Impacts of Institutionalisation

Dr Robyn Shields AM and Dr Andrew Ellis

This report was commissioned by the *Bugmy* Bar Book Project Committee.

Cover art

The front and back covers show artwork by Jeremy Worrall (Wright) – Ngarabal/Gamilaraay. Each is one segment of a larger work, *Peace beneath the blue gum*, reproduced below.

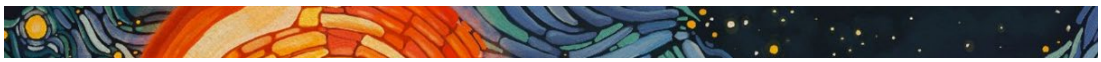
Peace beneath the blue gum. This artwork is a depiction of peace, both inner and physical. It portrays a place detached from colonial institutions, a place of natural beauty that fosters rest, reflection and learning. This artwork represents a dream, a blend of the physical – going back to country – and the surreal, with a painted sky and sun that show these places will only ever be a dream for some.

Publisher's acknowledgement

The publishers of the *Bugmy* Bar Book acknowledge the Aboriginal and Torres Strait Islander peoples of Australia and pay respect to their Elders, and their ongoing custodianship of Country. We acknowledge the diversity of Aboriginal and Torres Strait Islander communities, and the inalienable rights of Aboriginal and Torres Strait Islander peoples to freely determine their political status, and freely pursue their economic, social and cultural development.

Warning

This publication may contain names of Aboriginal and Torres Strait Islander people who have passed. Names of some clients (marked *) have been changed to protect their privacy.



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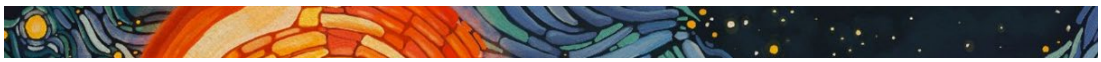

About the Authors

Dr Robyn Shields AM is an Aboriginal doctor from the Bunjalung Nation. Prior to her current role, she was a registered nurse working in mental health. During her career in nursing, she developed a model of mental health care for Aboriginal people in collaboration with the Director of Mental Health Services for Central Sydney Local Health Service, Professor Marie Bashir. The model of care was in partnership with the Aboriginal Medical Service, Redfern, New South Wales. It was recognised as the first service of its kind in Australia and still operates from Royal Prince Alfred Hospital, Sydney.

Robyn has given evidence to the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (*Bringing Them Home*, Report of the Australian Human Rights Commission, 1997) and contributed to the development of the first New South Wales Aboriginal Mental Health Policy.

Pursuing her commitment to supporting people with mental illness, in 2005 Robyn studied medicine at the University of Sydney. After graduating, she began her training in psychiatry. Today she continues to work in forensic psychiatry. In 2013 Robyn was appointed as an inaugural Deputy Mental Health Commissioner at the newly established Mental Health Commission of New South Wales. Past appointments include being a member of the New South Wales Mental Health Review Tribunal and being appointed to the Board of the Sydney Children's Hospital Network. She is currently a Board Member for the Justice Health and Forensic Mental Health Network and is Chair of the Aboriginal Health Committee.

In recognition of her achievements and contributions to Aboriginal Mental Health, in 2001 Robyn was awarded the Centenary Medal for her contribution to Australian society and government. In 2004 she was named a Member of the Order of Australia (AM) for her contribution to Aboriginal mental health. In 2015 she was recognised as a Westpac 100 Women of Influence.

Robyn holds a Bachelor's degree in Medicine (MBBS); Master of Public Health (MPH); and a Bachelor of Science Degree (BSc).

Dr Andrew Ellis was born and grew up in Newcastle, New South Wales. His family background is from Ireland and British settlers to Australia. He is a forensic psychiatrist, training first in medicine at Newcastle University. He is a fellow of the Royal Australian and New Zealand College of Psychiatrists and a fellow of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians in the United Kingdom. He has previously been the Chair of Training in Forensic Psychiatry for the Royal Australian and New Zealand College of Psychiatrists ('RANZCP'). He is a conjoint Associate Professor with the University of New South Wales Medical School, Discipline of Psychiatry, where he jointly leads the Master of Forensic Mental Health program. His research has been in the areas of forensic patients, prisoners, pharmacology, the intersection of law and medicine, impulsivity, arson, sex offences and offender profiling. His clinical work has predominantly been in public forensic

mental health services in New South Wales and the United Kingdom in secure hospitals, prisons, court services, police liaison and community services. Most recently he has been the Medical Superintendent of The Forensic Hospital in Sydney. He has been an expert witness in court cases covering a range of forensic psychiatry issues in most Australian and English jurisdictions. His work has brought him into contact with many Australian Indigenous people, and he values learning from Indigenous colleagues about how to better serve their needs.

Acknowledgements

We note as psychiatrists that our profession has issued a statement of apology to Indigenous Australians for the profession's involvement in colonial practices and institutions.[1]

As authors, we also acknowledge the Aboriginal and Torres Strait Islander peoples of Australia and pay respect to their Elders, and their ongoing custodianship of Country. We acknowledge the diversity of Aboriginal and Torres Strait Islander communities, and the inalienable rights of Aboriginal and Torres Strait Islander peoples to freely determine their political status, and freely pursue their economic, social and cultural development.

We acknowledge the work of First Nations psychologists Vanessa Edwige and Dr Paul Gray. Their report *Significance of Culture to Wellbeing, Healing and Rehabilitation* (2021)[2] is an important resource for health professionals, lawyers and judicial officers. Their report would assist in the development of culturally appropriate treatment plans and recommendations or conditions of court orders for First Nations people, including those affected by the impacts of institutionalisation.

Code of conduct for expert witnesses

We, Dr Robyn Shields and Dr Andrew Kenneth Ellis, acknowledge for the purpose of Rule 31.23 of the *Uniform Civil Procedure Rules 2005* (NSW) that we have read the Expert Witness Code of Conduct in schedule 7 to the said *Rules* and agree to be bound by it.

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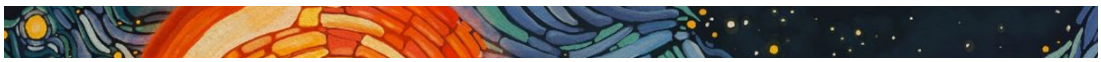
1 'Apology for the Role Played by Psychiatrists in the Stolen Generations', *The Royal Australian and New Zealand College of Psychiatrists* (Position Statement, April 1999).

2 Vanessa Edwige and Paul Gray, *Significance of Culture to Wellbeing, Healing and Rehabilitation* (*Bugmy* Bar Book, 2021).



Introduction

[1] This report has been commissioned by the *Bugmy* Bar Book Project Committee.[3] It is a psychiatric report about institutionalisation and its impacts, which includes detention and custodial as well as out-of-home care settings. The report includes reference to research and opinion about particular impacts for First Nations peoples.

[2] To prepare this report, we have conducted a thorough review of the institutionalisation literature as it applies in the context of detention, custodial and out-of-home care settings. We have used this in conjunction with our combined training, study and experiences of working in institutions, including psychiatric hospitals for adults and children, adult prisons, youth detention facilities and working with persons subject to community restrictions.

[3] In the Appendix, we have provided de-identified amalgam case examples to illustrate the points made in the report. These are cases from our practice. While they have been altered to protect identities, they retain the key clinical elements of the presentation.

[4] We have reviewed the *Bugmy* Bar Book chapters titled 'Impacts of Imprisonment and Remand in Custody' and 'Out-of-Home Care', and we accept the findings of the research set out in those chapters and recommend that this report be read in conjunction with those chapters.

[5] This report may be used in legal proceedings to assist the courts, tribunals, inquiries, inquests, as well as lawyers, advocates, practitioners, health and allied health professionals, and others to understand the impacts of institutionalisation in youth detention, prison and out-of-home care.

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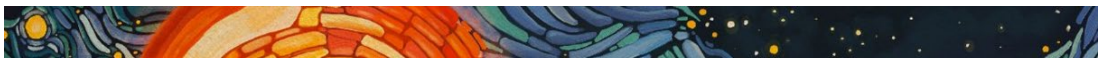
[3] The *Bugmy* Bar Book is a free, evidence-based resource for lawyers and legal decision-makers, as well as policy makers and other professionals. The research summaries ('chapters') provide accessible material about the impacts of experiences of trauma, socioeconomic inequality, structural disadvantage and strengths-based rehabilitation. These chapters may provide an evidence base to support legal advocacy and decision-making and are intended to improve understanding of the experiences of people who are brought into contact with the legal system.



Institutionalisation in Context

Youth detention, adult incarceration and out-of-home care

[6] Institutions have been used to foster certain behaviour in society. 'Institutions' can refer to many societal and physical structures such as schools, universities, ships at sea, monasteries and military academies. There may be some benefits to individuals and society from these structures, such as teamwork, learning and group cohesion. However, some institutions have developed with the idea of removing certain people from society at large, at the same time aiming to reform their characteristics and their behaviour. These institutions are not entered by choice and serve as places of banishment.[4] This might be to protect a person considered incapable of caring for themselves, or to prevent unintentional threat and intentional danger.

[7] These particular institutions have been termed 'total'[5] or 'complete and austere'[6] institutions by socio-anthropological observers. The term traditionally covers prisons, youth detention, orphanages and locked psychiatric hospitals, particularly those designed for confinement of the 'criminally insane'. These are closed systems, isolated from the rest of society. Total institutions have been defined by 'bricks and mortar', with high walls, locked doors and often geographically remote locations.[7] The architecture leaves residents in close proximity to others inside, separated from the outside, and it reduces autonomy (eg the facility to cook one's own food or choose one's own clothing may not be available). As will be seen, other features of institutions might render the architecture and geography less relevant, as institutions might be 'permeable' – without walls, but sharing other features. Other factors to be taken into account when considering the total institution are the policies and legal frameworks that govern its function. These rules limit the freedom of individuals placed within the institution – for example, who they can visit, their timetable of activities, what possessions they can keep. These things regulate everyday life and may not require walls. The institution relies on external control and the paternalism of staff charged with the care of the residents or 'service users' of the system – again a feature that may not require physical isolation.

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4 J Gunn, 'Prisons, Institutional Care and the Adult Mentally Abnormal Offender' (1988) 1(6) *Current Opinion in Psychiatry* 694.

5 Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor Books, 1961).

6 Michel Foucault, *Discipline and Punish: The Birth of the Prison* (Pantheon Books, 1977).

7 Winnie S Chow and Stefan Priebe, 'Understanding Psychiatric Institutionalization: A Conceptual Review' (2013) 169(13) *BMC Psychiatry* 1.

Terminology and knowledge base

[8] 'Institutionalisation' refers to a process of change that occurs when a person is placed in an institution. While not itself a psychiatric diagnosis or medical condition, typical patterns of behaviour and changes in physical status have been observed in people subject to confinement in institutions. The terms 'institutionalism', 'institutional neurosis' and later 'institutionalisation' were initially coined in the context of closures of large psychiatric hospitals, where it was noted that patients appeared indifferent to the outside world, showed worsening symptoms of mental illness and were reluctant to leave.[8] Various theories and empirical studies have shed light on how and why these changes occur. Biological changes are noted to occur in these settings as well as a psychological and social adjustment to the circumstance of institutionalisation. Specific mechanisms are outlined below. However, it should be noted that negative outcomes for institutional placement are not universal, and some positive outcomes have also been demonstrated. Again, these are not universal.

[9] Youth detention, either for criminal acts or as placement in orphanages, has been well documented to be a source of institutionalisation.[9] The impact is likely accelerated compared with adults, as the biological, psychological and social development of detained children are still in progress. Children are less able to tolerate highly constrained environments without distorting their developmental trajectory. Of particular note is the development of attachment styles in the developmental period.[10] 'Attachment' refers to early adaptation and connectivity in experience, leading to formation of a template for conceiving of one's self and how one relates to others. The quality of primary attachment relationships strongly influences early personality organisation. If the primary caregiver is replaced by an institution this impacts on the meaningful development of self-identity, and in turn how the child and later adult relates to others.

[10] Adult prisons have also been well documented to result in institutionalised behaviour among prisoners.[11] Some of this may be attributed by the greater numbers of persons with mental disorders who have been detained in prisons in western countries since the closure of large psychiatric institutions, a phenomenon termed 'trans-institutionalisation'. [12] Simply, the problems encountered by psychiatric patients in old asylums have now transferred to the prison estate – likely with some worse impacts, as persons with mental disorders in prisons show greater rates of self-harm, harm to others and institutional rule infractions. On the other hand,

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8 John K Wing, 'Institutionalism in Mental Hospitals' (1962) 1(1) *British Journal of Social and Clinical Psychology* 38.

9 Vicente Garrido, and Santiago Redondo, 'The Institutionalisation of Young Offenders' (1993) 3(4) *Criminal Behaviour and Mental Health* 336.

10 John Bowlby, *Attachment and Loss* (1969, Basic Books).

11 Terence Morris and Pauline Morris, 'The Experience of Imprisonment' (1962) 2(4) *British Journal of Criminology* 337.

12 Ashley Primeau et al, 'Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions' (2013) 2(2) *Comprehensive Psychology* 1.

institutionalisation can occur without serious psychiatric illness during both long and short sentences, as a 'revolving door' phenomenon of quick returns to custody can be coupled with positive thinking about imprisonment combined with fatalism about coping with obstacles such as homelessness or substance addictions, and distrust of 'helping' professionals.[13] One even sees people who commit minor crimes in order to return to prison, where there is some certainty in their life, and their role in life, alongside shelter and food.

[11] Features of institutionalisation can be seen in people who are subject to out-of-home care ('OOHC').[14] As noted, institutions do not require walls to have that effect, as policy, rules and reduced independence serve to foster the changes that institutional care or confinement leave. The long-term outcomes for children placed in this type of care show wide-ranging disadvantage in multiple domains of function.[15]

[12] What distinguishes Australian institutionalisation is that it has been based largely on race, initially explicitly directed towards Indigenous peoples in terms of policy and legislation. It is estimated that from 1910 to 1970, between one in three and one in ten Indigenous children (approximately 25,000) were forcibly removed from their families and communities.[16] The impact of forced removal on Aboriginal and Torres Strait Islander children was felt by both the families who had their children taken away and by the children themselves. Institutionalisation's main goal – to effect assimilation policy – was key to the concept of homogeneity across the Australian nation. For Aboriginal and Torres Strait Islander people the intergenerational impacts are a stark reminder of the failings of these institutional policies and practices. The dismal and confronting figures have resulted in the over-representation in generational incarceration rates, generational homelessness and unemployment, reduced opportunities to education and home ownership for this current generation, and high rates of youth suicide.

[13] Now, although the policies are ostensibly applicable to all, Indigenous people are grossly over-represented in places of detention and OOHC. These longstanding policies have left those who experienced institutional separation being charged with bringing up their own children, leaving generational effects still felt currently. Yet the types of western studies of institutionalisation have largely focused on European and North American experiences, and western concepts of mental and physical function. They are not likely to capture the impact and quality of Indigenous sense of loss in response to colonisation and the associated race-based institutional system.

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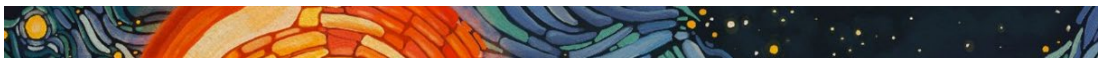
13 Amanda Howerton et al, 'The Consolations of Going Back to Prison: What "Revolving Door" Prisoners Think of Their Prospects' (2009) 48(5) *Journal of Offender Rehabilitation* 439.

14 Elizabeth Fernandez et al, '"There's More to be Done; "Sorry" is Just a Word': Legacies of Out-of-Home Care in the 20th Century' (2017) 42(3) *Children Australia* 176; 'Out-of-Home Care', in *Bugmy Bar Book* (September 2021).

15 Amir Sariaslan et al, 'Long-term Health and Social Outcomes in Children and Adolescents Placed in Out-of-Home Care' (2022) 176(1) *JAMA Pediatrics* e214324:1–11.

16 'Aboriginal and Torres Strait Islander Stolen Generations and Descendants' in *Bugmy Bar Book* (January 2020).

[14] The ideology that previously influenced political institutions went on to shape political agendas, and in turn profoundly shaped outcomes. As these ideologies become recognised and accepted as part of policy, they have become difficult to change. Political institutions become institutionalised into their own rules and the norms of the broader society, and this process results in constraining public policy. The prominence of 'racist' or particular policies directed at 'race only' can only be based on the assumption of assumed inferiority. This assumption has been applied to Aboriginal and Torres Strait Islander people and has dominated Australia's governmental policy agenda. The ongoing perception that Aboriginal and Torres Strait Islander people may have ideas of superiority has never emerged nor been accepted in the Australian landscape.



Impacts of Institutionalisation[17]

Mental health

[15] Institutionalisation has a complex relationship with psychiatric disorders. Some conditions require institutional care in order to treat acute episodes. Many psychiatric conditions are the reason for a person being placed into an institutional setting, and are thus over-represented within them. Some institutions allow access to psychiatric treatment not otherwise available in community settings, and psychiatric symptoms can improve in response. The quality of the institution, and the treatment within, impact the relationship.

[16] The worst impacts of institutions are the development of new psychotic conditions ('prison psychosis') in response to solitary confinement. This can worsen existing psychotic conditions, generate these conditions in a person without psychosis and lead to increased mortality from many causes.[18]

[17] There are some general factors found in persons admitted to long-term psychiatric institutions that show worse outcomes, particularly for social adjustment.[19] It is difficult to determine whether this is due to the severity of illness or the institution itself, but while generative settings and community support enhance some functions, the institution itself can have a corrosive effect on a person's mental state.

[18] The psychiatric impacts of prison are particularly acute for Aboriginal and Torres Strait Islander people; for example, Aboriginal and Torres Strait Islander women in prison are hospitalised for mental illness at triple the rate of Aboriginal and Torres Strait Islander women in the broader community.[20]

[19] Institutions negatively impact mental health generally, as prisons are controlling and punitive institutional environments which 'worsen mental health for all people, particularly those who have suffered from past traumas'.[21] Prisons have been found to be 'harming vulnerable people by exacerbating existing mental health conditions

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17 See also *Bugmy* Bar Book chapters 'Out-of-Home Care' (n 14) and 'Impacts of Imprisonment and Remand in Custody' (November 2022).

18 Luigi Mimosa et al, 'Shedding Light on "the Hole": A Systematic Review and Meta-Analysis on Adverse Psychological Effects and Mortality Following Solitary Confinement in Correctional Settings' (2020) 11(840) *Frontiers in Psychiatry* 1.

19 Sayaka Sato et al, 'Rehospitalisation Rates after Long-term Follow-up of Patients with Severe Mental Illness Admitted for More than One Year: A Systematic Review' (2023) 23(788) *BMC Psychiatry* 1.

20 Legislative Council Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into Victoria's Criminal Justice System* (Report, 22 March 2022) 594.

21 Ibid.

and causing new experiences of poor mental health.'[22] It has also been found that 'prolonged incarceration of people with mental illness is rarely clinically justified', as it can cause trauma and exacerbate mental health outcomes, negatively impacting behaviour patterns and the ability to engage in treatment and rehabilitation upon release.[23] Some of the practices in prison that have been found to negatively impact mental health include: isolation, restricted visiting, overcrowding, limited access to healthcare and programs, and negative interactions with corrections staff members.[24]

[20] Children placed in institutions or foster care show elevated rates of anxiety, depression, attention deficit disorder, oppositional defiant disorder and conduct disorder. Insecure patterns of attachment are common and associated with the diagnosis of reactive attachment disorder in these groups.[25]

[21] Children who are leaving care have been identified as experiencing negative mental health issues such as depression and post-traumatic stress disorder. These issues are ever-present, impacting their everyday life, and often result in a need for psychiatric care.[26] A large number of children leaving care 'described holding suicidal thoughts or actually attempting suicide',[27] with suicide rates comparatively higher than for the general population.[28] Aboriginal and Torres Strait Islander people who had been removed from their families were more likely to attempt suicide while in prison.[29]

[22] Children who are detained in youth detention facilities are also more likely to have poor physical and mental health and reduced cognitive ability.[30]

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22 Ibid (Finding 55).

23 Ibid 593 (ermha365, Submission 84, p 5).

24 Ibid 594.

25 Karen Bos et al, 'Psychiatric Outcomes in Young Children with a History of Institutionalization' (2011) 19(1) *Harvard Review of Psychiatry* 15.

26 Senate Community Affairs References Committee, Parliament of Australia, *Forgotten Australians: A Report on Australians Who Experienced Institutional or Out-of-Home Care as Children* (Report, 2004) 154 ('*Forgotten Australians* Report').

27 Ibid 155 [6.23].

28 Ibid 16 [1.64]. See also Cabinet Office (NSW), Special Commission of Inquiry into Child Protection Services in New South Wales (Report, 24 November 2008) vol 3 836 [20.50] ('NSW *Child Protection Services* Inquiry').

29 Katherine McFarlane, 'Care-Criminalisation: The Involvement of Children in Out-of-Home Care in the New South Wales Criminal Justice System' 2018 51(3) *Australian & New Zealand Journal of Criminology*) 412–33, citing research presented in the author's PhD dissertation of the same title (University of New South Wales, 2016).

30 Australian Institute of Health and Welfare, *Australia's Children* (Report CWS 69, 2020) 357.

Social and emotional wellbeing

[23] Aside from formal psychiatric diagnoses, changes in attitude can be observed in people within institutions. A 'mortification process' is described by Erving Goffman in the seminal textbook *Asylums*,[31] whereby the person is symbolically stripped of identity and support from outside. Uniforms and limits on contact are imposed. The person must submit to authority for even the most basic activities, such as when to use the bathroom. A system of privileges and punishments is often used, and each person acquiesces or resists this. A special language develops among the residents and staff as a way to communicate.

[24] On an individual level, the effects of forcible removal and institutionalisation persist into adulthood, appearing to be lifelong. Dr Brent Walters, summarising his observations and experiences working with Aboriginal and Torres Strait Islander people, wrote that he found the institutional impacts on many Aboriginal and Torres Strait Islander people include, but are not limited to, having multiple unstable relationships, being extremely susceptible to depression, and using drugs and alcohol as a means of masking their personal pain. Dr Walters went on to say that some Aboriginal and Torres Strait Islander people saw themselves as worthless, and were easily exploited, laying themselves open to other forms of victimisation.[32]

[25] All these factors distort and impact wellbeing and social development.

[26] A multitude of negative factors can impact psychological wellbeing in institutional settings. They include: limits on the ability to exercise and socialise; lack of privacy; limited exposure to fresh air and natural light; and limited ability to engage in activities.[33] In conditions of overcrowding, these issues are exacerbated.

[27] Social psychologist and academic Craig Haney, writing about research on the psychological impact of prison,[34] noted that adaptation to a custodial setting 'exacts certain psychological costs'[35] on most people, and whilst some are more vulnerable to the 'pains of imprisonment'[36] than others, these psychological impacts and 'pains of imprisonment'[37] can impede post-prison adjustment. He notes that being in custody can disable and psychologically harm people and result in 'long-term

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31 Goffman (n 5).

32 Australian Human Rights Commission, *Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (Report, April 1997) 164 ('*Bringing Them Home* Report').

33 Inspector of Custodial Services (NSW), *Full House: The Growth of the Inmate Population in NSW* (Report, April 2015) 59, citing Coroner of South Australia, *Finding of Inquest: Marshall Freeland Carter* (2000).

34 Craig Haney, 'Psychological Impact of Incarceration: Implications for Post-Prison Adjustment' (Conference Paper, US Department of Health and Human Services, 30 January 2002) 77–9.

35 Ibid.

36 Ibid.

37 Ibid.

consequences from having been subjected to pain, deprivation and extremely atypical patterns and norms of living and interacting with others'.[38]

Physical health

[28] The physical health of psychiatric patients in institutions (either prisons or locked hospitals) can be poor, related to diet, access to exercise and restrictions on incidental physical activity.[39] Indigenous people in these settings are particularly vulnerable to the lifestyle diseases that impact cardiac and metabolic function. Institutions can also be physically unsafe, with greater risk of exposure to violence and self-harm.[40]

[29] Imprisonment has been shown to 'worsen prisoners' physical health, exacerbate mental illness and cause inmates' human capital to decline, with costs increasing with the length of imprisonment.'[41]

[30] Institutional care has clear impacts on children's physical health, particularly on their development.[42] Height, weight, head circumference and a number of other physical characteristics are all found to be reduced in these children.

[31] Children in out-of-home care have a high prevalence of acute and chronic health problems and developmental disabilities.[43] The research indicates that once in care, in addition to mental, emotional and behavioural ill-health, children and young people 'have significantly poorer health outcomes in relation to visual defects, dental health, hearing impairments, speech development, and completed immunisations'.[44]

[32] There are insufficient publications on the intergenerational impacts experienced by Australian Aboriginal and Torres Strait Islander people. However, the Australian Institute of Health and Welfare ('AIHW') found that descendants of removed individuals were more likely to have an adverse outcome. The descendants were twice as likely to have felt discrimination, twice as likely not to speak an

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38 Ibid.

39 Trevor Ma, Tobias Mackinnon, and Kimberlie Dean, 'The Prevalence of Cardiometabolic Disease in People with Psychotic Disorders in Secure Settings: A Systematic Review' (2021) 32(2) *Journal of Forensic Psychiatry and Psychology* 281.

40 Christine Howlett, 'Cultures of Institutional Violence: Deaths in Juvenile Detention' (1995) 19(43) *Journal of Australian Studies* 24.

41 Queensland Productivity Commission, *Inquiry into Imprisonment and Recidivism* (Final Report, August 2019) 89 (citations omitted). See also the *Bugmy* Bar Book chapters 'Incarceration of a Parent or Caregiver', 'Unemployment' and 'Out-of-Home Care'.

42 Marinus H van IJzendoorn et al, 'Institutionalisation and Deinstitutionalisation of Children 1: A Systematic and Integrative Review of Evidence Regarding Effects on Development' (2020) 7(8) *The Lancet Psychiatry* 703.

43 NSW *Child Protection Services* Inquiry (n 28) vol 2, 617 [16.119].

44 Ibid [16.120].

Indigenous language and 1.6 times more likely not to have good health. In addition, life expectancy is reduced.[45]

Living skills, adaptive skills and other day-to-day functioning

[33] Aside from the impacts of psychiatric conditions themselves, being placed in an institution can lead to further functional impairment. Within a total institution where functions such as cooking, cleaning, washing clothes and shopping are either taken up by the institution or curtailed, obvious 'lack of practice' effects occur as children lack exposure to these tasks.

[34] For some people who have been institutionalised for long periods without access to technologies such as mobile phones, internet and even public transport payment systems, the rapidity of societal change can be a daunting adjustment on release.

Decision-making ability

[35] Decision making is impacted by multiple factors (for example intelligence, education, psychiatric diagnosis, life experience and interpersonal skills). All these factors could be impacted by institutional processes.

[36] In addition to developing individual psychiatric conditions, or negative development in other areas, the institutional process can lead to passivity and deference to others in decision making. Thus, although there are limited specific scientific evaluations to determine whether the individual contribution of institutionalisation impacts a person's decision-making capacity, it is reasonable to presume it can be impacted in multiple ways, over and above the identified impacts it has on general mental function.

[37] Imprisonment imposes a rigid routine on people 'that removes the potential for individual decision-making in many aspects of daily life' and in removing opportunities to exercise these skills people become decreasingly able to live independently and can lose a sense of personal responsibility.[46] This can be compounded by a lack of purposeful activity that many people experience when in custody.[47] Other manifestations of institutionalisation include hypervigilance, aggression, emotional over-control and loss of self-worth.[48]

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[45] *Australian Institute of Health and Welfare*, 'Health and Wellbeing of First Nations People' (Web Article, 2 July 2024) < https://www.aihw.gov.au/>.

[46] Australian Institute of Criminology, *Interventions for Prisoners Returning to the Community* (Report, Attorney-General's Department (Cth), February 2005) 37 (citations omitted).

[47] Ibid.

[48] Ibid.

Identity and self-worth

[38] For Indigenous people, the impact of loss of identity, connection with land, language, culture and people is profound and difficult to measure. As noted, this impact is likely to be multigenerational. The impact of multiple and recurring traumas is known to be cumulative. There continues a sense of alienation from 'white' culture compounded by a lack of identity within their own Aboriginal and Torres Strait Islander culture.[49]

[39] This situation is identified as directly associated with risk of offending and self-harm behaviours through 'a self-destructive cycle of loss of identity and purpose that fuels anger and trauma behaviours, such as acts of violence and alcohol and drug misuse'.[50] Grief and loss requires a whole-of-life perspective when related to this generational trauma.

[40] Further, either wittingly or unwittingly, many Aboriginal and Torres Strait Islander children were inculcated into a Christian religion and their Aboriginal and Torres Strait Islander culture and history was erased. To the dominant society, Aboriginal and Torres Strait Islander culture or history was considered completely irrelevant and was never considered as being important.[51]

Emotional and behavioural regulation

[41] Related to the research on formal psychiatric diagnosis are measures of general emotional and behavioural expression. In line with the elevated rates of formal diagnosis, practitioners observe elevated presentations of emotional dysregulation, poor attention and concentration, hyperactive behaviours, self-destructive behaviours, substance use and poor stress coping tolerance.

Neurological development

[42] Delays in neurological developmental milestones are seen most prominently in children raised in institutions.[52] This is the most obvious and easily measured area of development, and it raises a powerful argument for placing persons in settings as close to family as possible.[53]

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49 *Bringing Them Home* Report (n 32) 165, citing Dr Elizabeth Sommerlad.

50 Caroline Lisbeth Atkinson, 'The Violence Continuum: Australian Aboriginal Male Violence and Generational Post-Traumatic Stress' (PhD Thesis, Charles Darwin University, December 2008) 6–7.

51 See Aboriginal Legal Service of Western Australia, *Telling our Story: A Report by the Aboriginal Legal Service of Western Australia (Inc) on the Removal of Aboriginal Children from Their Families in Western Australia* (Report, 1995).

52 Paraskevi Giagazoglou 'Motor Developmental Delays of Institutionalised Preschool-aged Children' (2013) 183(5) *Early Child Development and Care* 726.

53 Steven Allen et al, 'Institutionalisation and Deinstitutionalisation of Children' (2020) 4(11) *Lancet Child and Adolescent Health* e40.

Relationships

[43] As noted, the institution limits the type and scope of interactions with others. This can then distort ordinary patterns of relating. The greater risk of dislocation from family, friends and community occurs. In Australia this is compounded by geographic distance.

[44] Being confined in an institution can lead to development of a strong identification with the incarcerated group. Conversely a person may strongly identify with the controlling group, either covertly – by superficially interacting with authority, but maintaining subversive behaviours – or by adopting the values and beliefs of those perceived as strong and powerful.

[45] Impacts on relationships associated with remand in custody (that is, even for people who are not yet convicted), include disintegration of social supports and family ties, disruption of education, employment and housing, and being cut off from supports and programs. There is an increased risk of suicide, and all of these factors increase the risk of reoffending and limit support that might address the factors underpinning the alleged offending.[54]

[46] Further consequences for Indigenous people include loss of connection to culture and family.[55] The impact is profound when there is a breakdown in the links between family and communities 'as every individual has a role to play including financial and social'.[56] If people are removed then the community is heavily burdened and weakened 'exacerbating economic distress creating prime conditions for further offending behaviour'.[57]

[47] Family and community impacts of incarceration are more pronounced for imprisoned Aboriginal and Torres Strait Islander parents, especially women. The impact of imprisonment on women, their families and communities is profound, especially in relation to the high number of Aboriginal and Torres Strait Islander men in custody. 'The sheer number of men and women missing from some families and communities creates devastating gaps in terms of parenting, income, childcare, role models and leadership'. The ripple effects on families and communities, of the

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54 Australian Law Reform Commission, *Pathways to Justice: An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report No 133, December 2017) 287 [9.17] ('*Pathways to Justice* Report').

55 Australian Institute of Health and Welfare, *Improving Mental Health Outcomes for Indigenous Australians in the Criminal Justice System* (Report, 14 July 2021) 7 ('*Improving Mental Health Outcomes* Report'). See also Ed Heffernan et al, 'Mental Disorder and Cognitive Disability in the Criminal Justice System' in Pat Dudgeon, Helen Milroy and Roz Walker (eds) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Commonwealth of Australia, 2nd ed, 2014) 165; *Bugmy* Bar Book chapter 'Cultural Dispossession'.

56 Senate Legal and Constitutional Affairs References Committee, Parliament of Australia, *Value of a Justice Reinvestment Approach to Criminal Justice in Australia* (Report, 20 June 2013) 22 [3.20].

57 Ibid.

incarceration of women, even for a short period of time, can have 'long-term cumulative effects'.[58]

[48] Being in out-of-home care can create interpersonal difficulties for a young person, affecting their ability to establish and maintain relationships. This, too, can have intergenerational impacts, including inability to provide a secure and stable family environment for raising children. Thus 'feelings of shame and fear of rejection about their childhood history can become cyclical. Each new generation, lacking a sense of security and parental role models, is unable to provide these vitally necessary foundations for the next generation'.[59]

[49] For Aboriginal and Torres Strait Islander children, a principal effect of removal from their families is the destruction of important family and cultural connections. This can result in alienation, loss of identity, frustration and stilted development of skills and learning. Disruption of attachment bonds between parents and children is most damaging during infancy and can lead to unresolved trauma and grief.[60]

[50] Youth detention can be damaging for children and young people and can 'increase the risk of stigmatisation and the likelihood of experiencing physical and psychological harm. Detention also results in disruptions to family life, development, education and employment.'[61]

Education

[51] Most people subject to institutional care report interference with schooling. Fewer complete high school due to lack of availability, lack of encouragement, poor attentional skills, not being able to afford education, or needing to work.[62]

[52] Young people in care are less likely than their peers to complete education beyond the minimum school leaving age. They are more likely to attend multiple schools and have substantial school absences as a result of placement changes. They are also at higher risk of suspension and expulsion due to behavioural issues.[63]

[53] The poor educational results of children in out-of-home care has, internationally, been a matter of concern for decades.[64] Australian research has found the following

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58 Human Rights Law Centre and Change the Record Coalition, *Over-Represented and Overlooked: The Crisis of Aboriginal and Torres Strait Islander Women's Growing Over-Imprisonment* (Report, May 2017) 13.

59 *Forgotten Australians Report* (n 26) 152 [6.19].

60 *Bringing Them Home* Report (n 32) ch 11, 'The Effects'.

61 Legislative Council Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into Victoria's Criminal Justice System* (Report, 24 March 2022) vol 2, 445.

62 Fernandez et al (n 14) 176.

63 NSW *Child Protection Services* Inquiry (n 28) vol 2, 620 [16.136].

64 NSW Department of Family and Community Services, *Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care in NSW: Wave 1 Baseline Statistical Report a* (June 2015) ch 6, 126.

to be more common for children in OOHC: 'spending significant time away from school, falling behind academically, behavioural issues, social issues, suspension, expulsion, bullying, early school leaving and leaving without qualifications.'[65]

[54] Children in out-of-home care who are engaged in education have lower results and outcomes than their non-care peers with evident barriers to engagement with school life.[66] Their education outcomes are significantly lower in primary school and early high school, as demonstrated in numeracy and literacy results, and this pattern continues into later high school. This is a serious issue for young people in education who lag behind academically when they enter high school are unlikely to catch up.[67]

[55] When people enter prison, especially those serving short sentences, they are 'less likely to be able to access programs or training, and in that regard, the time in prison does little to address offending behaviour or to develop skills that might later promote desistence from offending'. [68] Even where remand programs exist, government findings suggest they may not be regularly or consistently made available. Barriers identified include lack of resourcing, prioritisation of provision of programs to sentenced prisoners, and high frequency of inmate movements between centres.[69]

Lack of access to treatment and healthcare

[56] It is widely recognised that a lack of 'appropriate access to health care services can have adverse effects on the health and wellbeing of prisoners'.[70] The current prisoner health model of custodial settings have 'significant shortcomings with the potential to adversely affect the health of prisoners', including: 'inadequate inpatient facilities; the lack of medical services available at some regional prisons; and difficulties with prisoners attending specialist appointments due to limited transport arrangements.'[71]

[57] There are often 'inadequate physical and mental health services available to prisoners' including grossly inadequate psychiatric beds available to prisoners with mental health issues; lengthy waiting periods for prisoners to access specialist health

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65 Ibid (citations omitted).

66 Michelle Townsend, *Are We Making the Grade? The Education of Children and Young People in Out-of-Home Care* (Research Report, Department of Family and Community Services, 2012) 5, drawing on Michelle Townsend, 'Are We Making the Grade? The Education of Children and Young People in Out-of-Home Care' (PhD Thesis, Southern Cross University, 2011).

67 Ibid 5, 40.

68 *Pathways to Justice* Report (n 54) 269 [7.155].

69 NSW Inspector of Custodial Services, *Women on Remand* (Report, February 2020) 76 [6.2.1].

70 See, eg, Victorian Ombudsman, *Investigation into Deaths and Harm in Custody* (Report, 25 March 2014) 106.

71 Ibid 8, 105.

services; and inadequate time for medical staff to conduct comprehensive medical assessments of prisoners.[72]

[58] In addition to these barriers, Aboriginal and Torres Strait Islander people are less likely to be able to access culturally safe healthcare in prison than in the community. The AIHW (2022) found that only 9 per cent of incarcerated Aboriginal and Torres Strait Islander people in Australia report receiving treatment or consultation from an Aboriginal Community Controlled Health Organisation or Aboriginal Medical Service while in prison.[73]

[59] Poor health outcomes for incarcerated individuals continue to persist after release, including an increased risk of mortality.[74] People released from prison are also at increased risk of hospitalisation or contact with mental health services, compared with the general population.[75]

[60] Children in out-of-home care also experience significantly poorer health outcomes than their peers.[76] Outcomes for children in OOHC have been assessed 'against the key themes of the National Standards across the three main types of care (kinship care, foster care and residential care)', including safety and stability, participation in decision making, access to health and education, connection to family and community, and transition from care. It was found that '[o]verwhelmingly … outcomes for children and young people in out-of-home care across these indicators remain poor'.[77]

Removal from accommodation and homelessness

[61] Housing difficulties faced by care leavers often relate to financial insecurity, with many 'forced to live in public housing, subsidised rental accommodation or living

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72 Ibid 105–6, citing Victorian Ombudsman, *Investigation into Prisoner Access to Health Care* (Report, August 2011).

73 Australian Institute of Health and Welfare, 'Health of People in Prisoners' (Web Article, 7 July 2022). 'This is despite the recommendations of the Royal Commission into Aboriginal Deaths in Custody for Aboriginal people in prison to have access to culturally safe health care and Aboriginal-specific health services': Sacha Kendall et al, 'Incarcerated Aboriginal Women's Experiences of Accessing Healthcare and the Limitations of the "Equal Treatment" Principle' (2020) 19 *International Journal for Equity in Health* 47.

74 Michael Hobbs et al, *Mortality and Morbidity in Prisoners after Release from Prison in Western Australia 1995–2003* (Australian Institute of Criminology, Trends & Issues in Crime and Criminal Justice No 320, July 2006) 2.

75 Ibid 3.

76 Senate Community Affairs References Committee, Parliament of Australia, *Out of Home Care* (Final Report, 2015) 275 [10.1].

77 Ibid 79 [4.3].

on the street'.[78] A young person who spends time in out-of-home care or detention has a significantly increased risk of homelessness.[79]

[62] It is widely recognised that imprisonment has adverse effects on future outcomes including homelessness, social exclusion and unemployment, and these effects can be lifelong.[80] More than half of people exiting Australian prisons expect to be homeless following release, either staying in short-term or emergency accommodation, sleeping 'rough', or not knowing where they would be able to stay.[81]

[63] Aboriginal and Torres Strait Islander women exiting prison are the least likely to find appropriate accommodation, especially where they have dependent children.[82] A study of New South Wales and Victorian Aboriginal and Torres Strait Islander women between 2001 and 2003 found that none of the women leaving prison were able to find stable family accommodation, and half of these women were still homeless nine months after release; in addition, over two-thirds returned to prison within nine months.[83]

[64] Social housing tenants who experience incarceration may be forced to relinquish tenancies while in prison if the period of incarceration exceeds the length of time they are permitted to be absent from their housing.[84]

Stigmatisation

[65] Children in OOHC are often stigmatised for being in out-of-home care. They can be treated as 'second-rate citizens' for a range of reasons, such as being unwanted by their parents, or for wearing ill-fitting and second-hand clothes.[85] They are often segregated at school and seen as 'being different' from their peers. The stigma of being in out-of-home care often has an enduring impact on their life, particularly leading to feelings of low self-esteem and self-worth.[86]

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78 *Forgotten Australians* Report (n 26) 162 [6.43].

79 Human Rights and Equal Opportunity Commission, *Our Homeless Children: Report of the National Inquiry into Homeless Children* (Report, 10 February 1989) 109 [10.4].

80 *Improving Mental Health Outcomes* Report (n 55) 2.

81 Australian Institute of Health and Welfare, The Health of People in Australia's Prisons 2022 81. An earlier study for the Australian Housing and Urban Research Institute had found that being transient or homeless was a predictor of reincarceration: Eileen Baldry et al, *Ex-prisoners and Accommodation: What Bearing Do Different Forms of Housing Have on Social Reintegration?* (AHURI Final Report No 46, August 2003) 22 [4.3].

82 *Pathways to Justice* Report (n 54) 356 [11.41].

83 Ibid.

84 Australian Housing and Urban Research Institute, *Exiting Prison with Complex Support Needs: The Role of Housing Assistance* (August 2021) 30.

85 *Forgotten Australians* Report (n 26) 146 [6.6], 153 [6.20]–[6.21].

86 Ibid 146–7, [6.7].

[66] The potential long-term impacts of OOHC on a person's relationships stem from 'past experiences of fear, intimidation, humiliation and abuse endured by the care leaver as a child'[87]. Care leavers often encounter 'difficulty in initiating and maintaining stable, loving relationships' as a consequence of growing up without a nurturing and secure environment.[88]

[67] Being held in corrections facilities can be extremely damaging for children and young people. Exposure to these facilities can increase the risk of stigmatisation and the likelihood of experiencing physical and psychological harm.[89]

Risk of institutional sexual abuse

[68] Children in institutions continue to be at risk of sexual abuse. In out-of-home care settings there are 'identified persistent weaknesses and systemic failures that continue to place children at risk of sexual abuse'. The major *Royal Commission into Institutional Responses to Child Sexual Abuse* (2022) found that 'sexual abuse by carers, their family members, visitors, caseworkers and other children in care continues to occur … and that sexual exploitation is a growing concern, especially for children in residential care'.[90]

[69] The Commission identified the impacts of sexual abuse in OOHC as resulting in 'complex trauma and cumulative harm'. There can be 'feelings of betrayal and loss of trust when abused in this context.' In addition to experiences of sexual abuse in an institution there can also be a poor institutional response to that abuse which can 'compound other adverse experiences in childhood, setting some children on a pathway to drug and alcohol abuse, homelessness and criminal behaviour.' These experiences can have intergenerational effects such that survivors of sexual abuse in out-of-home may have had parents that had been sexually abused in care, or their own children had been taken into care, or both.[91]

[70] Youth detention centres are also high-risk institutional settings for sexual abuse.[92] Youth detention centres are 'closed, secure environments under the control of adults who exercise a high degree of power and authority over detained children.' This institutional setting can 'allow perpetrators to exploit opportunities to sexually abuse children, prevent abuse from being identified and inhibit disclosure, both at the

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87 Ibid 145 [6.3].

88 Ibid 148 [6.9].

89 Legislative Council Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into Victoria's Criminal Justice System* (Report, March 2025) 445.

90 'Contemporary Out-of-Home Care', *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 15 December 2017) vol 12, 13.

91 Ibid 14.

92 'Contemporary Detention Environments', *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 15 December 2017) vol 15, 47.

time of the abuse and in the following years.'[93] The impact can result in 'deep, complex trauma that pervades all aspects of their lives'.[94]

Self-sabotage

[71] A particularly difficult and hard to comprehend behaviour is self-sabotage of plans and progress.[95] It can be explained by the ambivalent way the person perceives the institution and the difficulties they may face in understanding complex situations. In the face of change (such as release or transfer of care) their situation may prove overwhelming and lead to anxiety-driven behaviours that return the person to the institution.

Heightened risk factors

[72] Factors that heighten the risk of developing an institutionalisation syndrome or negative outcomes include longer times in institutions, earlier age at first institutional contact, deprived environments within the institution, and exposure to violence (including sexual violence) while in the institution. As a general rule, the more vulnerable the person prior to institutional exposure, the more likely it is that there will be adverse outcomes from that exposure.

Background of trauma

[73] A background of trauma is an additional risk factor for institutionalisation and adverse mental health and social and emotional wellbeing impacts. Trauma – particularly occurring early in life or in repeated form – is a risk factor for multiple mental disorders, including the most severe psychotic conditions. People exposed to trauma would thus be considered vulnerable and more prone to experience the negative impacts of institutionalisation. Violence or sexual violence within the institution can further repeat and exacerbate traumatic related psychiatric symptoms.

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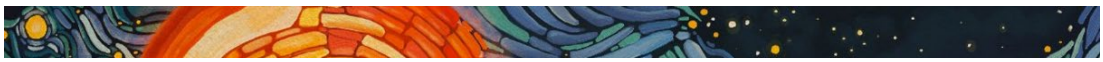
93 Ibid 81.

94 Ibid 99.

95 Randy A Sansone, Jamie S McLean and Michael W Wiederman, 'The Relationship Between Medically Self-Sabotaging Behaviors and Borderline Personality Disorder among Psychiatric Inpatients' (2008) 10(6) *Primary Care Companion to the Journal of Clinical Psychiatry* 448.



Remedial Measures

During detention and in care settings

[74] Detention centres, prisons and out-of-home care settings can take measures to reduce the likelihood of impacts of institutionalisation, based on knowledge of the factors that can improve the outcomes of people subject to institutional exposure. There is some debate about whether institutionalisation is always negative, as some studies show improvement in various outcomes with institutional care. This circumstance usually arises where the alternative to restriction or confinement is likely to lead to worse exposure – for example, homelessness, exposure to drugs, and violence. Another example would be forensic patients placed in hospitals, where their outcomes are significantly better than if they were placed in prisons.[96] For example, forensic patients (those found not criminally responsible for serious criminal charges due to a mental health or cognitive impairment and diverted to hospital settings) released to the community from the New South Wales forensic mental health system show a 4.7 per cent rate of violent reoffence over a 7.6 year average follow-up period. By contrast, persons with similar charges dealt with by the criminal justice system through prison, show a 53.7 per cent rate of return to prison in a similar timeframe (8–10 years), and the return to custody is faster for persons with psychosis than for those without. Internationally, this finding is replicated in most jurisdictions.[97]

[75] If restrictive practices such as seclusion and restraint are reduced there are better overall outcomes. Access to any enriching activities such as sports, arts and education can improve outcomes. Peer workers and Indigenous staff improve outcomes. Having a trauma-informed approach, with explicit goals to reduce restrictive practices, applying the least restrictive principle, improves outcomes. Robust external oversight of institutions assists in maintaining a positive focus. Adequate staffing and training levels, with access to clean indoor areas with natural light, and to outdoor spaces, improves outcomes.

Post-institutionalisation measures

[76] Measures can also be taken to address the impacts of institutionalisation when a person is released from detention or prison, or has left out-of-home care. A key aim in rehabilitation is to replicate the good aspects of the institution (such as

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96 Heather Hayes et al, 'A 21-Year Retrospective Outcome Study of New South Wales Forensic Patients Granted Conditional and Unconditional Release (2014) 48(3) *Australian & New Zealand Journal of Psychiatry* 259; Olav Nielssen et al, 'Outcome of Serious Violent Offenders with Psychotic Illness and Cognitive Disorder Dealt with by the New South Wales Criminal Justice System' (2019) 53(5) *Australian & New Zealand Journal of Psychiatry* 441.

97 Seena Fazel et al, 'Patient Outcomes following Discharge from Secure Psychiatric Hospitals: Systematic Review and Meta-Analysis' (2016) 208(1) *British Journal of Psychiatry* 17.

predictability, consistent support and material goods) while introducing greater individual responsibility in a manner that tests but does not overwhelm a person's capacity to succeed. 'Setting up to fail' without sufficient supports will likely lead to return to institutional settings. Having access to a range of individualised supports, including appropriate cultural supports, is important. The cultural supports can lend legitimacy to other supports from mainstream services and encourage adherence where there may otherwise be suspicion.

[77] In conclusion, we again acknowledge and recommend the work of First Nations psychologists Vanessa Edwige and Dr Paul Gray, whose *report Significance of Culture to Wellbeing, Healing and Rehabilitation* (2021)[98] is an important resource for health professionals, lawyers and judicial officers. It would assist in the development of culturally appropriate treatment plans and recommendations or conditions of court orders for First Nations people, including those affected by the impacts of institutionalisation.

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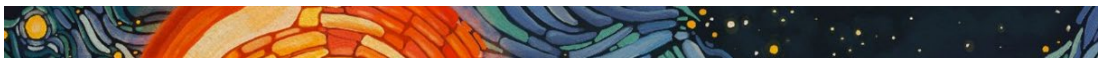
[98] Edwige and Gray (n 2).



Appendix: Case Studies

Case 1

[78] Ms Mason* (not her real name) is an Aboriginal woman born in semi-rural New South Wales during the 1950s. Since childhood, Ms Mason has a long-documented history of institutional placement, beginning life as a baby in an orphanage, where she remained until her early adolescent years. There were reported instances of absconding, resulting in her being sent to Palm Island,[99] where she remained for three years and was schooled in what she called 'home training' as a domestic cleaner. During her time on Palm Island Mission she was subjected to emotional, physical and sexual abuse.

[79] Ms Mason was subjected to Queensland's *Aboriginals Protection and Restriction of the Sale of Opium Act 1897* and was under the control of the Chief Protector. The Chief Protector had the authority to remove children and make administrative decisions without a court hearing. From 1939 to 1971, this power was held by the Director of Native Affairs.

[80] When released from Palm Island Mission Ms Mason moved to Brisbane, working as a domestic cleaner. She got involved with a male who fathered her three male children. After this relationship broke down, she moved back to her rural town in New South Wales. When living in that town, her children were removed by Family Services, allegedly due to neglect.

[81] In her late teens she established a history of polysubstance dependence and later in her life began to use intravenous amphetamine and cocaine. Then, in early adulthood (by the age of 20), she was involved with petty crime, stealing and illegal drug use. She spent years incarcerated often related to impulsive acts while intoxicated. Her earliest convictions dated back to 1975 to 1980. There were no recorded convictions from the early 1980s to 1994, but during the period of 1995 to 1998 there were numerous incarcerations.

[82] In 2000, during a period of incarceration, Ms Mason was charged with serious assault of a fellow inmate, and her charges resulted in a finding of Not Guilty due to Mental Illness ('NGMI'). By this stage she had a well-established diagnosis of schizophrenia characterised by delusions, disordered thoughts and behaviour, and paranoid thoughts. She had by then attracted a diagnosis of personality disorder characterised by her impulsive negative behaviours, difficulty in forming attachments and maintaining relationships, even with her own children and community. There were significant mood changes resulting in impulsive acts of anger, directed either at

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[99] Palm Island was established in 1918 by the Queensland State Government, closed in 1975 and then became a self-governing community in 1986. The dormitories on the Palm Island Mission housed young Aboriginal and Torres Strait Islander children who were forcibly removed from the parents. Palm Island had a harsh reputation: high death rates, residents arrested if they were a minute late from morning roll call and nightly curfews. See *Bringing Them Home* Report (n 32) Confidential Submission 776 – Murray.

herself through illicit drug use or directed at others. She remained in custody and was eventually given conditional release to live in her hometown, to be followed up by the local community mental health team. However, her conditions were breached due to poor compliance with antipsychotic medication and her relapsing into substance abuse, and she then committed further offences.

[83] In 2002 she was taken back into custody and has since been on a course of failed attempts at integration back into the community. She had failed placements in medium-secure hospitals and later in life, when placed in aged care facilities, was returned to a high-security unit. Her placement there is deemed unsuitable due to her fragility and the vulnerabilities of an aged person. In Ms Mason's case institutionalisation has instilled a hostile dependence on a system that failed her in the first instance and now has limited her chances of success for integration into her community and returning to her family.

[84] Ms Mason's ongoing care readily acknowledges many challenges due to her struggles in life. Cultural dislocation and her institutionalisation are the most likely contributing factors to her suboptimal placements. The cycle of system and systemic failures has been ongoing for this elderly Aboriginal woman. At an early age as an infant, she experienced separation from the care and connection to her kinship and Aboriginal community. She lived in institutions – starting her life living in several missions. In her adult life she experienced numerous incarcerations and spent time in high-security environments. If not for the removal and separation from her family in the first instance, and the exposure to cyclic institutionalisation failures, her trajectory may have been very different.

[85] Curiously, Ms Mason usually interacts with Dr Ellis in a pleasant and deferential manner, presumably referencing experiences of dealing with white males in positions of authority where 'stepping out of line' may lead to harsh consequences or lack of privileges in these settings. She is more likely to be rude and antagonistic with Dr Shields, despite sharing gender and culture. This is an example of the distorted attitudes and relationships that can develop in institutional settings, including the distortion in relation to her identity.

[86] Treatment and rehabilitation recommendations are difficult to provide in the structure of current service arrangements. Acceptance to any type of residential setting is beset with problems as the behaviours displayed by Ms Mason do not neatly 'fit' with the design of services. Nonetheless, she lacks skills and capacity to live independently. She displays chronic symptoms of mental illness, cognitive impairments, lack of emotional ability and interpersonal conflicts. Her age and physical state require ongoing care and support. Providers of services designed to address single problems find reasons to exclude her. Staff are more fearful of interacting with her, although objectively her ability to cause harm is low.

[87] As a starting point, good physical health care, diet and a placement with adequate natural light and access to nature would be ideal. Familiar staff who can broker interactions with medical specialists can assist in getting physical health needs met. Judicious prescriptions of psychotropic medication requires regular review; while they can assist, the side effects disproportionately impact her physical state and cognition. Having cultural supports work with her in brokering interactions with placement staff can assist. Most pressingly, having others advocate for service

change (such as her public guardian) can assist in having services designed for patients, rather than patients needing to adapt to existing structures.

Case 2

[88] Mr Hill* is a 33-year-old single male who identifies as an Aboriginal person. He is a member of the lesbian, bisexual, transgender, queer, intersex, asexual (LBGTQIA+) community. Mr Hill was born in rural New South Wales, has no dependants, and was in receipt of Centrelink income. Mr Hill was living with his mother in an outer suburb of a large town and has three siblings from his mother's previous relationships. He and his siblings on his maternal side have different fathers.

[89] In terms of his parents' Aboriginality, his father was born in a small town in New South Wales, and he identified as Aboriginal. Even though his father was born during the time when Aboriginal people were subject to rule by the Aborigines Protection Board, later in 1940 replaced by the Aborigines Welfare Board (which had the authority to remove Aboriginal children without having to establish in court that the children were subject to neglect), his father remained with his biological family. Mr Hill's mother was born in New South Wales, also identified as Aboriginal, and was removed from her family. His mother had four other siblings. All five children were automatically removed under the decision of the Aborigines Welfare Board. On that day, his mother and her siblings were separated and placed into different homes, and when aged 18 she went looking and found her family. Mr Hill recalled hearing his mother talk about her difficulties in fitting in with her biological family and her struggle to integrate back into the Aboriginal community where she should have belonged. During the discussion with Mr Hill, he had lamented, 'I wish that car did not come up the driveway on that day, my life would have been different'.

[90] Mr Hill's in utero obstetric history showed he was exposed to maternal drug and alcohol use.[100] He reported that his mother had been in violent relationships with all her partners, including Mr Hill's biological father. Mr Hill disclosed at an early age that he had moved around a lot due to his mother's violent relationships with partners. He started school at age five, was given a diagnosis of attention deficit disorder ('ADD'), and was treated with medication. By age 7 he was suspended for punching other students and by the age of 13 had changed schools again as he continued to get into trouble and often truanted. At age 13 he started smoking cannabis and hanging around areas in the town, prostituting himself for money to pay for his drugs. He described his own behaviour as out of control. He had contact with the police on occasions, but due to his age he was not charged and was usually taken home.

[91] When aged 14, Mr Hill was sent to live with his biological father because his mother could no longer cope with his behaviour, but this was short-lived. He said he did not have a close relationship with his father, saying his father often picked on him, because he was 'too much like his mother'. Mr Hill said his father had made fun of his looks and in particular his poor dental hygiene. Mr Hill recalled his father had taken him on a hunting trip where he witnessed a kangaroo being killed with a joey in the pouch. Mr Hill described being traumatised by this incident and his father's response: he was told to 'toughen up'. His father's comments were also directed at his sexuality and he would tell him to 'man up'. He returned to the city and completed his year 10 at a TAFE college, following which he had short periods of employment, but he continued to do sex work to support his addictions.

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[100] 'Fetal Alcohol Spectrum Disorders (FASD)', in *Bugmy* Bar Book (November 2019).

[92] Mr Hill started using illicit drugs at an early age. It started with smoking cannabis and cigarettes. He then moved to drinking alcohol and by age 18 was a regular drinker and methamphetamine user. His drug use escalated to daily use of methamphetamine and gamma hydroxybutyric acid ('GHBA'), a psychoactive stimulant. He had numerous attempts at addressing his illicit drug use and reported he had been in and out of drug rehabilitation facilities. He reported that the longest he had been drug-free was between ages 25 to 26 when in a country prison.

[93] Mr Hill's formal records of criminogenic behaviour was extensive, indicating a cycle of incarcerations, which occurred mostly in the context of being intoxicated by illicit drugs mixed with alcohol.

[94] Later in life Mr Hill had attracted further diagnoses of depression and post-traumatic stress disorder. He had been treated with antidepressant medication. He had multiple admissions to both private and public mental health facilities. His sister, older brother and mother all had suffered from depression and post-traumatic stress disorder. He had a history of self-harming behaviour and most of his admissions to public mental health facilities were in the context of his actions of harming himself. He was sexually abused by one of his mother's partners.

[95] When Mr Hill was asked about his own identity and 'Aboriginality', his response was he was 'never proud of his Aboriginality'; he said it brought a lot of racism, negativity and 'shame'. He often lied about his identity and claimed to be associated with other dark-skinned groups as a protective mechanism. He described his intoxication with alcohol and drugs as helping to ease his identity crisis in some way. When asked about his sexuality he said he had difficulty talking about this, and at times he would never disclose his sexuality, particularly when in prison.

[96] In summary, Mr Hill had experienced early childhood trauma and a lived experience of intergenerational exposure to complex trauma, over a long period, and these were repeated throughout several generations. The intergenerational trauma on his maternal side – his mother's separations and attachment history (his mother's poor attachment and emotional dysregulation) – had contributed to family dysfunction and poor attachment, including his mother's attachment dysfunction. His experiences have had a lasting negative impact on what an ordinary childhood development and attachment would be like. It is known that individuals who experience childhood trauma tend, later in life, to have a sense of insecurity and difficulties in making and maintaining relationships. There is also an increased risk of developing mental disorders of the type suffered by Mr Hill. His mother had difficulty with his behaviour, resulting in his living with his father for a short period, during which his mother knew about his father's violence. His stay with his father saw him being subjected to ridicule and seeing animal cruelty. The parenting arrangement between his mother and father had resulted in his exposure to unacceptable levels of violence and sexual abuse. The evidence from his description of growing up reflected disadvantage, exposure to neglect, and development of 'rebellious behaviour'. This is by no means a criticism of his mother's parenting style; it reflects the difficulties people of the stolen generation and those with institutional behaviours have struggled with in raising their own families.

[97] Purely based on her Aboriginality his mother was traumatised by removal and subjected to a life growing up in an institution with no positive reinforcement related to her Aboriginality. The denial of humanity and decency resulted in her returning to a

so-called family only to continue in isolation, humiliation, and loss of identity. Mr Hill was able to identify that his mother struggled with her own issues – a combination of trauma and lifelong generational and intergenerational impacts on her wellbeing. Mr Hill's damage to his identity and self-worth had set early in life, affecting his developmental milestones and reducing his ability to function both within his own 'world' and in society in general.

[98] Overall, Mr Hill's presenting issues arise predominately from his major loss and grief, the consequences of family members' removal and the impacts of his mother's history of institutionalisation. The removal of his mother and not his father was arbitrary. Disruption to Mr Hill's sense of his Aboriginality, strong bonds to family and kinship have been the most significant factors contributing to his emotional and mental health problems, which in turn resulted in poor physical health outcomes and drug use, low self-esteem and a poor sense of his identity as an Aboriginal person. His Aboriginality was not positively affirmed, and he was ashamed to claim his identity first as an Aboriginal man and secondly as a gay man. The accumulated effects of his Aboriginality had intertwined with other abuses inflicted on him, including his repeated cycles of incarcerations, mental health issues and illicit drug use, which became his way of life.

[99] Mr Hill's mental conditions are relatively severe and interact with each other. Thus, he has complex rehabilitation needs that traverse a number of services. These include health substance use services, health psychiatric services, educational and vocational providers and non-government organisations. Service division is the mode of rehabilitation currently practiced, so he will have to navigate multiple providers, each with different intake and exclusion criteria. To make these reviews valuable, treating clinicians should have his previous records available to them. His rehabilitation needs are likely to last years, and support will be required at some level, potentially indefinitely, given the long-term nature of his problems. Having cultural support to navigate and broker services is a necessary 'glue' to ensure adherence to plans.

[100] The first issue to tackle was substance use rehabilitation. This commenced in a residential facility with group programs and continued when he was released to the community through outpatient group and individual therapy. Testing for substance use would help with motivation for abstinence.

[101] Mr Hill benefits from psychiatric review to monitor for any development of a relapse in his mood, and from ongoing treatment of his depression, anxiety and post traumatic symptoms with appropriate medications. A number of other antidepressant medications more directly target anxiety, and specifically symptoms of PTSD and depression, would likely have a greater benefit in promoting a regular sleep routine, reducing anxious reactions and keeping a responsive mood. They take a longer time to work (4-6 weeks) and have a more gradual effect than sedatives. Other medications (usually used to treat high blood pressure) could also reduce the experience of nightmares, which would be beneficial. Any medication that reduces PTSD symptoms and depressive symptoms can have a large effect on reducing relapse to pathological mood states. As a class, they have more modest effects on reoffending (needing to work in conjunction with psychosocial rehabilitation). There

is new evidence suggesting that some antidepressants reduce impulsivity and reoffending.[101]

[102] Mr Hill benefits from psychotherapy to address post-traumatic stress symptoms and personality disorder. This can occur in a group settings or individually, depending on the skills of the therapist. He also benefits from remedial education and vocational training.

[101] Tony Butler et al, 'Tackling Violent Crime Using Pharmacotherapy' (2020) 32(10) *Judicial Officers Bulletin* 103.

Case 3

[103] Master Stanley* is a 15-year-old boy. He is of Indigenous background from his mother's side of the family, and Pacific Islander on his father's side. He has no dependants.

[104] He was born in rural Queensland. He was exposed to maternal drug and alcohol use in utero. He is one of five children to his mother. He has had no contact with his biological father. His mother usually lives in a capital city. He was taken from his mother's care at age three and at first placed with relatives. He was subject to violence by his mother and then grandmother, leading to his placement under state care. He was then placed under the care of the Minister and placed with foster families. Some placements have been in hotels with worker supervision, rather than families. Carers noted scars, including cigarette scars on his body, and restricted eating patterns, often found in people who have been denied food.

[105] Master Stanley attended multiple different primary schools. He barely went to school. He usually stayed at home and hung out with friends. Some of these friends were the same age, and some were older. He had been suspended from school for fighting.

[106] He had been to different Koori and Pasifika festivals. He thought these were 'alright' and would like to learn more about them. He had limited identification with his heritage. He said he had been the subject of racist name-calling for most of his life.

[107] He had general health and specialist mental health interventions throughout his childhood. He undertook a formal measurement of general intelligence which placed him in the borderline range of intellectual function when he was 10 years old. He was observed as hypervigilant, with poor sustained attention at the time. Non-verbal therapeutic techniques were recommended to deal with his emotional and behavioural regulation problems.

[108] Master Stanley attracted the child psychiatry and paediatric diagnoses of attention deficit/hyperactivity disorder ('ADHD'), conduct disorder, post-traumatic stress disorder, depression and anxiety by age 12. The same year, a speech pathology assessment noted problems with receptive (moderate delay) and expressive (mild to moderate delay) language.

[109] He has been placed in youth detention for the past two years, remanded on serious charges. He was moved to another centre approximately two months prior to the reviews, as a result of climbing on the roof of the previous facility with other boys.

[110] Prior to entering custody, he was living in a hostel room provided by Family Services, and had been there about two months. He said he was off all prescription medications at this time, and had been for some months. He had been moving around a lot. He was enrolled in school but was infrequently attending. He had not seen a mental health or general health professional for some months.

[111] Master Stanley is currently housed in a single cell. He attends school within the facility enrolled in year 10. He receives visits from his brother and a community mentor from the Pacific Islander community. He is prescribed medication for ADHD

(guanfacine) and to assist with sleep (melatonin). He sees the centre's psychologist and participates in programs.

[112] His background is marred by significant risk factors for developmental disorders. He was exposed to alcohol in utero, which could predispose him to developmental problems with speech and language, attention, hyperactivity, impulsivity, general cognition and developmental social reciprocity. This was further complicated by his direct exposure to violence and then the abandonment by caregivers he suffered. He was then dislocated from familiar environments and moved between professional and surrogate family caregivers on a frequent basis throughout his life. This lack of stability would have compounded the risk for the conditions described.

[113] These types of traumas may in some cases lead to more discrete traumatic symptoms. Some of these are described in the historical documents, such as his presentation as hypervigilant in assessments, having poor emotional regulation, restricted eating and poor sleep. He does not currently describe these symptoms, but he also fails to recall the traumas he has been exposed to. This type of amnesia for psychologically stressful events is not an uncommon response. While he does not meet the criteria for PTSD *simpliciter*, he would be considered to suffer from the complex effects of trauma and complex post-traumatic stress disorder,[102] which predispose him to specific psychiatric disorders, as well as more general emotional dysregulation. The chronic exposure and relational nature of the trauma more commonly has broad impacts on mental function, rather than discrete trauma related symptoms. Earlier, this likely affected his cognitive development, evidenced by his poor performance on structured measures of cognition which have subsequently improved with abstinence from substances, regular education exposure, treatment for ADHD and stable professional supports.

[114] He has been noted to present with difficulty concentrating and controlling motor urges since childhood. This has been noted by teachers, carers and clinicians. Structured measures of sustained attention show impaired function. He is often described as impulsive. He presented with these difficulties in attenuated form at both clinical interviews, likely due to the effects of treatment. He has shown improvement on medication for ADHD when in custody, noted by his teachers with improved academic performance. On this basis he meets the criteria for ADHD, with a combined presentation of both inattention and hyperactivity.

[115] He has been exposed to significant and repeated childhood physical and attachment (relational-emotional) trauma. He has been hurt and abandoned by caregivers, and has then had unstable caregivers throughout his life. This has likely affected the development of his emergent personality. His peer relations in the year prior to the offence influenced his conformity to antisocial behaviour. He displays conduct problems that are typical following this exposure to caregiver trauma, and reinforcement from people in his environment. He reports, and is recorded to have engaged in, fights, truancy, theft and fire setting. He describes impulsive and irresponsible decision making. He has difficulty managing anger and trust. It is likely

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[102] World Health Organization, *Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders* (2024).

that he would meet criteria for conduct disorder with antisocial traits related to these childhood and ongoing developmental traumas.

[116] His experimentation with substances does not rise to the level of a substance use disorder alone at this time. It may be considered, at this point, a form of self-medication for distressing psychological symptoms or peer-group behaviour. He is currently in a controlled environment, limiting access to substances.

[117] Treatment and rehabilitation recommendations focus on interventions that will allow him to best complete his education and form a stable personal identity. Effective management of ADHD will assist with academic performance and confidence in these settings. Having access to mentoring programs in the community can help form an identity wider than the narrow world of suburban gangs. Individual psychological therapy can assist in minimising emotional and trauma-related symptoms. If he is to be placed long-term in a youth justice facility, attention should be given to his participation in education and vocational training to allow for the best possible outcome when released.