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Disability in Prisons: A National Disgrace!

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Executive Summary

People with disabilities are significantly overrepresented in Australia's criminal justice system. This paper synthesises recent research and case studies to highlight systemic failures in identification, support, and rehabilitation for people with disabilities in custody. It offers evidence-based recommendations for government to drive urgent reform, focusing on improved screening, staff training, data collection, and cross-system accountability.

1. Introduction

People with disability in prison are both everywhere and invisible (Thorneycroft & Asquith, 2021). Their overrepresentation in the justice system is troubling and despite international obligations and national frameworks, it continues. Inadequate identification, poor data collection, and fragmented or non-existent support services perpetuate cycles of disadvantage resulting in recidivism. The failure to identify and adequately accommodate disability in custodial settings violates Article 13 of the UN Convention on the Rights of Persons with Disabilities (the right to access justice on an equal basis with others), undermining rehabilitation, health equity and human rights.

Disability prevalence among people entering custody far exceeds community rates:

- **Mental Health and Disability**: People in prison experience significantly higher rates of mental health disorders (Butler et al., 2006; AIHW, 2015; JH&FMHN, 2017a, b). 48% of adults with custodial contact in NSW were identified as having a disability (BOCSR, 2025) or mental health condition, compared with 22% of the general population (Royal Commission, 2023). While people living with diagnosed disabilities are over-represented, many people in custody live with undiagnosed and unsupported disabilities (Inspector of Custodial Services, 2024).
- **Intellectual Disability**: While only 2.9% of the Australian population has an intellectual disability, this figure increases to 15% in prisons and when accounting for both intellectual disability and borderline intellectual disability, 30% (Royal Commission, 2023; Baldry et al., 2013, 2015).
- **First Nations People**: First Nations people with cognitive disabilities, especially youth, are among the most overrepresented in custody. A 2015–2016 study at Banksia Hill Detention Centre in Western Australia found that 36% of young people assessed had Foetal Alcohol Spectrum Disorder (FASD), and 89% had at least one domain of neurodevelopmental impairment (Bower et al., 2018). These conditions contribute to justice involvement due to their effect on behaviour, comprehension, and capacity to properly engage with court or legal processes (Bower et al., 2018). In NSW one in four First Nations youth in custody has an intellectual disability (Royal Commission, 2023).
- **Brain Trauma**: People in prison also experience significantly higher rates of acquired/traumatic brain injury (Durand et al., 2017) and substance use addiction related disorders (Fazel et al., 2006).

2. Evidence base

This paper examines the intersection of disability and justice, drawing on reports, scholarly research, state inspectorate reporting, Royal Commission findings, jurisdictional reviews and case studies from Western Australia. Coherent, rights-based reforms are needed to ensure equitable treatment and support for some of our most disadvantaged citizens.

Primary evidence comes from Advocacy WA case studies, a disability advocacy agency with many years' experience supporting prisoners with disability. Quantitative and secondary evidence used in this paper comes from population data (NSW), ABS/NPHDC summaries, WA Office of the Inspector of Custodial Services reports, Royal Commission (Disability) findings, Human Rights Watch, jurisdictional inquiries, prevalence studies (including FASD in youth detention), and the recent WA report "People in custody with an intellectual disability" (2024).

3. Literature

Prevalence, health burden and complexity of need

Disability and mental health conditions are pervasive among people entering and leaving custody. WA entrant surveys reported 1 in 4 had mental health diagnoses, 1 in 9 suffered psychological distress entering/leaving prison, and prisoners recorded higher rates of core activity limitations compared to the community (AIHW, 2020). Multiple co-occurring impairments (Acquired Brain Injury (ABI), FASD, intellectual, psychosocial, sensory) and social determinants that significantly influence health outcomes (homelessness, substance use, trauma) were also prevalent (AIHW, 2020).

Despite clear evidence that early diagnosis and intervention can reduce incarceration rates and shorten incarceration time for people living with disability, the system has failed to act (Inspector of Custodial Services, 2024). This impacts both incarcerated individuals with disability and the taxpayer, with the Department of Justice spending approximately $408 per day to house each prisoner (Inspector of Custodial Services, 2024). Between 2018 and 2023, only 6% of the adult and youth custodial population identified as having a cognitive/developmental/intellectual disability. This figure is dramatically lower the 30% of prisoners identified by the Disability Royal Commission (2023). Why? - most corrective and youth justice agencies lack systematic, culturally validated screening and rely on self-reporting (Doyle et al., 2022). Fragmented record transfer from youth systems, inconsistent definitions and poor interagency data linkage exacerbates identification problems (Inspector of Custodial Services, 2024).

Institutional thoughtlessness and staff capability gaps

Custodial structures, routines and policies are not designed to properly consider disability. Behaviour resulting from impaired cognitive functioning, emotional dysregulation or neurodevelopmental conditions is frequently misread as deliberate misconduct (Reddy, 2025). Staff training to be able to identify and deal with disability is minimal (e.g., a short online disability induction) and ongoing training is largely absent. Staff inability to distinguish disability-related behaviour from deliberate misconduct breaches CRPD Article 13 which "States

Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff."

Most prison officers receive approximately 1.5 hours of disability awareness during induction, with youth custodial staff receiving an additional 3 hours focused on FASD (Inspector of Custodial Services, 2024). Beyond this, there are no compulsory training requirements. This leaves staff ill-equipped to understand, respond to, or support people with disability, and leads to misinterpreting disability-related behaviours as aggression or attention-seeking behaviour.

Inadequate clinical continuity and specialist rehabilitation

Custodial health services frequently fail to provide continuous psychiatric, or disability specialist follow-up. Access to specialist assessments is limited and most referrals lapse past the three-day validity period (Inspector of Custodial Services, 2018). Where specialist rehabilitation is clinically required (amputee care, ABI programs), custodial provision is often generalist and clinically inadequate (see case study 2).

NDIS–justice boundary confusion and inconsistent access

Under NDIS legislation, if the NDIA is not satisfied that a support is the responsibility of the Scheme (i.e., considers it should be funded through another service system), that support will not be included in a participant's plan. There is often confusion over justice/NDIS boundaries (commonwealth versus state responsibilities), particularly where they intersect. A core challenge is the difficulty in distinguishing between disability-related supports and criminogenic-related supports. For example, behaviours that lead to involvement with the justice system may stem from a person's disability, but the system may not recognise them as disability-related, leaving individuals without appropriate supports. The Applied Principles and Tables of Support Justice Table (2015) states that only disability-related supports that are additional to reasonable adjustments should be funded by the NDIS in custodial settings. In practice, most NDIS supports are suspended or difficult to deliver in custody. NDIA decisions often hinge on evidence of permanence or exhaustion of treatment options that imprisoned people cannot readily document. Funding disputes arise where custodial services exist, lack disability specialist adequacy, and funding is blocked based on "duplication" reasoning (see case study 2).

The NDIA's Justice Liaison Officers (JLOs) and justice panel do offer mechanisms to support access, planning and transitions, but their capacity and integration within custodial processes are variable due to limited staff numbers, unclear policy and integration issues (Yates et al., 2022). The failure of the system also means that prisoners are not able to exercise NDIS principles of choice and control (a key tenant of the NDIS) due to restricted autonomy and lack of advocacy in custody.

For individuals entering custody without an existing NDIS plan, eligibility requires assessment, however, accessing this is difficult while in prison (Inspector of Custodial Services, 2024). Private assessments are unaffordable, public pathways are either unworkable or unavailable, and mental health assessments from state psychiatric hospitals have a long waitlist and do not

prioritise prisoners (Inspector of Custodial Services, 2024). Most adults in custody will never be assessed during their sentence.

Transition failures and recidivism risk

Disability pre-release planning is often absent in prisons. Few specialist support coordinators or advocacy services operate in custody and last-resort provider mechanisms are largely missing. This produces discontinuity of supports, leaving many released prisoners without housing, therapy or NDIS activation, increasing the risk of recidivism (Marchand, 2023). Despite a policy rhetoric of throughcare within most states, those working to support people with disability leaving prison say there is no universal integrated system supporting people at an individual level to transition back into the community (Schwartz et al., 2020). Government and community services are siloed, compounding disadvantage for marginalised people.

Pre-release programs need to be wraparound to be successful, addressing issues such as homelessness, drug and alcohol use, social isolation, disability/mental health, economic participation and trauma (Schwartz et al., 2020). NSW has the Extended Reintegration Service (ERS), a partnership with CSNSW, Housing NSW, Mental Health Services, South Western Sydney Local Health District and the Community Restorative Centre (CRC), that has experienced some success. Service providers work in collaboration with Community Corrections to link clients to services that address needs identified in their case plan, working together to reduce the risk of reoffending (Schwartz et al., 2020).

Rural, Regional and Remote

The NSW Legislative Council (2018) inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW found that there was a shortage of services available to assist people to break entrenched cycles of drug addiction and imprisonment. Rehabilitation services in rural and remote areas are limited or non-existent, requiring people from rural areas to travel long distances to access services (Schwartz et al., 2020). Distance intersects with two other issues people with disability face in rural areas, a lack of public or accessible transport and community based orders that include travel conditions meaning rehabilitation services cannot be accessed (Schwartz et al., 2020).

Intersectional and First Nations impacts

As previously mentioned, particular sections of the community are overrepresented in the justice system. Women with disability who experience violence, individuals with both cognitive and psychosocial disabilities, and people with hearing impairments, are disproportionately represented (Disability Access Bench Book, 2025). However, First Nations people with cognitive disabilities are among the most overrepresented, especially young people (Shepherd, 2017). Diagnostic invisibility exacerbates this when custodial systems lack culturally validated screening and deprioritise First Nations' disability needs when they enter the justice system (Royal Commission, 2023). A high prevalence of FASD in Aboriginal young people, linked to colonial policies such as the impacts of dispossession resulting from the forced removal of children, systemic marginalisation and intergenerational trauma, also intersects with the justice system

(Bower et al., 2018). These factors intensify when issues such as family violence, substance misuse, and poverty are present (Bower et al., 2018).

Systemic Failures

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023) highlights the significant overrepresentation of people with disability in Australia's criminal justice system and establishes that this is not due to any inherent link between disability and criminal behaviour. Instead, the link is found in broader issues of social and economic inequality (McCausland and Baldry, 2023). Many people with disability experience poverty, disrupted family relationships, exposure to violence and abuse, substance misuse, unstable housing, and lack of access to early intervention and appropriate supports, all of which increase the chances of entering the justice system (McCausland and Baldry, 2023).

Systemic issues not only compromise health outcomes but contribute to ongoing disadvantage and marginalisation (Doyle et al., 2022). Across the entire WA custodial estate, there are only three dedicated units for prisoners with complex needs comprising 75 beds (Inspector of Custodial Services, 2024) for a total prison population of over 8,500 inmates (Hansard, 2025). These spaces are few and far between considering the size of the prison population. For those with a cognitive or intellectual disability (15% – 30% of the prison population) there are only 10 beds available in WA at the Bennett Brook Disability Justice Centre.

Screening and Identification: There is no consistent approach across states and territories for identifying disability in justice settings (Royal Commission, 2023). Most systems rely on self-reporting, which is unreliable and often misses undiagnosed or unrecognised disabilities. The Office of the Inspector of Custodial Services (2024) has acknowledged the difficulties in identifying disabilities, particularly intellectual disabilities.

Staff Training: Some online disability awareness training is provided to prison officers in western Australia however this is minimal.

National Disability Insurance Scheme (NDIS) and Justice System: There is confusion over boundaries between commonwealth and state responsibilities, and “institutional thoughtlessness," in prison systems results in failure to consider the needs of prisoners with disability (Doyle et al, 2022). The NDIS is designed to fund disability-related supports, yet people in custody frequently experience suspended or limited access to NDIS supports. There is confusion around responsibility and NDIS plans are often paused during incarceration, leading to significant delays in service resumption after release. These systems, like many government systems, operate in silos (Doyle et al., 2022).

4. Case Studies

1. Barriers to NDIS Access for a Prisoner with Psychosocial Disability

This case study illustrates the systemic barriers faced by incarcerated individuals with psychosocial disabilities, both in accessing the NDIS and in receiving responsive and equitable health care within the custodial environment. It highlights how the intersection of disability, incarceration, and institutional neglect contributes to continued marginalisation and cycles of incarceration.

An individual currently held in custody with long-standing diagnoses of schizophrenia and post-traumatic stress disorder (PTSD), came to Advocacy WA for support. The individual sought access to the NDIS while incarcerated due to the chronic and disabling nature of these conditions. Despite a documented psychiatric history of treatment through community mental health and acute inpatient services, the National Disability Insurance Agency (NDIA) declined the application, citing that the individual had not exhausted all available treatment options and therefore did not meet the criteria for access.

Advocates supporting the application appealed the decision, requesting that the Department of Justice provide evidence confirming the permanence of the individual's condition and demonstrating that all reasonable treatment options had been explored. Prison Offender Services indicated that the evidentiary requirements of the NDIA could only be fulfilled by a treating psychiatrist with a sustained therapeutic relationship with the applicant. Due to systemic deficiencies within the custodial health system, the individual did not have access to a regular treating psychiatrist, or the ability to choose or maintain continuity. Furthermore, despite their institutional role to provide health care to incarcerated individuals, staff explicitly declined to provide a supporting letter or any clinical documentation for the NDIS application.

Staff were able to offer some professional support, however, they maintained that only a psychiatrist with a long-term therapeutic relationship could provide the necessary evidence. This refusal represents a gap in capacity and an abdication of responsibility by a system charged with delivering health care to the vulnerable. This case underscores three central issues:

1. **Inadequate Continuity of Mental Health Care in Custody**: The lack of consistent, long-term psychiatric care within the correctional environment impedes the ability to properly diagnose and document complex psychosocial disabilities. This undermines clinical outcomes and access to essential support services.
2. **Structural Barriers to Disability Support within the Justice System**: The custodial system's disengagement from disability advocacy and its failure to provide meaningful assistance with NDIS applications illustrate a systemic failure to uphold the rights of individuals with disabilities outlined in the UNCRPD. Instead of facilitating pathways to care and support, the system often obstructs them.
3. **Health Inequity and Systemic Disadvantage**: Unlike individuals in community settings who can access continuous care and establish relationships with specialists, prisoners

> are denied these opportunities. This inequity in access to healthcare and support services represents a broader social injustice and highlights the disproportionate barriers faced by people with disabilities in the justice system.

This case reveals how the justice system's failure to provide equitable, continuous health care for individuals with psychosocial disabilities contributes to their exclusion from critical supports such as the NDIS. The inability to meet health and support needs within custodial settings perpetuates cycles of incarceration, social exclusion, and systemic neglect, ultimately undermining both rehabilitation and human rights objectives.

2. Inadequate Rehabilitation for a Prisoner with a Physical Disability

This case study illustrates the failure of both the justice and disability support systems to respond to the disability-specific needs of an individual who acquired a significant physical impairment. Rather than receiving targeted, evidence-based rehabilitation and support, the individual was subjected to generic health interventions that did not align with best-practice care. The case highlights the structural inflexibility of the NDIS and the continued neglect of disability-specific rehabilitation needs within custodial health settings.

An incarcerated individual underwent a leg amputation. Following the procedure, he began rehabilitation through physiotherapy services provided by the prison system. However, the physiotherapist assigned to his care did not possess any specialist training or clinical experience in working with amputees. Despite this, the custodial health service and the NDIA maintained that the provision of generalist physiotherapy by the prison fulfilled their obligations.

After months of basic rehabilitation and therapy, the inmate continued to experience significant ongoing pain and functional impairment. The lack of specialised physiotherapeutic intervention contributed to diminished recovery and quality of life. Despite these concerns being raised, the justice system failed to acknowledge the inadequacy of the treatment or that it had caused enduring pain and poor quality of life.

Advocacy WA intervened to request that the custodial health service engage a physiotherapist with specialist training in amputee rehabilitation. The request was denied, with the justice system asserting that the current provision of a general physiotherapist met minimum health care obligations. In parallel, Advocacy WA submitted supporting documentation to the NDIS which included a specialist report outlining the clinical requirements for effective amputee rehabilitation. The report stated:

> "This will require gait retraining and specific balance exercises to ensure he gets the most out of the prosthetic. It is advisable that he work with a specialist physiotherapist with training and background in working with amputees for at least the first 2–3 months of using the prosthetic and then have a structured program with specific exercises following this."

Despite the specialist evidence provided, the NDIS declined to fund access to a physiotherapist with expertise in amputee rehabilitation. Their rationale was that since the justice system was already providing a physiotherapy service, the individual's rehabilitation needs were being met. The NDIS determined that funding a specialised physiotherapist would constitute a duplication of supports, even though the service offered in custody was generalist, lacked relevant expertise, and had already proven insufficient. This decision further reflects a fundamental misunderstanding of disability, the nature and quality of supports required for rehabilitation, and a failure to differentiate between the existence of a service and its clinical appropriateness.

A protracted, months-long period of negotiation and advocacy followed, marked by extensive back-and-forth communication between Advocacy WA, the prison system, and the NDIS. Repeated efforts were made to secure access to the specialist care that the inmate required. Although advocates came close to achieving a positive outcome, the individual was released from custody before these supports could be implemented, leaving critical rehabilitation needs unmet at the point of community re-entry, an issue correlated with recidivism (Marchand, 2023).

This highlights a systemic failure in disability-responsive health care within the justice system. Rather than ensuring access to appropriate, timely, and specialised rehabilitation, the system's delays and inadequacies left critical post-operative needs unaddressed. Upon release, the individual needed to reengage NDIS support systems, having never received the specialised care required while in custody. Delayed access to essential post-operative rehabilitation has the potential to significantly increase the risk of long-term mobility issues, employment barriers and social exclusion, further compounding the disadvantage already experienced.

5. Discussion: the revolving door justice system for people with a disability

People with disability are more likely to interact with the justice system due to higher rates of victimisation, unmet health and social support needs, barriers within the justice system resulting in a lack of the supports, adjustments and aids needed to defend criminal matters, and data and service gaps that leave needs invisible (AIHW, 2024). On entering the custodial environment this discrimination continues starting with failure to identify, acknowledge or understand disability.

Without a solid foundation of accurate, reliable data, it is difficult to fully understand or address disability issues in custodial care. However, early intervention, targeted supports, and a better understanding of the underlying causes of criminalisation, especially for people with complex needs, are essential to reducing the number of people with disability who are unnecessarily drawn into the justice system.

There are no consistent or culturally appropriate screening processes in place, instead the system relies on self-disclosure, an approach that is flawed, as people with disability may be unaware of their disability or unwilling to disclose it due to stigma or fear (Smith et al., 2016). Although some correctional facilities provide disability-specific units with trained staff, these are

limited in availability and unable to meet demand (Doyle et al., 2022). Most individuals with disability are housed in mainstream units, where formal support is lacking.

Rather than serving as a point of intervention, incarceration often becomes a missed opportunity to assess and address disability-related needs (Doyle et al., 2022) and the underlying causes of criminal behaviour from people with disability. People with disability experience poverty at significantly higher rates than other people and are at risk of entrenched poverty (SCIA, 2023). Incarceration further compounds the risk of poverty, while poverty further compounds the risk of incarceration (Western, 2019), reciprocal determinism.

Prison environments are ableist regimes that overlook and compound disability (Yates et al., 2022):

- Visibility and evidence: Without standardised, culturally competent screening and forensic assessment pathways, disability will remain invisible in prisons. People who need NDIS supports struggle to produce the clinical documentation the NDIA requires for a plan.
- Institutional culture: “Institutional thoughtlessness” normalises prison cultures and policies that penalise impairment-related behaviour, increasing segregation and punitive sanctions, reducing engagement with rehabilitation and increasing the risk of recidivism.
- Fragmented responsibilities: Ambiguous NDIS/justice boundaries and narrow interpretations of duplication leave prisoners without specialist care. JLOs and justice panels are under-resourced and inconsistently integrated.
- Clinical time-sensitivity: Delays or refusals for specialist assessment, including clinical evidence of functional impact, lead to missed windows for rehabilitation, undermining the success of reintegration and escalating re-offending risk.
- Equity and rights: Failure to meet CRPD obligations (training, reasonable adjustments, access to justice) disproportionately harms all people with disability including First Nations people and those with complex needs, deepening social injustice.
- Staff Training: There is minimal disability awareness training for custodial staff. Without disability awareness staff cannot identify when a behaviour is disability related or what supports might be needed to assist with rehabilitation.
- Health Inequity: Prisoners with disabilities receive lower quality care than those in the community.

People with disability are rarely placed in minimum-security prisons or prison farms, for the reasons outlined. Data from October 2023, suggests only 23 prisoners with a ‘known’ intellectual disability were placed in such facilities (Inspector of Custodial Services, 2024). These facilities offer a greater focus on rehabilitation and reintegration.

6. Recommendations

Central to equality in justice for people living with disabilities is a human rights based approach guided by participation, accountability, equality and empowerment. Every person has the right to quality health care outcomes, whether they are in custody or not. For people living with disability in custody this means being active and equal participants in their healthcare decision making and access to quality health interventions that both improve health outcomes and reduce the risk of recidivism. This requires transparent, identifiable health outcomes and accountability from governments, correctional services and disability service providers. It also requires equality in access to the NDIS. Empowering people in their health care reduces recidivism by improving health, strengthening autonomy, increasing treatment engagement, and lowering the structural drivers of reoffending such as untreated mental health issues and substance dependence.

Priority reforms include:

1. Overarching custodial disability model (nation-wide)

Adopt a rights-based, co-designed model embedding disability visibility, reasonable adjustments and accountable pathways across reception, sentence management, program delivery and transition. Make co-design with First Nations organisations and people with lived experience mandatory. People with lived experience of addiction, recovery, mental health and incarceration provide a deeper level of understanding and empathy and can act as role models for prisoners as they transition into the community (Schwartz et al., 2020).

2. Mandatory, culturally validated screening and interoperable data systems

Require functional impairment screening at reception (including ABI, FASD, cognitive, psychosocial and sensory domains) using tools co-designed with First Nations partners and ensure any interventions are culturally appropriate. Record results in offender management systems and implement privacy-protected data linkage across youth justice, adult custody and health systems to enable both public reporting and integrated disability support across health/justice systems.

Systemic reforms are needed to address the underlying causes of Aboriginal youth incarceration. Without change, young people, particularly those with neurodevelopmental impairments, will continue to face significant barriers to rehabilitation and reintegration. Early identification of developmental needs, alongside tailored support, mitigate the risk of further criminalisation and improve long-term outcomes. A more comprehensive, holistic approach to justice and social services is essential to breaking the cycle of disadvantage and ensuring more equitable treatment for Aboriginal youth in detention (Bower et al., 2018).

3. Clinical continuity, forensic assessment capacity and evidence pathways

Mandate custodial health obligations to provide continuous psychiatric and specialist follow-up and to supply NDIA evidence when clinically appropriate. Fund a fast-track forensic assessment

team (psychiatry, neuropsychology, specialist rehabilitation) to provide in-custody, or offsite, assessments.

4. Clarify NDIS–justice responsibilities and operationalise in-custody access

Finalise state/NDIS protocols specifying supports the NDIS will fund in custody (preventing duplication refusals), further expand Justice Liaison Officer networks, and introduce a justice health panel with clear escalation routes for prisoners. Provide clearer definitions, improved data collection, and stronger coordination between the NDIS and the justice system to ensure people with disability understand their rights and are not left without essential supports.

5. Specialist units, workforce and last-resort provision

Establish additional dedicated high-needs units, ABI/FASD specialist teams, physical disability rehabilitation contracts and fund custodial specialist support coordinators and culturally competent advocates. Create a funded last-resort provider framework to guarantee immediate post-release supports in market failure scenarios (e.g., rural and remote).

6. Reform custodial practice and eliminate punitive segregation for disability-linked behaviour

Prohibit solitary confinement for people with identified disabilities; require independent review of confinement decisions; revise behaviour management to mandate functional assessment and support alternatives; embed mandatory, ongoing disability-focused de-escalation training for all justice staff per CRPD Article 13.

7. Make programs accessible and support program completion

Limited access to support and other necessary adjustments can hinder a person with disability's capacity to participate in rehabilitation and pre-release programs, leading to increased risk of recidivism (Australian Human Rights Commission, 2014). Require all rehabilitative and parole-relevant programs to be Plain English and Easy Read and provide supported completion options (small groups, one-to-one). Adapt in-prison programs to suit and support those with cognitive or learning disabilities. Prisoners' ability to complete these programs, often critical for parole, is frequently contingent on informal support from staff, which is inconsistent and heavily dependent on interpersonal relationships rather than structured policy (Doyle et al., 2022).

8. Pre-release activation, plan literacy and immediate post-release windows

Identify NDIS participants on entry, ensure pre-release plan activation, facilitate first-week post-release specialist appointments and provide funded bridging supports (for example, first 14 days). People in prison need targeted mental health care plans and appropriate medications in prison, which they can follow and access once released.

There is a need for holistic and long-term service delivery that addresses the complex needs experienced by people in prison. It is not adequate to address just one part of a client's need (i.e. housing) without also providing appropriate case management and counselling support (i.e. to address their underlying trauma, drug and alcohol addiction or mental health needs) (Schwartz et al., 2020).

9. Strengthen advocacy, legal support and Inspectorate oversight

Fund disability-specialist legal/advocacy services across policing, courts and corrections; expand Inspectorate powers and resources to monitor screening, segregation use, NDIA access outcomes and instances where custodial health refuses to provide evidence.

10. Equity and First Nations priorities

Make First Nations co-design mandatory, fund culturally safe diversionary programs and supported accommodation, and prioritise culturally trained clinicians and advocates within custody and transition services.

8. Conclusion

The evidence converges on a single imperative: disability is overrepresented in custodial populations and must be acknowledged and resolved. Current practices: diagnostic invisibility, institutional thoughtlessness, inadequate clinical continuity, opaque NDIS boundaries and weak transition planning, are active drivers of rights violations and causes of recidivism. Implementing an overarching custodial disability model that mandates culturally validated screening, guarantees clinical continuity and forensic assessment capacity, clarifies NDIA–justice responsibilities, funds specialist in-custody and transition roles, embeds First Nations co-design and strengthens independent oversight, will protect human rights, improve rehabilitation outcomes and reduce the avoidable cycle that traps many people with disability in the criminal justice system.

Without urgent reform, people with disabilities will continue to face systemic disadvantage and exclusion within Australia's justice system. State/territory justice systems are responsible for making programs intended to prevent re-offending accessible for people with disability (Yates et al., 2022). Without clear processes, trained staff, and proper integration between justice and disability services, the health and wellbeing of this population continue to be compromised, exacerbating social and structural inequalities. Addressing these gaps is essential to uphold human rights, reduce recidivism, and promote social justice. Governments and researchers must work together to implement evidence-based reforms that ensure prisoners with disabilities are treated with dignity, respect, and the necessary support to meet their health and disability needs, both during incarceration and beyond.

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