the NDIS in relation to a person in custody will be responsible for reasonable and necessary supports other than the day-to-day care (including supervision, personal care and general supports), including transition supports for people in a custodial setting (including remand). These supports include those required due to the impact of the person's impairment/s on their functional capacity and additional to reasonable adjustment, and are limited to:

- aids and equipment;
- allied health and other therapy directly related to a person's disability, including for people with disability who have complex challenging behaviours;
- disability specific capacity and skills building supports which relate to a person's ability to live in the community post-release;
- supports to enable people to successfully re-enter the community; and
- training for staff in custodial settings where this relates to an individual participant's needs.

There is currently a lack of culturally validated, responsive and appropriate tools and supports, including provision of interpreters, for Aboriginal and Torres Strait Islander people to access and navigate the NDIS. Based on anecdotal feedback there also appears to be low levels of cultural competence amongst NDIS staff, disability service providers and the disability system more broadly. The NDIS is a bureaucratic process, and much of the information around referral processes and access is difficult, especially for Aboriginal and Torres Strait Islander people where English is a second language or where literacy and numeracy is an issue. All of these factors contribute to the very real possibility that as a result here is a great risk that this cohort is likely to be left behind by the NDIS and further disadvantaged in that they will not be able to access the Scheme.

For many Aboriginal and Torres Strait Islander people with cognitive impairment and complex support needs, the access to the NDIS can be challenging and as per recommendations 1, 2 and 3 it is suggested, as per previous reports on this matter, that this group have access to an advocate or support person to assist with the NDIS application process, particularly those facing the additional disadvantage of being a cohort within the criminal justice system. It is crucial, however, that the limitations of cognitive assessment with Indigenous clients is understood and that functional capacity assessment aims to ensure that issues of test bias are addressed in a more qualitative rather than quantitative manner as per Davidson (1995).

Many in contact with the criminal justice system may also be unwilling to identify as disabled and as such may form part of an 'invisible' cohort, not recognising their own needs for assistance. This failure to self-identify as having a disability may also be due to cultural reasons where disability is not an accepted term within their cultural upbringing and family group. It is for these reasons, among many others, that Guiding Cultural Principles- and the use of culturally competent systems, processes and

planning services are critical in order to meet the needs of Aboriginal and Torres Strait Islander people with a disability and in contact with the criminal justice system.

Becoming an NDIS participant while in custody

Under the NDIS Rules (2013), while in custody, people can make an access request to the NDIS and engage in the planning process to develop a plan, however it seems that often there is conflicting information regarding process, availability of planners and coordination for the implementation of plans in such circumstances. As such, there is much uncertainty and a lack of clarity in WA around what is available and importantly how a more supported, coordinated and enabled approach can be taken to support access to the NDIS for people in Prison.

The need for strong collaborative relationships between the NDIA, NDIS and the Departments of Justice, Communities (Disability), and other relevant specialist and mainstream services, including reintegration services is critical. Such collaborative practice can lead to streamlined access and planning processes for eligible NDIS participants who are in Prison, including:

- Referral to the NDIA for Access to the NDIS
- NDIS planning taking place in Prison
- Application for Specialist Coordination
- Funded supports with the aim of supporting a successful transition to the community
- Ongoing engagement with existing support workers throughout the reintegration into community.

Initiatives and suggested strategies for better outcomes

To address current challenges and improve Aboriginal and Torres Strait Islander registration and participation in the NDIS, the NDIA developed an *Aboriginal and Torres Strait Islander Engagement Strategy* aimed to develop a collaborative planning and working model to inform practice – see Attachment 1.

The Aboriginal and Torres Strait Islander engagement priorities articulated through this Strategy provide a good foundation for improving service access. However, they need to be looked at within the context of pre-requisite Guiding Cultural Principles in order to underpin the move from conceptual into a translatable and operational context that can facilitate improved access and participation in the NDIS for Aboriginal and Torres Strait Islander people. They include:

- Communication and sharing of information
- Cultural competency
- Sharing Best Practice
- Participant-centric design
- Market enablement
- Leveraging and linking
- Cultural Leadership
- Supporting internal infrastructure
- Tracking progress

Some of the tangible ways that improved engagement can be facilitated includes:

- Increased support for Aboriginal Community Controlled Organisations to become more engaged and connected to the NDIS
- A focus on workforce development and culturally responsive workplaces
- Targeted outreach services
- Development of Guiding Cultural Principles for application to policy and practice
- Translation, interpreting and plain language services
- Engagement and feedback loops established with the Aboriginal and/or Torres Strait Islander community

Some of the suggested strategies are listed as recommendations.

A Case Study at Attachment 2 provides a very good example of how a person in the Prison system can be better supported through the NDIS.

Barriers to participation

Many Aboriginal and Torres Strait Islander people in the Prison system are unlikely to seek out NDIS support as they would rather not draw attention to any impairment they may have or draw attention to themselves given their already vulnerable predicament. It is also known that many people with cognitive or psychiatric disability may not have the skills or the supports required to know about the NDIS, go through the process of becoming a participant and adequately represent their needs in a planning meeting. It is due to these factors that culturally competent and trained staff, including assertive outreach services, be available in prison settings.

The training currently provided to Prison staff through the Department of Communities (Disability) Disability Justice Teams in relation to disability, challenging behaviours, and the NDIS is critical. It is this specialist training and support, as well as the involvement of Departmental Disability Justice Coordinators and Regional Intensive Support Coordinators that remains critical to not only steward potential and current NDIS participants but navigate systemic barriers that can exist within the complex Justice system and Prison environment.

The NDIA, Justice interface and complex pathways

Following discussions at a public hearing in April 2017 at the NDIS Joint Standing Committee, and at a follow up meeting in June 2017, the Australians for Disability Justice group and others put forward the proposal of creating an NDIA criminal justice unit, which would potentially:

- Provide expertise to the NDIA around the interface of criminal justice and disability
- Develop expertise in planning and funding for people with disabilities in the context of the interaction of the national disability system and the state and territory justice systems as well as other mainstream agencies with inter sectoral responsibilities
- Act as the NDIA point of contact for state and territory criminal justice systems in the context of people with disabilities
- Ensure people with disabilities in the criminal justice system have access to the full range of disability supports and protections provided through the NDIS

(https://ddwa.org.au/wp-content/uploads/2017/12/Advice-to-NDIS-Chair-on-NDIA-Criminal-Justice-Unit-19-Jun-2017.pdf)

It is unclear as to whether the NDIA has progressed with work in this area, however they do have a 'Complex Pathways' team, with one recently established in WA. It may be that further work with this team could assist to develop a strategy to ensure people in custody, including in indefinite detention, have access to an NDIA planner (an Aboriginal and/or Torres Strait Islander planner if possible) and, if eligible, be provided with NDIS services.

With Aboriginal and/or Torres Strait Islander prisoners being more likely than non- Aboriginal and/or Torres Strait Islander prisoners to experience a disability, their disabilities are less likely to be identified. Among prisoners with a disability, a range of literature and anecdotal evidence would say that those who identify as Aboriginal and/or Torres Strait Islander are less likely to have received disability services before incarceration. This effectively means that Aboriginal and/or Torres Strait Islander people with a disability can find the experience of prison even more difficult as they serve their sentences with what is often an invisible disability. Given this can lead to a lack of consistent care it is not unreasonable to assert that this continues to perpetuate the inequalities that Aboriginal and/or Torres Strait Islander people experience prior to incarceration.

More likely to return to custody

Transition to the community requires people with a disability to adapt rapidly to new circumstances and interact with a complex service environment. Many prisoners, particularly Aboriginal and/or Torres Strait Islander prisoners with intellectual or other disability often remain unidentified and unsupported when they return to the community with functional impairments that in turn impact on their capacity to care for themselves across the areas of health, employment, housing, etc.

Given that intellectual disability is a risk factor for return to custody. Ex-prisoners with generally poorer health are more likely to return to custody. Effectively meeting the health, social and cultural needs of Aboriginal and/or Torres Strait Islander prisoners with a disability is central to ending the cycle of incarceration and closing the gap.

The cycle in and out of the criminal justice system often faced by prisoners, and in particular Aboriginal and/or Torres Strait Islander prisoners with complex support needs, is often exacerbated through the lack of established formal diagnoses. This lack of established diagnoses in this group, the predominance of mild to borderline intellectual disability, and foetal alcohol spectrum disorders, commonly co-occurring with mental health impairments, together with their complex presentations makes this highly disadvantaged group particularly vulnerable to exclusion from the NDIS.

Given the vulnerabilities faced by this group, an in particular Aboriginal and/or Torres Strait Islander prisoners, it is crucial that appropriate measures are taken by the NDIA to ensure that *all* people with cognitive disabilities who come into contact with the criminal justice system receive access to appropriate assessment and support.

A systematic approach to the identification of cognitive disability through an increased integration between Justice systems, the NIDA, and the NDIS is critical in reducing harm for Aboriginal and/or Torres Strait Islander prisoners. The provision of substantive supports can only come about through identification and recognition of the support this group of prisoners need.

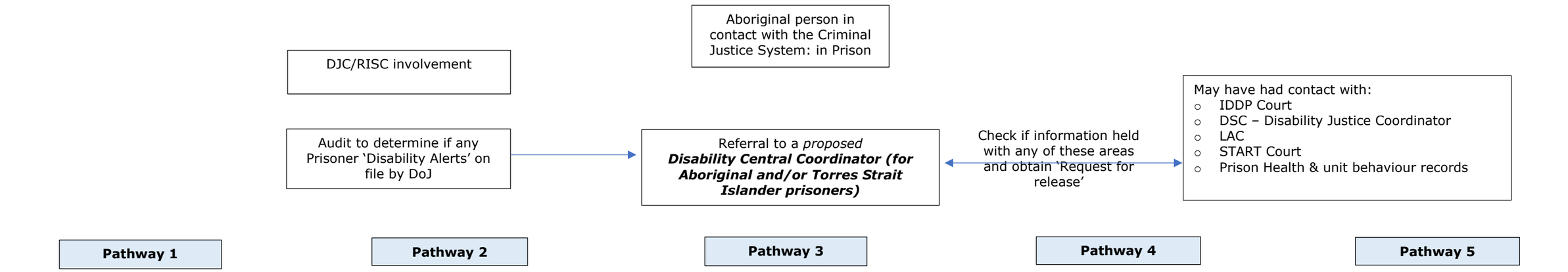
Research has shown that ex-prisoners with intellectual disability return to custody at twice the rate compared to their counterparts without intellectual disability (Holland et al: 2011) and on release many find the navigation of the service systems they are faced with to address their complex physical, mental, substance use and social service needs overwhelming (Mannynsalo et al: 2009). Through-care support has been shown to provide the best outcomes for this cohort, and for Aboriginal and/or Torres Strait Islander prisoners working with culturally responsive support services and personnel is critical for success.

A more targeted and coordinated approach to in-prison support, including pre-release planning is advocated for Aboriginal and/or Torres Strait Islander prisoners with, or suspected to have, a disability. This is outlined at Attachment X. Recognising and addressing the risks that result from having a disability are crucial for improved support in prison, through transition planning, and in reducing the unnecessary return to prison.

Best practice in mainstream post-release support has for the last two decades consistently stressed the importance of through-care as a central feature in pre-release planning (Borzycki, et al: 2003). Through-care is critical in preventing reoffending, as well as improving community integration and ultimately enhancing community safety. The current disconnect between the NDIS and the correctional settings for Aboriginal and/or Torres Strait Islander prisoners with disability and complex needs presents an ongoing area of concern.

Enabled Aboriginal and/or Torres Strait Islander client access and transition to the NDIS

Figure 3: Enabled Aboriginal and/or Torres Strait Islander client access and transition to the NDIS



Pathway 1 – Registered NDIS participant and with Plan in place
Pathway 2 – Registered NDIS participant and has had a Plan prior to incarceration (currently suspended)
Pathway 3 – Has a disability diagnosis but not NDIS registered participant
Pathway 4 – Suspected disability that impacts on functional capacity
Pathway 5 – In prison and:

1. Under Mentally Impaired Accused Act
2. On a life sentence
3. A dangerous sex offender

NDIS Justice Supports

There remains a degree of confusion around what NDIS supports are available for people living in Prison. This section provides some clarity surrounding this and further work in this area needs to be done in order that people within the Justice system, particularly in Prison are not unduly disadvantaged where they require disability support to improve their quality of life. The information below is summarised in a table at Attachment 4, however a note of caution is made around this advice as it may change given the nature of the NDIA and the rolling changes that are occurring across the NDIS as part of the National and WA 'rollout. A range of recommendations relate to this section.

Further information is available in the NDIS Rules at r.7.24(b) of the Supports for Participants Rules as well as at **https://www.ndis.gov.au/understanding/ndis-and-other-government-services/justice**).

Supports funded by the NDIS

Disability supports for people on community-based orders

- Supports required by the participant as a result of their functional impairment to meet any court-imposed conditions (e.g. transport assistance and assistance with personal care)

For people in custody

- Reasonable and necessary supports in relation to the participant's functional impairment required while the person is in custody. Reasonable and necessary supports must not replace the supports provided by the justice system under reasonable adjustment and universal service obligations.
- Aids and equipment required by a participant for the purpose of improving functioning regardless of the activity they are undertaking but not fixed aids and equipment such as a hoist (in the same way as for people not in custody to the extent appropriate in the circumstances of the person's custody).
- Reasonable and necessary supports on the same basis as all other people in relation to a person not in custody.
- Supports to facilitate the participant's transition from custody to the community where these needs are specific to the participant's disability and additional to transition needs of other people living in custody

What the Justice system funds

- Reasonable adjustments.
- Supports to ensure people with disability have access to similar supports available to the general population.
- Day-to-day care and support needs of a person in custody, including supervision, personal care and general supports.
- Ensuring criminal justice system services are accessible for people with disability including appropriate communication, adjustments to the physical environment, accessible legal assistance and appropriate fee waivers.
- General programs for the wider population, including programs to prevent offending and re-offending, and the diversion of young people and adults from the criminal justice system.
- The management of community corrections, including corrections-related supervision for offenders on community based orders.
- The operation of secure mental health facilities that are primarily clinical in nature.

*Further information is available in the NDIS Operational Guidelines, Planning section 10.8.10. Reference to this section of the Guidelines will provide further guidance on whether justice supports are appropriately funded through the NDIS.

Supports which, dependent on their purpose, may be funded by the NDIS or other parties for people living in the community:

- ***Assistance in managing life stages, transitions and supports***, can be funded by the NDIS or by other parties. In determining which system is more appropriate, the system that is delivering the majority of supports is usually more appropriate to assist in the coordination of these supports:

  - NDIS: assistance where the majority of the coordination and transition supports relate to supports funded by NDIS, or to non-clinical supports,
  - Other parties: assistance where the majority of the coordination and transition supports relate to supports funded by other parties.

- ***Development of daily living and life skills and behavioural support***– where the participant requires support specifically related to the functional impairment to live as autonomously as possible, including skills in daily life activities, communication and social skills, problem solving and behaviour management.

  - NDIS: supports that build the participant's general capacity and functional ability, such as social relationships, communication, behaviour management, and
  - Other parties: supports are specific to offending behaviours, such as programs that aim to reduce specific criminal behaviours

- ***Assistance with daily life tasks in a group or shared living arrangement*** – where the participant requires an integrated accommodation and support setting in order to assist them with activities of daily living, including supervision to address behaviours of concern:

  - NDIS: where this support is in a community-based setting (i.e. the primary purpose of the support is to support the participant with activities of daily living rather than to protect the community or for clinical treatment), and
  - Other parties: where the setting is designed specifically to protect the community, prevent offending or deliver clinical services

Supports generally funded by other parties:

Day-to-day supervision and operations - of custodial settings and custody-like settings (except aids/transition as outlined above). See Rule 7.24(a).

Legal support – guardianship, advocacy, community visitors, legal aid, victims or witnesses of crime

Management and compliance services - to ensure compliance with court or parole orders for people living in the community

Effective service delivery for Aboriginal people in prison

Westerman (2003) reinforces the need to ensure that any service model that is developed should be clinically and culturally appropriate, specific to the needs of clients, and also strengths based. The below framework is provided as a guide to working with Aboriginal and/or Torres Strait Islander people.

PRE-REQUISITE = Cultural Competence in service delivery at service and practitioner levels. Defined by:
Extensive community networks
Ability to engage appropriate levels of cultural consultants in intervention and assessment of Aboriginal clients;
Ability to identify the role of culture as a causative and / or maintaining factor in presenting problem
Ability to facilitate a range of culturally appropriate interventions
Demonstrated Cultural Competence at the *individual and organisational levels*

↓

CULTURAL EVENTS AS TRIGGERS AND MAINTAINING FACTORS
Understanding the role of Aboriginal identity, social policy, racism, trauma, cultural shock, oppression, socio-economic status, abuse, family violence, education, physical health, grief and loss experiences at the
Assessment of the *individual* meaning attributed to these experiences

↓

IDENTIFYING RISK and PROTECTIVE FACTORS
Existence of Indigenous Specific Risk Factors
Understanding the role of mainstream risk factors
The role of cultural resilience as a moderator of risk
Recognition of the role of individual and community stressors

↓

ARE BEHAVIOURS CULTURAL OR SOMETHING ELSE?
Assessing the predominant belief system of client
Assessing for cultural triggers to disorder (e.g. external attribution belief system; SEWB factors; men's versus women's business; payback etc.)
Assessing for culture-specific disorders (e.g. longing for country as opposed to organic depression etc.)

↓

CULTURALLY VALID ASSESSMENT / INTERVENTION
Able to make the distinction between culture-bound syndromes / mental health complaints
Able to facilitate engagement of appropriate cultural consultants to resolve culture-bound disorders
Use of culturally appropriate assessment, counselling skills and intervention processes

Figure 4: A framework for the delivery of services to Aboriginal and/or Torres Strait Islander people and communities (Westerman, 2003).

In addition to the above service delivery framework, when starting to work with new clients and seeking to undertake or negotiate informed cultural and clinical consent with Aboriginal clients the following Model, developed by Westerman (2003;2010) is recommended for use:

INFORMED CULTURAL CONSENT MODEL (WESTERMAN, 2003;2010)

Stage 1: The practitioner undertakes cultural vouching process. This means that the following information should be provided to their clients about themselves:

- Their full name.
- Details of where they work, and type of work conducted.
- Their Country/area of origin (e.g. Darwin, Brisbane, Adelaide area, etc.).
- Their traditional people (e.g. Yamatji, Murri, Yolgnu etc.).

Stage 2: If the worker consults with a supervisor then clinical and /or cultural vouching needs to occur. The following information should also be provided to their client:

- The name of the supervisor.
- The supervisors qualifications.
- If Aboriginal then state their Country/area of origin.
- Their traditional people.
- The purpose and reasons for the consult or supervision needs to be explained to the client and this is the responsibility of the Counsellor.

Stage 3: The informed clinical and cultural consent of the client should always be sought prior to carrying out any consultation. Discussion should cover:

- What information will be discussed.
- The purpose of disclosing the information.
- How information of a culturally sensitive nature will be treated – i.e. that the client has the right to not disclose information that is culturally sanctioned.

Stage 4: Informed cultural consent should also cover any advice or supervision from a third party such as a supervisor, manager or cultural consultant and should disclose:

- What information will be discussed.
- The purpose of disclosing the information.
- How information of a culturally sensitive nature will be treated – i.e. that the client has the right to not disclose information that is culturally sanctioned.

Stage 5: The client must be informed of their right to withdraw their consent at any stage during the counselling relationship.

Figure 5: Informed Cultural Consent Model (Westerman, 2003;2010).

Gaps in Service Delivery and concluding remarks:

The interface between the justice system, associated services and the NDIS is complex and further work in the area is required in order for Aboriginal and/or Torres Strait Islander people in contact with it to receive equitable support through the Scheme.

NDIS participants in contact with the justice system, and who are currently serving jail terms, are not automatically categorised as having Complex Support Needs Pathway by their NDIA planner and this is an area that needs to be addressed; with Justice issues and Prison to community transition requirements meeting the threshold of a complex support need.

Access to a Complex Support Need pathway and Specialist Support Coordinator will also enable a greater focus on staff in these roles being adequately trained in both disability and Aboriginal and/or Torres Strait Islander cultural support requirements, with a focus on:

- Culturally responsive and appropriate service delivery
- Community reintegration
- Therapeutic support
- Training of NDIS support workers
- Assistance with accommodation and support to maintain it
- Disability specific family support
- Assistance in coordinating or managing life stages, transitions and supports
- supports to facilitate the participant's transition from custody to the community-where needs are specific to the participant's disability

Recommendations

With the reported high rate of Aboriginal and Torres Islander peoples with disabilities in the criminal justice system, the committee recommends the NDIA develops a specific strategy to ensure early intervention and culturally appropriate services are delivered for this group by specialised trained staff.

Service access to the NDIS for Aboriginal and/or Torres Strait Islander people

Recommendation 1: That in order to provide specialist and streamlined support to potential and existing Aboriginal and/or Torres Strait Islander potential and currently eligible NDIS participants in custody, that a disability support agencies seek to have an Aboriginal Disability Support Specialist funded, akin to the NSW Ability Links Coordinators, or "Linkers", to work in a targeted way with the Department of Justice and Communities (Disability) to:

a) Create a process to support the NDIS to work with the criminal justice system to better support prisoners to receive disability services through the NDIS whilst in custody, and through targeted outreach as part of reintegration support.

b) Access Specialist Court information, including assessments and other relevant records that may assist with eligibility requirements for the NDIS.

c) Access other relevant past medical and assessment information to support eligibility assessment through the NDIS

*A proposed pathway model is at Figure 3.

Recommendation 2: That UnitingCare West seek funding to engage a Specialist Aboriginal Community Linker as per the (particularly their Aboriginal identified Linker positions), who work with people, their families and carers to help them plan for their future, build on their strengths and skills, and develop networks in their own communities so they can do what they want with their lives – outside of the traditional disability service system.

Recommendation 3: Funding should be made available for a disability support organisation to develop a program and targeted approach to works with the Department of Justice and Communities (Disability) to identify Aboriginal and/or Torres Strait Islanders with disabilities currently not accessing required supports within the Prison environment.

Recommendation 4: That the disability sector, potentially through National Disability Services (NDS) as the Peak agency, work with the Department of Communities (Disability Services) to advocate for the ongoing Disability Justice Coordinator role, and the expansion of the Regional Intensive Support Coordinator (RISC) role to better support Aboriginal and/or Torres Strait Islanders prisoners to access the NDIS.

Recommendation 5: That further work be done with the Department of Justice to look at the current pre-release medical and psycho-social assessment process for Aboriginal and/or Torres Strait Islander people.

Recommendation 6: Refer to the project "Getting it Right", as at Attachment 3 and seek to have a similar very targeted project funded for Aboriginal and/or Torres Strait Islander people current within the Justice system in WA in order to improve access opportunities in a way that would enable them to be:

- Comfortable with the NDIS
- Informed about the benefits of the NDIS

- Supported to engage with the NDIA's access and eligibility processes
- Encouraged to participate in the planning and implementation of their NDIS plan

Recommendation 7: A referral pathway for assessments between Aboriginal Health Council of WA members be established to strengthen culturally appropriate referral pathways that interface between NDIA and Aboriginal Health.

Recommendation 8: Translation, interpreting and plain language services be provided to Indigenous clients. This directly addresses assessment and test error with Aboriginal clients but also importantly, ensures the uptake of services consistent with need.

Cultural Competence within the NDIS

Recommendation 9: In the absence of an Aboriginal Community Controlled Disability Service Provider that Guiding Cultural Principles be developed and integrated into referral pathways for Aboriginal people transitioning from Prison back to the community. Cultural competency assessment and training should also be provided to all Transition Managers and other Justice personnel involved in release planning and transition of Aboriginal prisoners back into the community.

Recommendation 10: That UnitingCare West request, through the NDIA, access to the 'framework of cultural competency for use by NDIS funded services', as well as access to the cultural competence expert reference group and that this information be shared amongst other disability service organisations.

Recommendation 11: That UnitingCare West establish what cultural competency training the NDIA is currently providing to its staff and partners, as informed by the advice of the cultural competence expert reference group (see recommendation 9) and seek to establish and/or advocate disability service organisations to have access to expertise across:

(a) assessment/cognitive as a focus as well as adaptive functioning

(b) consumer advocacy

(c) expertise in disability services delivery

Assessments

Recommendation 12: The following assessment tools be adopted (and associated training for staff be provided in their accredited use):

- The Westerman Aboriginal Symptom Checklist – Youth (WASC-Y) and Westerman Aboriginal Symptom Checklist -Adults (WASC-A), as culturally validated and psychometrically determined tools for Aboriginal people.
- The Acculturation Scale for Aboriginal Australians (Westerman, 2003) be utilised as a method of determining cultural connection and engaging with cultural identity, beliefs and values as part of the standard assessment protocols to determine culturally best practice support.
- That the Acculturative Stress Scale for Aboriginal Australians be utilised as a method of understanding and responding better to the impacts of racism and marginalisation for Aboriginal clients.

Workforce development and training

Recommendation 13: That the NDIA create a position or provide a dedicated Aboriginal and/or Torres Strait Islander planner or require that LC providers do so, utilising Special Measures provisions, noting

that Aboriginal and/or Torres Strait Islander will have specialist knowledge and understanding for roles requiring a strong involvement with Aboriginal and/or Torres Strait Islander communities and participants.

Recommendation 14: Support be provided through, or contracted by, the NDIA for mainstream organisations and their workforce to build their capacity to deliver culturally sensitive services to Aboriginal and Torres Strait Islander people

Recommendation 15: All Justice Service Providers be encouraged to undertake cultural competency training such as the Westerman General Cultural Competency Profile (GCCP) and that the competency levels of staff be measured over time. This could be facilitated across the sector through Curtin University who works closely with Dr Westerman and would support in building an evidence base in this area.

Resources

Recommendation 16: Contact Torres Strait Islander Consultancy who, in partnering with Connection Inc., created a supplementary worksheet and visual tool to assist in guiding and aiding NDIS planning conversations around supports, goals and aspirations, particularly those sensitive to any language and location barriers.

Recommendation 17: Contact the NPY Women's Council who have translated some of the key principles of the NDIS into language, and art work, highlighting that the Scheme is a wrap-around service and that it is for people with a range of disabilities and also what appropriate and inappropriate use of NDIS funding is.

Recommendation 18: Justice Service providers to keep a record of all resources available within the sector that can assist in engagement with Aboriginal Prisoners and ensure staff are made aware of these resources and how they can be used and implemented as part of their supports.

Attachment 1: NDIS Aboriginal and Torres Strait Islander Engagement Strategy

Attachment 2: NDIS participant and indefinite detention: A Case Study

“5.16 The case of an NDIS participant in indefinite detention was also brought to the attention of the committee by Ms Pearce, the Public Advocate of Victoria at a public hearing in Melbourne on 28 April 2017. The following account of events raises important issues around the role and responsibility of the NDIA to provide reasonable and necessary supports and to ensure a provider of last resort service is allocated when no providers are prepared to work with a participant. Additionally, it raises the issue of NDIA's ability to be responsive and deal with complex issues in a timely and effective manner. Ms Pearce reported:

Ms Z has been on remand for over 12 months. She is being held in a prison mental health unit and is in lockdown 23 hours a day in part due to her distressing behaviours. While she has a diagnosis of autism, she has also spent time in mental health services in the community as well as in the Thomas Embling Hospital, which is a Victorian high-security mental health forensic service. Recently a jury found her unfit to stand trial and her charges are at the minor end of offending. The presiding judge has expressed concern about her lengthy incarceration in onerous conditions, that the systems are not meeting her needs and that she remains incarcerated. She is allowed out of her cell for one hour a day and, not surprisingly, she is extremely distressed. When she is returned to her locked cell she spends hours and hours just screaming, vocalising her distress. If she had accommodation and supports, it is absolutely clear, she would be released. No-one wants to prosecute this case but there are no options for her. Her basic care needs are difficult to meet in a prison setting.(...)

She urgently needs to be transitioned to a residential environment with appropriate, ongoing clinical and therapeutic supports. The inability to identify an appropriate service provider and her behavioural presentations make it very difficult to successfully transition her to an alternative, community based environment. (...) The really good news in terms of Ms Z's circumstances is that NDIS has cut through all of that. She is, in fact, an NDIS participant. However, there is a limit as to what can be implemented while she remains in prison, in part because of the NDIS rules and the interface with the justice system. Only support coordination has been funded thus far, and other funded supports will not be available until there is a release date. Multiple agencies have so far declined to accept a referral to provide support coordination for this complex client.(...) There are no choices when there are no providers prepared to work with her. In order to ensure people with complex presentations who are involved with the criminal justice system can participate in and benefit fully from the scheme, the NDIS must be more flexible and responsive in its approach.[16]

5.17 At a public hearing on 12 May 2017, the committee was provided with a progress update on Ms Z's case. Ms Pearce reported:

(...)We do believe we may now have a case planner, but they are looking to see whether their services match the needs of this individual. This is one of the issues for people in the criminal justice system who are eligible participants—many of them will have high and complex needs, but, in a market driven environment, service providers can choose who they wish to provide services to. The NDIS still is unwilling to engage in any kind of service planning (...) But, without the involvement of the NDIA in a more proactive way than simply writing to my office and saying, 'This is what we are prepared to fund,' we are just not getting the cooperative, coordinated working relationships that we need to ensure that there is a smooth transition from one service system to another.[17]

5.18 The committee invited Ms Pearce to provide a further update on 28 July 2017. Ms Pearce reported:

(...)In May we found an agency who was able to do that, and at the moment her plan includes funding for specialist support coordination, and as I said, this is now being provided. A proposal has also been developed for a plan that includes post-release supports. An NDIS funded provider has prepared a proposal for a staged transition from prison, which includes a detailed explanation of the types of supports Ms Z will require to safely transition from her current restrictive environment to

independence within the community. The plan is quite substantive. (...)As I understand it, the proposal now sits with the NDIA. Since my last appearance before you, the NDIA has been more engaged.

They were given the proposal in June and have informed me that it is still under consideration and that approval is yet to be confirmed. In the meantime we've mostly relied on the hard work and goodwill of agencies like the one who prepared the proposal. For instance, a service provider included in the plan—the same agency that would provide the support for Ms Z in her house—is proactively collaborating with the prison. The prison has agreed to bend their protocols around transitioning in order to allow the agency to enter the prison and begin engaging with Ms Z in preparation for discharge. (...) As mentioned, we are very thankful for the attention you've paid to this case. It has certainly been a factor in the gains that have been made. However, despite recent progress, all parties are now at a standstill until the NDIA approves the plan. In other words, the case is progressing, but unfortunately not quickly enough to prompt her release from prison.[18]"

Joint Standing Committee on the National Disability Insurance Scheme, accessed 17 May 2019 https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MentalHealth/Report/c05

Attachment 3: “Getting it Right” Project Report

Attachment 4: NDIS Justice Supports summary table

Supports generally funded by NDIS	Supports which, dependent on their purpose, may be funded by the NDIS or other parties	Supports generally funded by other parties
Disability supports for people on community-based orders – including supports required by the participant as a result of their functional impairment to meet any court-imposed conditions (e.g. transport assistance and assistance with personal care) **For people in custody** (see r.7.24(b) of the Supports for Participants Rules): ▪ aids and equipment required by a participant for the purpose of improving functioning regardless of the activity they are undertaking but not fixed aids and equipment such as a hoist (in the same way as for people not in custody to the extent appropriate in the circumstances of the person's custody), and ▪ supports to facilitate the participant's transition from custody to the community where these needs are specific to the participant's disability and additional to transition needs of other people living in custody	**For people living in the community:** **Assistance in managing life stages, transitions and supports**, can be funded by the NDIS or by other parties. In determining which system is more appropriate, the system that is delivering the majority of supports is usually more appropriate to assist in the coordination of these supports: ▪ NDIS: assistance where the majority of the coordination and transition supports relate to supports funded by NDIS, or to non-clinical supports, ▪ Other parties: assistance where the majority of the coordination and transition supports relate to supports funded by other parties. **Development of daily living and life skills and behavioural support**– where the participant requires support specifically related to the functional impairment to live as autonomously as possible, including skills in daily life activities, communication and social skills, problem solving and behaviour management. ▪ NDIS: supports that build the participant's general capacity and functional ability, such as social relationships, communication, behaviour management, and ▪ Other parties: supports are specific to offending behaviours, such as programs that aim to reduce specific criminal behaviours **Assistance with daily life tasks in a group or shared living arrangement** – where the participant requires an integrated accommodation and support setting in order to assist them with activities of daily living, including supervision to address behaviours of concern: ▪ NDIS: where this support is in a community-based setting (i.e. the primary purpose of the support is to support the participant with activities of daily living rather than to protect the community or for clinical treatment), and ▪ Other parties: where the setting is designed specifically to protect the community, prevent offending or deliver clinical services	**Legal support** – guardianship, advocacy, community visitors, legal aid, victims or witnesses of crime **Management and compliance services** - to ensure compliance with court or parole orders for people living in the community **Day-to-day supervision and operations -** of custodial settings and custody-like settings (except aids/transition as outlined above). See Rule 7.24(a).

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