

BRAIN INJURY AUSTRALIA

Policy Paper:

Out of Sight, Out of Mind: People with an Acquired Brain Injury and the Criminal Justice System

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1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

Local and international surveys both of head injuries with loss of consciousness and chronic substance abuse in adult corrections and juvenile justice indicate very high rates of acquired brain injury (ABI). As many as 60 per cent of offenders report histories of ABI. This rate would account for 17,900 - out of 29,700 - adult prisoners in Australia.

This paper examines the research evidence for an association between ABI and subsequent, sometimes violent, offending. While problems people may experience with thinking and behaviour the result of their ABI place them at the highest risk of re-offending and re-incarceration, the disability receives low recognition throughout the criminal justice system.

The Council of Australian Governments (COAG) claims as one of its “current commitments” under the National Disability Strategy “court diversion programs for people with disability...designed to address the mental health or disability needs of defendants and their offending behaviour”. **This paper demonstrates that people with an ABI are ordinarily ineligible for such programs due to restrictive legislation or access criteria. Whether in courts’ considerations of granting bail or “fitness to be tried”, or in sentencing, or referral to specialist tribunals of “therapeutic jurisprudence”, programs of diversion from the criminal justice system are narrowly targeted, commonly at people with an intellectual disability or mental illness.** “While these population groups certainly face significant problems in the criminal justice system and ought to be priorities for action, the pre-occupation with these groups to date must not be allowed to obscure the equally serious problems facing other impairment groups, including persons who are deaf, deafblind, persons with severe communication impairments, and persons with acquired brain injury.”¹

The apparent prevalence rates of ABI among both adult prisoners and juvenile justice detainees are far from unknown to governments. Both groups have been surveyed relentlessly. Neither are their criminogenic needs – involving impulsivity, increased irritability, reduced anger control, verbal and sometimes physical aggression, disinhibition etc. – unacknowledged. They are the subject of vast academic study. Yet **Brain Injury Australia could identify only one established offence-related program in the criminal justice system specific to the needs of the disability, and for which offenders with an ABI were directly eligible - in just one of Australia’s 87 adult prisons.**²

One benefit of the academic study, above, is a sound evidence base for what programs of rehabilitation for people with an ABI are effective, and cost-effective. At the time of writing, Australian governments are considering a draft National Crime Prevention Framework. **The costs of crime are around \$36 billion per year. Australian governments spend almost \$3 billion per year on corrective services, equivalent to over \$200 per prisoner per day. More than one-third of prisoners released during 2007-2008 had returned within two years.**

As a signatory to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the Australian Government commits to ensuring “effective access to justice for persons with disabilities on an equal basis with others”. The National Disability Strategy’s “six policy areas” are not only “aligned to the articles” of the UNCRPD, but the Strategy “will help ensure that the principles underpinning the Convention are incorporated into policies and programs affecting people with disability, their families and carers. It will contribute to Australia’s reporting responsibilities under the Convention.” On that basis, **it is the overall recommendation of this paper that the Australian Government and COAG, through the Community and Disability Services Ministers’ Conference - under not only their obligations both to the UNCRPD and the National Disability Strategy, but also as an exercise in crime prevention - engage in an urgent program of legislative and policy reform alongside service development to ensure that offenders with an ABI have access to programs of diversion and offender rehabilitation “on an equal basis with others”.**³

R E C O M M E N D A T I O N S :

Recommendation 1:

Brain Injury Australia recommends that the Australian Government and the Council of Australian Governments (COAG) - through the Community and Disability Services Ministers' Conference (CDSMC) - enlist stakeholders such as the Prisoner Health Information Group, the Juvenile Justice Research and Information Group and the National Forensic Disability Working Group to modify reception screening and other assessments to render optimum detection of ABI. This will serve to fulfill both the Australian Government's obligations as a State Party to Article 31 ("Statistics and data collection") of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) as well as COAG's commitment to "good data" under the National Disability Strategy.

Recommendation 2:

Brain Injury Australia recommends that the Australian Government - as a State Party to Article 31 ("Statistics and data collection") of the UNCRPD - and COAG, through the CDSMC - as part of the National Disability Strategy's commitment to "good data" - enjoin the Corrective Services Administrators' Council and Australasian Juvenile Justice Administrators to develop and implement an accurate, efficient, nationally consistent and culturally sensitive screening tool for ABI.

Recommendation 3:

Brain Injury Australia recommends that the Australian Government make both a reference to the Australia Law Reform Commission and representations to the Standing Committee of Attorneys-General to investigate uniform model legislation - in bail, "fitness to plead", the defence of mental impairment, sentencing, and "therapeutic jurisprudence" - that is genuinely inclusive of people with an ABI. This will serve to fulfill both the Australian Government's obligations as a State Party to Article 13 ("Access to justice") of the UNCRPD and COAG's commitment under "Policy Direction 5" of the National Disability Strategy; to "more effective responses from the criminal justice system to people with disability who have complex needs or heightened vulnerabilities".

Recommendation 4:

Brain Injury Australia recommends that the Australian Government direct the National Corrections Advisory Group and the National Forensic Disability Working Group to formulate both a nationally consistent definition of, as well as disability-specific and disability-relevant performance indicators for, offence-related programs. This will serve to fulfill both the Australian Government's obligations as a State Party to Article 31 ("Statistics and data collection") of the UNCRPD as well as COAG's commitment to "good data" under the National Disability Strategy.

Recommendation 5:

Brain Injury Australia recommends that the Australian Government and COAG - through the CDSMC, the Corrective Services Administrators' Council and Australasian Juvenile Justice Administrators - ensure that eligibility and access to offence-related programs are based primarily on need, and without regard to disability type, external cause or age. This will serve to fulfill both the Australian Government's obligations as a State Party to Article 13 ("Access to justice") of the UNCRPD and COAG's commitment under "Policy Direction 5" of the National Disability Strategy; to "more effective responses from the criminal justice system to people with disability who have complex needs or heightened vulnerabilities".

Recommendation 6:

Brain Injury Australia recommends that the Australian Government and COAG - through the CDSMC and in consultation with Brain Injury Australia and its Member Organisations - develop and deliver a nationally consistent curriculum of training in ABI for all criminal justice system personnel. This will serve to fulfill the Australian Government's obligations as a State Party to Article 13 ("Access to justice") of the UNCRPD, specifically to "promote appropriate training for those working in the field of administration of justice, including police and prison staff".

B R A I N I N J U R Y A U S T R A L I A

Brain Injury Australia is the national peak ABI advocacy organization representing, through its State and territory member organizations and network relationships, the needs of people with an ABI, their families and carers. The major components of Brain Injury Australia's role are:

- advocacy for Australian Government program allocations and policies that reflect the needs and priorities of people with an ABI and their families, and
- the provision of effective and timely input into policy, legislation and program development through active contact with Australian Government ministers, parliamentary representatives, Australian Government departments and agencies, and national disability organizations.

2. ACKNOWLEDGEMENTS

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3. TERMINOLOGY

Acquired brain injury (ABI) refers to any damage to the brain that occurs after birth. Common causes of ABI include accidents, stroke, infection, alcohol and other drug abuse and neurological disease. **Traumatic brain injury (TBI) is an ABI caused by external force applied to the head from, for example, an assault, a fall or a motor vehicle accident. ABI is common in Australia. According to a 2003 Australian Bureau of Statistics survey, 432,700 people (2.2% of the population) had an ABI with "activity limitations" or "participation restrictions"⁴ due to their disability. 317,900 Australian children were living with a disability, about 1 in 12 of all Australian children. 162,800 children had "physical/diverse disabilities" - an estimated 22,800 of whom were children with an ABI.⁵**

4. PREAMBLE

ABI is often referred to as the "hidden" or "invisible" disability. This operates in a variety of ways. Firstly, at the level of population; **in official prevalence estimates significant numbers of Australians with an ABI are not only outside the disability services system but genuinely unknown to government.** For example, one of the fundamental documents in estimating the scale of disability in Australia - the Australian Bureau of Statistics' Survey of Disability, Ageing and Carers (SDAC) – systematically underestimates the number of people living with an ABI. 2009's SDAC sample comprised "27,600 private dwellings and 200 non-private dwellings" as well as 1,100 "cared-accommodation...establishments". The "scope" of the SDAC did not include "persons living in very remote areas". Around 1 in 5 Indigenous Australians live in very remote areas. Indigenous ABI prevalence rates are up to three times that of non-Indigenous Australians. For "operational reasons", neither did the SDAC's "coverage" include "persons living in Indigenous communities in non-very remote areas". It also excluded the nearly 30,000 "persons living in gaols or correctional institutions" who constitute a large part of the focus of this paper.⁶

Secondly, due to the severity, multiplicity and complexity of disability experienced by people with an ABI, or the circumstances in which their brain injury was acquired - alcohol or other drug abuse, for example - many individuals "hidden" from such government surveys may not know that they have a disability.

Thirdly, due to the circumstances in which their brain injury was acquired, or as a function of the resulting disability, many people with an ABI may be reluctant to disclose their disability. For instance, they may blame themselves for their injury, or are ashamed from the stigma attached to alcohol or other drug abuse, for example. Feelings of embarrassment, guilt or shame are powerful deterrents to talking openly about disability.

Fourthly, lack of societal awareness compounds the problem. Roughly, three in every four people with an ABI make a good physical recovery. Often the injured person will show no outward signs of disability. Effects common to ABI, such as poor short-term memory, fatigue or irritability are misinterpreted as simply flaws in the person. People with an ABI are regularly mistaken as drunk, unintelligent, uncooperative, unmotivated or aggressive and unpredictable. **Brain Injury Australia believes that public awareness of ABI lags around 20 to 30 years behind that of other disabilities.** Such a lack of public understanding of ABI is doubly disabling for the person affected: not only are their “invisible” disabilities not recognised as resulting from an ABI, they are seen only as a function of who they really are.



On the basis of the above, people with an ABI in the criminal justice system comprise some of the most invisible Australians. In seeking to make them visible through this paper, to bring them into plain sight, to mind, **Brain Injury Australia is keenly aware of inferences that could be drawn from a description of the potential linkages between ABI and offending, criminal, behaviour. This paper needs to be read in the light of the following: as a small minority of the general population commit crime, similarly with people with an ABI. It is almost a given of the research both that ABI tracks social-locational disadvantage⁸ and that populations at the greatest risk of ABI overlap those with greater levels of contact with the criminal justice system.** The following statement is typical: “demographic variables of people at risk for sustaining a TBI are similar to demographic factors of those who are at risk for behaviour leading to incarceration. Low socioeconomic status, low education, male sex[sic], and propensity to engage in risky behaviour also characterize people both at risk of TBI and at risk of behaviour leading to incarceration and could confound the association between TBI and incarceration.”⁹ As far as Brain Injury Australia is aware, no Australian TBI incidence or outcomes study has traced TBI to, for example, the injured person’s residential address and, in turn, to markers for social disadvantage, such as the Australian Bureau of Statistics’ “Socio-Economic Indexes for Areas” (SEIFA). Brain Injury Australia has been able to obtain data from New South Wales’ Lifetime Care and Support Scheme – for people severely injured in motor vehicle accidents, regardless of fault. The Scheme collected postcode information on 450 participants and merged it with the social disadvantage measures used by the *Dropping Off the Edge*¹⁰ report. The analysis found Scheme participants are “more likely to reside in areas of higher disadvantage.”¹¹ Only 19% of participants came from postcodes in the top four deciles – from areas with mean taxable incomes of \$55,361 and above.

This paper focuses on people with an ABI as offenders, as perpetrators, rather than as victims of, or witnesses to, crime. The experience of people with a disability as victims of crime is the subject of considerable research, both in Australia and overseas.

Around 50,000 people are released from prison each year. 385,000 Australians, or 1.8% of the population, are ex-prisoners.¹² However, in keeping with the National Disability Strategy’s emphasis on the “early identification, diversion and support...of people with disability with heightened vulnerabilities in any contacts with the criminal justice system”, this paper does not include identification and analysis of post-release programs, focusing instead on opportunities for offenders with an ABI “upstream” in the criminal justice system.

5. PREVALENCE – ADULT CORRECTIONS

The apparent prevalence rates¹³ of brain injury among adult prisoners and juvenile detainees are not under-researched. A recent survey identified twenty studies of a combined total of 4,865 adult offenders, with "TBI prevalence estimates"¹⁴ ranging from 10% to 100%. The studies were conducted in the United States, the United Kingdom, New Zealand and Australia and with a variety of offender groups: inmates on death row; detainees in maximum security or prison hospitals; only those convicted of murder, sexual assault or domestic violence; and some with only male or female prisoners. Screening methods included short questionnaires, in-depth personal interviews and medical record reviews. A "host of definitions"¹⁵ were used to identify head injury and TBI. After attempting to correct for their heterogeneity, the studies produced an average estimated prevalence of TBI in offender populations of 60%. Application of this rate to the 2,292,100 prisoners in the United States as at the end of 2009 - including pre-trial detainees, those on remand – returns 1.38 million who would screen positively for TBI.¹⁶ Similarly applied, almost 57,000 (out of 94,505) prisoners in the United Kingdom¹⁷, 5,360 (out of 8,892) New Zealand and 17,900 (of 29,700) Australian prisoners would screen positively.¹⁸

While these rates certainly appear high, "there is little information about the lifetime prevalence of TBI in the general population"¹⁹ for the purposes of comparison. The "first study to meta-analytically compare the prevalence of TBI from incarcerated samples" surveyed 24 articles containing 5049 prisoner subjects - of whom 2079 (41.2%) had a reported history of TBI – and contrasted them with community surveys, returning lifetime TBI prevalence rates ranging between 2% and 31.6%. It concluded, "**TBI appears associated with incarceration, a finding consistent with reported associations between TBI and criminal-like behaviour.**"²⁰ However, the authors warn "studies definitively examining the association between TBI and incarceration will need to include control groups matched for sex, age, educational level, and socioeconomic position." To that end, the results of a survey of 200 men entering prison in the Hunter region of New South Wales - when compared with a control group drawn from the same location of usual residence - found much more similar TBI prevalence rates; 82% and 71.5%, respectively. A range of potentially protective factors against the "criminogenic" effects of TBI arises from the survey: "compared with the prisoner sample, community participants tended to be older, more likely to be in a married/de facto relationship, have higher educational attainment, less likely to play contact sports, more likely to consume alcohol in the 'safe' range and less likely to report using illicit drugs in the past 4 weeks."²¹ The authors found "**no significant association between TBI exposure and study group membership, making it difficult, at least with the current data, to invoke TBI as causally related to the subsequent conduct of criminal activity, as some have suggested it is. In this study, low educational attainment, drug and alcohol misuse, impulsivity and dissocial personality remained statistically highly significant predictors of being in the custody sample.**"²²

As part of the preparation of this paper, Brain Injury Australia asked every state and territory corrective services agency what information about prisoners with an ABI they sought and retained. "**No jurisdiction systematically tests and/or identifies prisoners/offenders with acquired brain injury in their databases**",²³ although some may refer prisoners for further assessment should they disclose their disability. A more detailed examination of this follows, below. A 2007 Australian Institute of Health and Welfare survey of prisoner health data collections found the only disability-specific information systematically collected related to the "numbers of identified inmates with an intellectual disability." Even then, "most jurisdictions either rely upon other government agencies (the Disability Services Commission in Western Australia, Disability Services in South Australia etc.), or upon the provision of social security benefits, to identify intellectually disabled inmates".²⁴ And while "there are no national collections on the prevalence of recent injury and assault among individuals entering the prison system", most jurisdictions collected information on both as part of their reception assessment. Only two collected information specifically relating to "head injury" - South Australia and the Australian Capital Territory.²⁵

The results from the first application of a set of "National Prisoner Health Indicators" to over 9,000 prisoners in 87 of the 93 public and private prisons throughout Australia during a 2009 "census" resulted in **over two-fifths (43%) of prison entrants reporting that they had "received a blow to the head resulting in a loss of consciousness...or blacking out."**²⁶ Brain Injury Australia understands that not all *head* injuries necessarily result in "loss of consciousness" or "blacking out" or *brain* injury, let alone in some manner of permanent and/ or profound *disability*. And while Brain Injury Australia feels it is a "non-specific and antiquated term"²⁷, asking about histories of "head injury" is more likely to produce meaningful answers in a prison environment - and be potentially less confronting to inmates - than questioning about their brain, or their lived experience of disability more broadly. **The Centre for Health Research in Criminal Justice's 2009 survey of 996 inmates from 30 New South Wales correctional centres found that more than half (52%) of all male - and more than one-third (35%) of female – detainees had a history of a head injury resulting in unconsciousness.**²⁸ TBI has been classified into "mild", "moderate" and "severe" based on duration of loss of consciousness lasting; less than 30 minutes, between 30 minutes and 24 hours, and more than 24 hours, respectively. **Fifty-four (13%) male and seven (10.1%) female respondents to the 2009 NSW Inmate Health Survey reported the "time unconscious for [their] most severe head injury" [italics added] lasted between "30 minutes and 24 hours" while 29 (7%) male and 5 (7.3%) female respondents reported the loss of consciousness for their "most severe head injury" lasted "24 hours or more".** Significantly, 14.7% of male, and 26.1% of female, respondents reported they "don't know" how long they were unconscious for at the time of their "most severe head injury".²⁹

Insofar as duration of loss of consciousness is any guide, the rate of self-reported "mild" TBI in respondents to the 2009 NSW Inmate Health Survey (65.4% of male, and 56.5% of female, prisoners) broadly matches rates in the community. "Mild" TBI following head injury comprises between 70% and 90% of all TBI hospitalisations.³⁰ While people sustaining a "mild" TBI "rarely require inpatient rehabilitation" for the cognitive and behavioural changes from which they ordinarily recover within 3 to 6 months of injury, 10%–15% "remain symptomatic in the longer term with a persisting post-concussion syndrome", including difficulties "with attention and memory; and irritability...Interpersonal relationships and work may also be affected. This large group of people with TBI can face many years of impairment, possibly affecting health, education, occupation, and social and emotional functioning."³¹ **Nearly three in every four (73%) of the NSW Inmate Health Survey's respondents who reported having sustained a head injury resulting in a loss of consciousness also reported "experiencing at least one neuropsychiatric sequela immediately following their most severe head injury."** These included: "headaches (50%); problems with coordination or balance (27%); poor concentration (24%); problems retrieving the appropriate words when speaking (22%); and psychiatric symptoms such as anxiety and/or depression (22%)".³² One-third of the Survey's respondents reported those sequelae remained unresolved; headaches (18%), anxiety and/or depression (11%) and memory loss (10%) being the most common.³³ Research on the outcomes of TBI has also demonstrated that the effects of multiple head injuries, even of a "mild" nature, can be cumulative. **Almost one-third (31.9%) of male, and one in every five female, (20.2%) respondents to the 2009 NSW Inmate Health Survey reported more than one head injury with loss of consciousness over the course of their lifetime. More than one in every 10 male (and one in every 20 female) detainees reported five or more head injuries with loss of consciousness.**³⁴

Significantly, prisoners in the Hunter region survey, above, were more likely to report "4 or more" TBIs (45%) than the community control group (18%). "The significant relationship between the number of unconscious episodes and the persistence of symptoms of head injury suggests a 'dose-response' effect; the accumulation of stressors specific to head injury (i.e. the number of post-head-injury symptoms) that accompany each period of unconsciousness may increase the risk of severe violent behaviour."³⁵ Research suggests that a first head injury increases the risk of subsequent injury. A United States study of hospital admissions for 390 people over a decade found a first head injury placed subjects at three times the risk of further head injuries compared to the rest of the population, and after a second head injury that risk increased to eight times.³⁶

"I had a hit on the head with an iron bar. I was in hospital and had to learn to walk and talk again. I had two operations at Royal North Shore Hospital. I lost a bit of my brain and had fragments in my skull."³⁷

Many of the head injuries reported by respondents to the 2009 NSW Inmate Health Survey were manifestly more than “mild”. 14.9% of men and 11.6% of women reported their “most severe head injury resulted in a skull fracture”.³⁸ While a skull fracture can occur without associated neurological damage and may not itself be clinically significant, a fracture in healthy bone indicates that a substantial amount of external force has been applied to the head. This will increase the possibility of structural injury and/or physiological disruption of brain function. Likewise, 25.1% of men and 17.4% of women reported they had experienced bleeding within their skull as a result of their “most severe head injury”. 16% of men and 12% of women “reported that they had required surgery”. While the Survey does not specify the reasons for surgery, unrelieved bleeding around the brain increases intracranial pressure leading to injury to the brain. Finally, almost one in every four (23%) of Survey respondents with a history of head injury resulting in a loss of consciousness “reported that they had had tests or scans that confirmed they had brain damage as a result of their head injury.”³⁹

As “strikingly high”⁴⁰ as these proportions of prisoners with an ABI might appear, they are likely still conservative measures of the disability. Firstly, most surveys of ABI in corrections are limited to markers for TBI.⁴¹ They do not ordinarily include screening questions about ABI resulting from stroke, brain infection (encephalitis, meningitis etc.), neurological diseases (such as Parkinson’s disease), hypoxic brain injury (due to oxygen loss from drug overdose, suicide attempts etc.) or brain injury due to chronic alcohol or other drug abuse. Real prisoner numbers in the last of these categories can perhaps only be guessed. The 2007 National Drug Strategy Household Survey found 3.8 per cent of men and 2.7 per cent of women drank at “long-term high risk” to health, inclusive of brain injury. Research conducted as part of the National Alcohol Indicators Project by the National Drug Research Institute concluded 44% of alcohol was “consumed at levels that pose risk in the long-term” to drinkers’ health. The 2009 National Prisoner Health Census found that just over half of prison entrants were “at risk of alcohol-related harm”.⁴² Of the 996 participants in the 2009 NSW Inmate Health Survey, 19% had engaged in “hazardous” alcohol consumption in the year prior to their imprisonment, 9% in “harmful” consumption and 30.8% were rated alcohol “dependent”.⁴³ **Corrections Victoria commissioned arbias – a specialist service provider in alcohol and other drug-related brain impairment - in conjunction with La Trobe University, to conduct “the only Australian study to examine ABI from all aetiologies among a correctional population”.⁴⁴ Of the 117 prisoners who completed a “comprehensive neuropsychological assessment”, 42% of male prisoners and 33% of female prisoners “had an ABI”.⁴⁵ Of those, 6% of male and 7% of female prisoners “were rated as having a severe ABI”.⁴⁶ The study found “drug and alcohol use appeared to be the main cause of ABI among prisoners”.⁴⁷ Almost 1 in 4 men and over 1 in 6 women screened positively for “ABI risk indicators” due to alcohol abuse (29.4% of men and 41.9% of women had “risk indicators” for TBI.⁴⁸ 46.5% of female and 25.7% of male prisoners screened positively for hypoxic brain injury due to drug overdose, 24.4% and 21.1% respectively due to “suicide attempt”. Of the 820 participants in the NSW Inmate Health Survey who had “ever used an illicit drug”, 21.5% of men and 30.1% of women reported having “overdosed or become unconscious”.⁴⁹**

Secondly, in a report for Queensland Advocacy Incorporated Phillip French found that prisoners with a disability “are particularly vulnerable to physical violence and abuse from other offenders, including sexual assault.” They are also “much more likely than other prisoners to be the subject of emotional and psychological abuse...which may lead to the development or exacerbation of psychosocial impairment, alienation, social withdrawal and anti-social behaviour”.⁵⁰

In research commissioned by Brain Injury Australia – in partnership with its New South Wales Member Organisation, the Brain Injury Association of New South Wales – the University of New South Wales extracted service use data from a large-scale study investigating 2,731 “People with Mental Health Disorders and Cognitive Disabilities” (“MHDCD study”) within New South Wales’ criminal justice system, 511 (18.7%) of whom “have evidence of an ABI”.⁵¹ It found **more prisoners with an ABI sought protective custody (60.3%, 308 instances) compared to those without an ABI (44.9%, 956 instances).**⁵² **Prisoners with an ABI also indicated higher rates of self-harm (53%, 270 occasions) compared to those without an ABI (38%, 800 occasions).**⁵³

The prison environment acts as a powerful disincentive to an inmate's open disclosure of their disability. (While the response rate to the NSW Inmate Health Survey was high - at 85% - Brain Injury Australia thinks it reasonable to assume that the overall self-reported rates of head injury would have been again higher with the involvement of the 15% of prisoners who did not participate.) Moreover, the circumstances in which a prisoner sustained their ABI may also make it difficult for them to disclose their disability – where the injury may have been their fault, or where it involved alcohol or other drugs, for example. Feelings of embarrassment, guilt or shame will be powerful deterrents to talking openly about disability, especially to corrections staff or a stranger conducting health research. While doubts might be raised about the honesty of prisoners' self-reports, it has been difficult for Brain Injury Australia to imagine any direct incentives – say, in hope of preferential in-prison “treatment” - in the concoction of stories about, for example, head injury or in the exaggeration of their number or severity, or in the overstatement of resulting impairment. **Questions about the reliability of prisoners' self-report have been addressed in Hunter Forensic Head Injury Project research, referred to above. Of 112 hospitalised TBIs reported by 164 prison entrants, supporting medical records – where available - were identified in 70% of cases.**

Thirdly, estimates of disability prevalence based on self-reported histories of injury are clearly susceptible to recall bias.⁵⁴ Nearly half (47%) of head injuries resulting in a loss of consciousness sustained by participants in the 2009 NSW Inmate Health Survey participants were reported to have occurred ten or more years earlier, 22% between five and ten years earlier.⁵⁵ This is crucially relevant to ABI, where memory impairment is its most commonly reported cognitive disability. Furthermore, the external cause for a prisoner's ABI may play a decisive role in the potential for recall bias. Assault was both the most frequent “convicted most serious offence (if sentenced)” and “charged most serious offence (if on remand)” for respondents to the NSW Inmate Health Survey.⁵⁶ “Struck by object/ person” was the most frequent (53%) “cause of most severe head injury”.⁵⁷ **A pilot study of an injury surveillance system in NSW prisons found assault was the second most common reason (in 24% of cases) for inmates to attend their prison's health clinic.⁵⁸ New South Wales also has the highest rate of “prisoner on prisoner” assault of all jurisdictions.⁵⁹ Ten per cent of participants in the Hunter project, above, said they had sustained their most recent TBI while in prison.** It may be reasonable to assume that, given the endemic nature of assault, for some prisoners - especially those who report “5 or more” head injuries with loss of consciousness that – where assault was the most common cause of their head injuries, they might simply lose count.

Fourthly, even where prisoners may retain good recall of the number and severity of their head injuries and honestly disclose them, as many as two in every five people with an ABI will have limited insight into the full nature, extent and range of the impairments that constitute their disability. This can be a function both of damage to those parts of the brain involved in higher level perceptions combined with a lack of acceptance, or outright denial, of disability.

R e c o m m e n d a t i o n 1 :

Brain Injury Australia recommends that the Australian Government and the Council of Australian Governments (COAG) - through the Community and Disability Services Ministers' Conference (CDSMC) - enlist stakeholders such as the Prisoner Health Information Group, the Juvenile Justice Research and Information Group and the National Forensic Disability Working Group to modify reception screening and other assessments to render optimum detection of ABI. This will serve to fulfill both the Australian Government's obligations as a State Party to Article 31 ("Statistics and data collection") of the United Nations Convention on the Rights of Persons with Disabilities (UNCPRD) as well as COAG's commitment to "good data" under the National Disability Strategy.

Lastly, contributors to this paper pointed out that many prisoners might not know they have an ABI or their ABI might be undiagnosed. “Screening assessments within corrections (and, I am assuming, juvenile justice) are brief and the most obvious diagnoses are assessed rather than trying to identify all problem areas or co-morbidity or tri-morbidity or their inter-relationships. In addition, the link between identified problem areas and the reason for being in the [criminal justice system] (i.e. offending) are not explored. For example, screening assessments are unlikely to determine whether an ABI has a causal link to drug-related offending or is an outcome of drug use. This cannot be determined in a 15-minute ‘tick ‘n’ flick’ assessment.”⁶⁰

One positive outcome from an increasing awareness of high rates of ABI among prisoners is the work being devoted to development of accurate, while cheap, screening tools - aimed partly to select out prisoners who may benefit from (more costly) neuropsychological assessments.⁶¹ (All such tools carry the potential for false negatives and positives. Application of the La Trobe University/ arbias' "Acquired Brain Injury Screening Tool", referred to above, resulted in a 23% false negative rate for male prisoners; "indicating that one in four male prisoners with an ABI was missed" on initial assessment.⁶²)

Brain Injury Australia is not in a position to judge the relative merits of competing screening tools for ABI generally, let alone in a context as complex as the criminal justice system. However, its impression of service development in "forensic disability" – whether government or non-government – is characterised by territoriality around client groups and, thus, budgets, "silo" mentalities, and a resistance to "interjurisdictional learning"⁶³ leading to chronic duplication of effort. **Moreover, as with the discussions of diversion and training, below, flurries of activity in the development of ABI screening tools tend to obscure the question of; then what? "A fundamental precept of screening is that it should only be undertaken if some consequence will follow when a screen is positive."**⁶⁴ Suffice to say, the provision of services and supports specific to the needs of offenders with an ABI cannot wait for, let alone be conditional upon, the development of a perfect screening tool for the disability.

Brain Injury Australia agrees it is a "tragedy that Aboriginal and Torres Strait Islander people are so over-represented in the correctional system."⁶⁵ While comprising 2.5% of the population, one quarter of the nation's 29,000 prisoners are Indigenous. Their numbers are increasing at almost 3 times the rate of non-Indigenous prisoners.⁶⁶ Indigenous young people are detained by juvenile justice at nearly 28 times the rate of non-Indigenous young people.⁶⁷ As with non-Indigenous respondents to the 2009 NSW Inmate Health Survey the most common cause of their head injury was assault. Between 1999 and 2005, 14,700 Indigenous people were hospitalized for head injury due to assault in Queensland, Western Australia, South Australia and the Northern Territory alone - 20 times the hospitalisation rate for non-Indigenous people. The rate of head injury due to assault in Indigenous women was almost 70 times that for non-Indigenous women.⁶⁸ Indigenous respondents to the 2009 NSW Inmate Health Survey reported: higher rates of head injury with loss of consciousness; higher rates of multiple head injuries; and more frequent, and unresolved, sequelae involving "personality change" than non-Indigenous prisoners.⁶⁹ While the apparent prevalence rates of ABI in Indigenous communities are up to three times that of the rest of the population, estimates are compromised by the lack of culturally appropriate (and widely available) cognitive assessment tools. "Administration of pencil-and-paper tests can be inappropriate for a culture that has no traditional written language and in which rates of English illiteracy can be high. Additionally, the common one-on-one approach used by many psychological tests can be both uncommon and objectionable to Indigenous Australians, who may reject direct approaches between strangers and can consider it rude to ask numerous questions."⁷⁰ Both "Cogstate" and the "Kimberley Indigenous Cognitive Assessment (KICA)" have proven successful with substance abusers in the Northern Territory and dementia testing in Western Australia, respectively.

6, PREVALENCE – JUVENILE JUSTICE

Australia's juvenile justice system is the "set of processes and practices for dealing with children and young people who are alleged to have committed an offence or who have been found guilty of committing an offence."⁷¹ In all jurisdictions, "a child is deemed to have criminal responsibility if they are 10 years or older. "Children under the age of 10 cannot be charged with a criminal offence in any state or territory in Australia."⁷² The upper age limit for consideration as a juvenile offender is 17 years everywhere except Queensland, where it is 16 years. Juvenile justice is the responsibility of state and territory governments and combines detention with a range of supervised and unsupervised community-based orders. The latter include "placing young people on supervised or conditional bail while awaiting trial or sentencing, and sentencing young people to good behaviour bonds, community service, probation or suspended detention."⁷³ On any given day during 2008-2009, around 7,200 young people were under juvenile justice supervision, almost 1,000 of them in detention.⁷⁴ In each of the 4 years to 2008–2009, a young person was around 6 times as likely to be under community-based supervision as in detention on any given day.

As part of the preparation of this paper, Brain Injury Australia asked every state and territory juvenile justice agency what information about ABI among young offenders they sought and retained. As with adult corrections, none screened specifically for ABI upon entry to detention or at commencement of community-based orders, though some indicated they might refer young offenders for further assessment should they disclose their disability. Apparent rates of brain injury among juvenile detainees are less well-studied than among adult prisoners. **During 2009, Justice Health surveyed 361 juvenile justice detainees - 80% of all**

young people in custody at the time – across 10 facilities in New South Wales. Nearly one-third (32%) of participants reported having had a “head injury that had resulted in a loss of consciousness.” While the number for men (32.3%) was lower than in 2003’s survey (38.9%) women almost made up the difference: 1 in 3 reported head injury in 2009, compared to 6% in 2003. (Brain Injury Australia notes both the 60% increase in female prisoner numbers over the last decade - compared to 35% for men⁷⁵ - as well as, perhaps related, the greater rates of increase in women as perpetrators of non-aggravated and aggravated assault.⁷⁶) While the majority (60%) of juvenile detainees reported a single head injury, 11% reported having five or more. While nearly half (49.5%) reported they had been unconscious for “only a brief moment” for their “most severe head injury”, almost 1 in 6 had been unconscious between 10 and 30 minutes, 3% for between 30 minutes and 24 hours, and 3% for more than 24 hours. Significantly, almost 1 in 3 “don’t know” how long they were unconscious for. Just under a half (47%) of participants who reported head injury also reported sequelae. The most common was headache (24.5%), followed by memory loss (9.8%), then poor concentration, coordination and balance (6.9%). “Personality change” was reported by only 1%. Over a third (37%) reported their sequelae were ongoing.⁷⁷

Young people on community-based orders in New South Wales have been surveyed separately. Between 2003 and 2005, Dianna Kenny and colleagues assessed 800 young offenders from 22 NSW Department of Juvenile Justice offices and compared the results with the Department’s 2003 Young People in Custody Health Survey. **“Head injury rates” were comparable with those found in the custody sample. 41% said they had “sustained a head injury in which they had become unconscious or ‘blacked out’.”**⁷⁸ While, as with the custody sample, assault (“struck by object/ person”) was the most common cause, fewer in the community sample reported: multiple head injuries (10% versus 14%); “personality/ behavioural...problems” (3% versus 13%); and that those “problems” were “unresolved” (2% versus 13%). These differences between community and custody samples may be suggestive of a relationship between more, and perhaps more severe, head injuries and more serious offending that is met with detention rather than supervision orders. **Crude application of these apparent prevalence rates would suggest that, of the 1,000 young Australians in detention “on an average day”⁷⁹ during 2008-2009, 320 would have experience of one or more head injuries with loss of consciousness. Of the 6,200 on community-based orders, over 2,500 would have experience of one or more head injuries.**

The same riders on estimations of ABI prevalence rates in adult corrections, detailed above, also apply to juvenile justice. Firstly, head injury with loss of consciousness is the sole marker for ABI. When the NSW Young People in Custody Health Survey administered the Alcohol Use Disorders Identification Test (AUDIT), scores for 78% of the respondents reflected “hazardous or harmful alcohol consumption”⁸⁰, “harmful” consumption for just under half (46%) and “dependent” consumption for just under one-third (29%) . Two-thirds (66%) of respondents said that “they were drunk at least weekly in the year before coming into custody, with over a fifth (22%) reporting this daily or almost daily.”⁸¹ Kenny and colleagues note “identifying problematic adolescent drinkers is difficult because no level of drinking is considered safe for young people less than 18 years of age. Currently, quantitative measures for detecting unsafe adolescent drinking are based on adult guidelines that do not take into account issues relating to neurological development of young people.”⁸² **Almost 1 in every 5 (17%) of young people on community orders met National Health and Medical Research Council criteria for drinking at levels “risky” or at “high risk” of long-term harm to health, including brain injury, compared to nearly 1 in every 4 (24%) of those in custody.**

A history of illicit drug use was “almost universal”⁸³ among participants in the Young People in Custody Health Survey. Nine out of ten (89%) reported using. Rates were very similar in the community sample. 89% had used cannabis, 46% amphetamines, 18% cocaine, 14% heroin. As with alcohol consumption, little is known about the long-term effect of the abuse of other drugs at a young age. Both have the potential to interfere with adolescent brain development especially in regions linked to the regulation of behaviour and emotion as well as those responsible for new learning and memory. While the Survey included questions about overdose – potentially resulting in hypoxic brain injury – deriving from self-harm generally and attempts at suicide, the responses are unreported. Of the 5% in Kenny and colleagues’ community sample who had attempted suicide in the previous 12 months, 36% overdosed on “pills”, alcohol or heroin, compared with the 23% of the custody sample.

A male inmate has a traumatic brain injury and cerebral palsy. He is a criminal recidivist. His father was severely violent to his mother and kicked her in the stomach while she was pregnant with him causing his brain injury. Another was a victim of shaken baby syndrome and suffered a severe brain injury. His father severely shook him as a baby when he was only a few months old. As an adolescent, he killed a paedophile who sexually exploited him.⁸⁴

Brain Injury Australia has written a separate policy paper on the high rates of inflicted traumatic brain injury (ITBI) in children - the leading cause of death and disability the result of physical abuse.⁸⁵ One hundred and sixty-three infant males (aged less than one year old) and 132 infant females were hospitalised due to assault in Australia during 2006-2007.⁸⁶ Of the 261 children admitted to New South Wales' Brain Injury Rehabilitation Program during the same year, seven per cent had sustained their ABI due to assaults the result of child abuse or domestic violence.⁸⁷ When Kenny and colleagues combined results from NSW Department of Juvenile Justice community and custody samples they found **23% of young male detainees and 25% of female detainees reported "severe" rates of physical abuse on the Childhood Trauma Questionnaire, 19% and 39% "moderate" rates, and 29% and 33% "low" rates, respectively. The rates were generally higher in the custody sample. While rates of child physical abuse within the broader community generally range between 5% and 10%, NSW's 2009 Young People in Custody Health Survey notes those among juvenile detainees are "extremely high in comparison".**⁸⁸ Furthermore, survey results from both the 2003 and 2009 custody samples "suggested that approximately 55% of young people...were under-reporting their experiences".⁸⁹ From their community sample, Kenny and colleagues found "forty percent (40%) (270) males and 29% (35) females endorsed at least one item on the Minimisation/Denial Scale of the [Childhood Trauma Questionnaire], suggesting some underreporting of abuse, neglect or trauma."⁹⁰

As part of the preparation of this paper, Brain Injury Australia was contacted by a doctoral student whose neuropsychological testing of juvenile justice detainees found "significant cognitive impairments across a number of areas of brain function, particularly executive function. These young people often report violent family backgrounds, where typically the father or mother's partner has been physically abusive towards them and other family members. Many of these young people report being hit around the head or having accidents when they were younger...For some of them, the father has been removed from the home after the mother took out an [Apprehended Violence Order] due to domestic violence. These young people, usually boys, seem to attract attention when they enter school due to their problematic, disruptive behaviours. They may see health professionals or school counsellors during the course of their schooling, however they often receive a diagnosis of [Attention Deficit Hyperactivity Disorder] or [Oppositional Defiant Disorder] and are moved to a 'behavioural school' or they drop out of school altogether. Interestingly, there was little evidence on psychometric testing to support a diagnosis of ADHD for some of the young people I saw...Many of the juvenile justice case workers I have spoken with have said that ADHD seems to be over-diagnosed in this population."⁹¹

Thirty per cent and twelve per cent of respondents to NSW's 2009 Young People in Custody Health Survey had been diagnosed with ADHD and Oppositional Defiant Disorder (ODD), respectively. Nineteen per cent of the community sample self-reported ADHD, Attention Deficit Disorder or Hyperactivity and 10% reported a "Conduct Disorder" or ODD. Brain Injury Australia acknowledges that an "established association exists between attention ADHD and head injury...Studies have suggested both that injury is more common in children with ADHD and that moderate to severe traumatic brain injury in school age children results in the development of ADHD."⁹² ADHD is reported to occur in 20% to 50% of children following brain injury.⁹³

R e c o m m e n d a t i o n 2 :

Brain Injury Australia recommends that the Australian Government - as a State Party to Article 31 ("Statistics and data collection") of the UNCRPD - and COAG, through the CDSMC - as part of the National Disability Strategy's commitment to "good data" – enjoin the Corrective Services Administrators' Council and Australasian Juvenile Justice Administrators to develop and implement an accurate, efficient, nationally consistent and culturally sensitive screening tool for ABI.

7. “CHALLENGING BEHAVIOUR”

“Challenging behaviour” – sometimes referred to as “behaviour of concern” – is common following ABI. Frequently identified behaviours include “disinhibition, irritability, aggression, sexual acting out, reduced anger control, immature behaviour (relative to age expectations), rigidity, social awkwardness, impaired social perception, egocentrism, depression and social withdrawal.”⁹⁴ “Challenging behaviour” has been defined as “any behaviour, or lack of behaviour of such intensity, frequency and/or duration that has the potential to cause distress or harm to clients/carers/staff or one which creates feelings of discomfort, powerlessness, frustration, fear or anxiety. It is also behaviour, which delays or limits access to ordinary community facilities and is outside socially acceptable norms.”⁹⁵ What constitutes such norms and what makes a particular behaviour challenging to them are clearly subjective. However, difficulties with regulating behaviour – particularly associated with damage to the frontal lobes of the brain (see below) – have been found to be more common in people with an ABI than in carefully matched control groups drawn from, for instance, similar socioeconomic backgrounds.⁹⁶ At least two conclusions can safely be drawn from the experience of people living with the disability. Firstly, people with an ABI can sometimes behave in ways that stretch the limits of social acceptability, placing considerable strains not only on family and work relationships but also with the broader community. The research literature has demonstrated a strong relationship between challenging behaviours and: poor levels of return to work; exclusion from needed services; increased staffing costs for services managing such clients; and unwanted admissions to inappropriate institutional care.⁹⁷ Secondly, for roughly 2 in every 3 people who behave in such ways – especially where insight into their challenging behaviour and its effects is also limited by damage to their brain and they have limited, or no, control (combined with lack of memory) over them – this is reported as being the most disabling part of their brain injury.

The understanding of the causes of such behaviour is imperfect, and they will vary with the person, but the following explanations have proven useful. Firstly, the behaviour may be the direct result of damage to specific areas of the brain – for example, those responsible for controlling impulses. Secondly, the behaviours may have been learned or adopted by the individual as a means of adjustment, or in response, to disability. Thirdly, the behaviours were exhibited prior to injury and are unrelated to it but to other individual factors.

New South Wales’ Brain Injury Rehabilitation Directorate has undertaken the most recent Australian research into the prevalence of challenging behaviour within a cohort of people with an ABI. **From a sample of 659 clients of the state’s 14-centre Brain Injury Rehabilitation Program more than half (53%) “met criteria for challenging behaviour”, including: “inappropriate social behaviour (30%); verbal aggression (26%); adynamia/lack of initiation (23%); perseveration/repetitive behaviour (13%); physical aggression against others (11%); physical aggression against objects (7%); physical acts against self (5%); inappropriate sexual behaviour (4%) and absconding/wandering behaviour (3%)”.**⁹⁸ Higher proportions of male, Indigenous and clients from regional and remote locations demonstrated challenging behaviours. Rates of challenging behaviour “increased significantly” with longer duration of the client’s Post-Traumatic Amnesia - the period immediately following TBI when the person is confused, disoriented and unable to remember day-to-day events – and with level of subsequent disability. In the case of the latter, “the rate of challenging behaviour increased from 23% for those with no disability to 100% for clients with severe disability.”⁹⁹ Many of the sample had complex comorbid mental health and drug and alcohol problems. While these may have contributed to the development of challenging behaviours post-injury, the Directorate’s study attempted to separate them from “a variety of other demographic and clinical variables”¹⁰⁰ that might have been explanatory. Six factors – a client’s pre-injury or current alcohol problem, symptoms of depression or other mental health problems, cognitive problems and their overall level of disability – “were able to correctly classify 74.2% of clients as having or not having challenging behaviour”.¹⁰¹ Brain Injury Australia notes both the high rates of alcohol and other drug abuse and dependence as well as high rates of mental illness in prisoners who participated in the NSW Inmate Health Survey, above. Significantly, “unlike most neurobehavioural consequences of TBI that improve over time, irritability, aggression and other behaviour problems may worsen, both in children and adults”.¹⁰² Robyn Tate and colleagues’ study of outcomes for 100 people with very severe TBI found roughly 1 in 4 were still experiencing impairments in the area of “behaviour regulation” 20 to 26 years post-injury.¹⁰³

While the Directorate’s study “did not systematically collect quantitative information”¹⁰⁴ on the subject, “increased contact” with “police and the criminal justice system” was one of the “notable consequences of challenging behaviour”.¹⁰⁵ The study recommended challenging behaviour be made “a matter of core business requiring implementation of long-term management strategies”, beginning with the identification of “evidence-based treatments”.¹⁰⁶ It also included detailed histories taken from interviews with 28 of the 650 clients. The following is typical:

"This 36 year-old male client was involved in a high speed single motor vehicle accident in August 2006 (aged 34) ...Post-operatively he had seizures that progressed to status epilepticus [continuous seizure activity] for 17 days, resulting in suspected hypoxic injury [the result of a decrease in supply of oxygen to the brain]. He developed residual myoclonic jerks [sudden, involuntary jerking of a muscle or group of muscles]. His movement disorder severely limits his day-to-day functioning. This client is married with two young children. He did not complete Year 9. He had worked casually as a labourer in an abattoir. The client had a significant forensic history with custodial sentences for drug-related offenses: stealing, assault, and grievous bodily harm. He had been incarcerated for periods ranging from two months to three years...The client had frequent periods of irritability, intense anger, and outbursts of verbal criminogenic needs including crying, yelling, swearing, and threatening. He would target individual staff and partner with his verbal attacks. He also threatens self-harm during these periods. Behaviour is attributable or at least exacerbated by his brain injury. He has shown physical aggression toward others and objects. He throws items, attempts to strike staff, use instruments to assault staff and spits...Conversely, he can interact with staff in an over familiar and inappropriately intimate manner, using sexually explicit language. He has a tendency to idealise relationships, seek out preferred caregivers, ostracise other carers and make intense demands...He is on a cocktail of medications to manage seizures, spasticity, and pain. He receives a disability support pension."¹⁰⁷

It is perhaps unsurprising then that the behaviours of some people with an ABI also challenge prison disciplinary rules. Administrative records data on the 511 people with an ABI in the MHDCD study found they had a higher average number of "offences in custody" (8.33) compared to the group without ABI (5.61).¹⁰⁸ A United States study of 17,500 prisoners over an 11-year period found both men and women with a "medically-attended"¹⁰⁹ TBI had a "significantly higher rate of behavioural infractions" than those without TBI, even after controlling for variables such as age, reading level, prior criminal history and sentence length. Female prisoners with a TBI experienced a 144% increase in their "violent infraction rate" over prisoners without TBI, compared to an 86% increase in men.¹¹⁰

8. "OFFENDING BEHAVIOUR"

Not long ago, I was referred a case because a lawyer was surprised by lack of offence history prior to a certain year and a history of chronic offending following this whereby the person was imprisoned every six months to a year after this. Since we had worked together previously, he asked the man if he had had a head injury and - sure enough - there was a history of significant head injury a year earlier. We carried out neuropsychological assessment and, yes, we did find deficits. Does this mean that everyone with head injury offends? No. Does this mean that no one offends who does not have a head injury? No.¹¹¹

The notion that exhibiting behaviour that challenges societal norms may result in increased contact with the criminal justice system would seem uncontroversial. The MHDCD study found the 511 people with an ABI had, on average, 16 more contacts with police than the other study groups - people with an intellectual disability or "mental health problems", but without ABI.¹¹² A number of contributors to this paper pointed out that much of this behaviour by people with an ABI could be safely classed as "nuisance" offending: "I am aware of a number of offenders with disabilities who become part of a revolving door scenario. They are usually well known to both police and prison staff. They are usually picked up for minor offences...and put back into custody. This typically occurs as a result of inadequate services in the community to manage these individuals."¹¹³ While those with an ABI in the MHDCD study "have a higher average number of convictions" (27.8) than those without an ABI (25.2), over 30% of the 14,216 convictions recorded by people with an ABI involved "public order" or "road traffic and motor vehicle regulatory" offences.¹¹⁴

This paper also demonstrates a clear association between incarceration and high rates of ABI. However, the research exploring any causal relationship between ABI and the commission of crime, specifically violent or sexual offending,¹¹⁵ is both equivocal and ambivalent. The latter due to sensitivity about further stigmatising an already marginalised group - as a small minority of the general population commit crime, similarly with people with an ABI. The former due to the plethora of potentially confounding variables; other known risk factors for violent offending, for example. "That prison inmates are characterised by manifold disadvantage has clearly and repeatedly been documented, with histories of disrupted family and social backgrounds; abuse, neglect and trauma; poor educational attainment and consequent limited employment opportunities; unstable housing; parental incarceration; juvenile detention; dysfunctional relationships and domestic violence; and previous episodes of imprisonment, all highly prevalent among samples of prison inmates."¹¹⁶ As stated in the "Preamble", above, the incidence of ABI also tracks social-locational disadvantage. Moreover, many of the studies exploring the causal relationship between ABI and the commission of crime are retrospective in design and run the risk of confusing correlation with causation; that because a person's offending behaviour began *after* injury it is therefore *due* to their ABI, discounting other pre-injury variables such as social-locational disadvantage.

At the same time, **those parts of the brain responsible for its higher, so-called "executive", functions – such as the monitoring and regulating of emotions, behaviour – are particularly vulnerable to the most common type of TBI, from a closed head injury** (where, for example, an object strikes the head but does not break the skull). "In particular, when frontal [lobe]¹¹⁷ control mechanisms are unavailable to regulate limbic [system] impulses,¹¹⁸ minor everyday provocation can cause aggressive or otherwise socially unacceptable responses. Irritability leading to aggression may be a direct consequence of these pathophysiologic changes, an exacerbation of pre-traumatic aggression, poor self-monitoring, an underlying mood disorder, overly restrictive treatments or any combination of these."¹¹⁹ United States' Vietnam Head Injury Study – that has followed 1,221 veterans for over 40 years – compared 279 with damage to their frontal lobes with a control group matched for age, education, length of tour of duty but without head injury. It found that "patients with frontal...lesions consistently demonstrated aggression/violence scale scores significantly higher than controls and patients with lesions in other brain areas."¹²⁰ A 2001 critical review of 17 studies found a "significant association"¹²¹ between frontal lobe dysfunction and violent and criminal behaviour from both neuropsychological testing and neuroimaging - such as computed tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) scanning of the brain. A recent analysis of 9 studies that evaluated the risk of violence in people with TBI or epilepsy - compared with unaffected control groups - found that, while epilepsy was inversely associated, the risk of violence after TBI was "threefold that of the general population...a similar magnitude to the risk of violence in those with major mental disorders after adjustments are made for socioeconomic status and comorbid substance abuse."¹²²

A number of studies have examined TBI as a risk factor for violent crime specifically with young offenders. Data collected on 12,200 Finnish people born in 1966 demonstrated not only that TBI was associated with an increased risk of criminality but also that convicted persons who had sustained a TBI prior to the age of 12 commenced criminal activity sooner after injury than those offenders who received their TBI at older ages. Furthermore, those who sustained a TBI during childhood or adolescence experienced a fourfold increased risk of developing a mental disorder with co-occurring criminal offending.¹²³ A United Kingdom study of 186 young offenders found 65% reported one or more TBIs. Participants who reported a history of TBI had an average of two more criminal convictions. Significantly, "three or more self-reported TBIs were associated with more violence in offences."¹²⁴ This conforms both to the conclusions of other research – that the effects of multiple mild TBIs can be cumulative – and to the results of the 2003 Young People in Custody Health Survey, referred to above; that higher rates of TBI in the custody, rather than community, sample are suggestive of more serious, perhaps violent, offending. A New Zealand prospective study of 1,265 children born in 1977 found those who sustained a mild TBI prior to age 5 were more likely to be arrested subsequently and involved in property or violent offences than a control group with no history of TBI. Even after adjusting for socio-economic status and gender, those with a history of mild TBI were at between 35% and 129% increased risk of contact with the criminal justice system when compared to the non-injured group.¹²⁵ The study's lead author notes "by the time these children reach the youth justice system, the link between TBI and behaviour is often not made".¹²⁶ A Spanish study that compared 36 prisoners convicted of violent crimes with 13 non-violent offenders found that the "only statistically significant differences between the two groups" – even after adjusting for "school problems", "learning disabilities", "childhood illnesses" and having "received psychological or psychiatric treatment" – was the former group's history of severe head injury during childhood or adolescence.¹²⁷

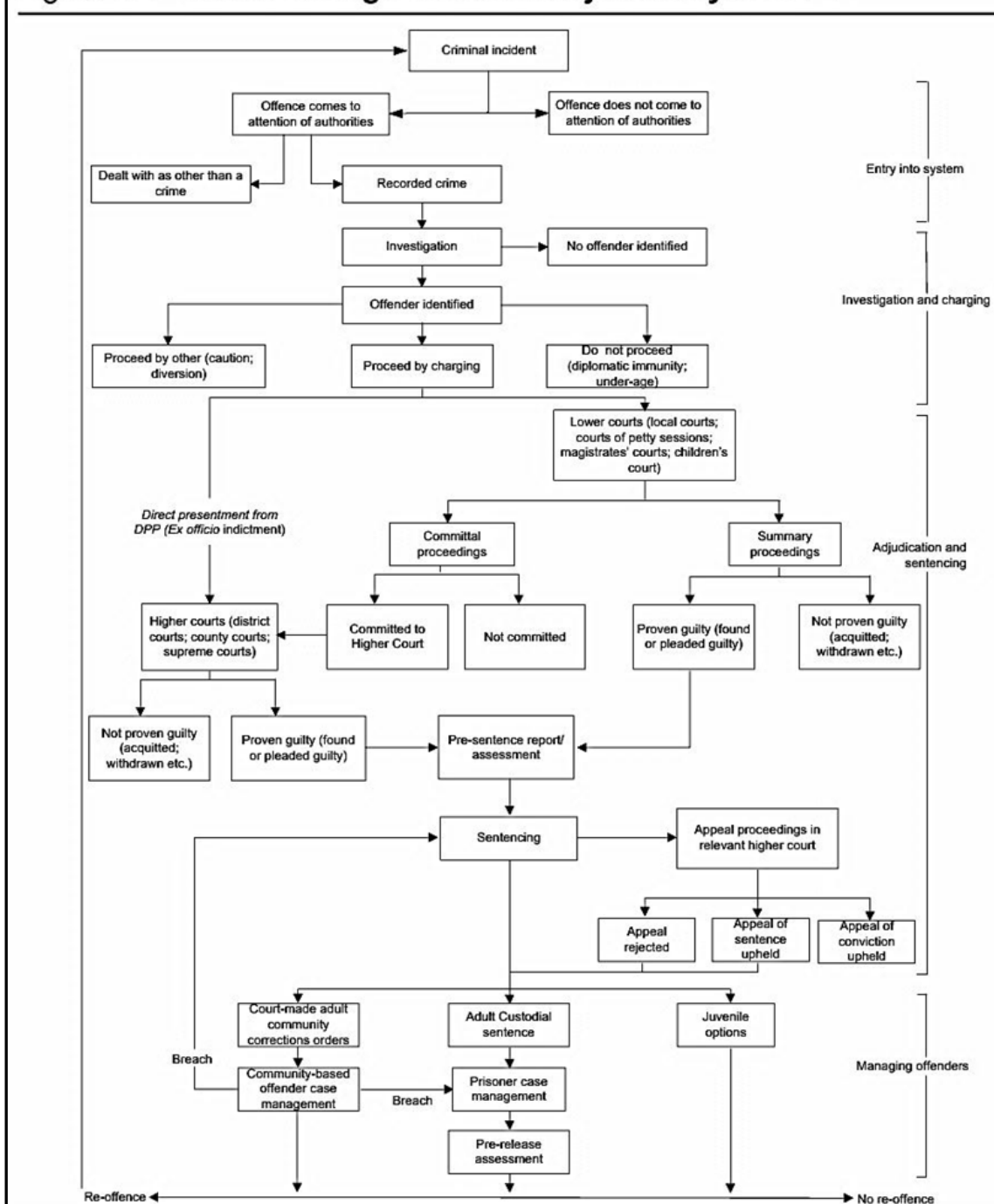
Of the 242 juvenile justice detainees who participated in a 2003 New South Wales survey, 85 (35%) reported a total of 161 head injuries during which they “blacked out” or became unconscious. 20 per cent of participants who reported a history of head injury had committed a “severe violent offence” compared to 10% of those without head injury. Furthermore, the “severity of the head injury (related to the period of time unconscious) was also found to be significantly related to participation in serious violent offences.”¹²⁸ The authors conclude **“the most parsimonious explanation for the relationship between head injury and violent offending is that head injuries increase disinhibition of aggressive impulses, especially in the presence of harmful/hazardous alcohol use, which raises the risk of severe violence within an offence pattern.”**¹²⁹ Importantly, “no cognitive variable (IQ or educational attainment) was related to head injury or violent crime”.¹³⁰ This finding reinforces both the inapplicability and inequity of IQ scoring as both a screen for ABI and a determinant of eligibility for access to programs of “offender rehabilitation”.

All of the studies referred to above have their limitations. Most rely on self-report of ABI. Others suffer from small samples. Most are retrospective and thus may never be able to completely control for all the potentially confounding variables that lie between a head injury in the early years of life and subsequent offending behaviour. **While Brain Injury Australia considers the plight of offenders with an ABI a crucial area of untapped advocacy, it is equally wary of even the most indirect suggestion that an ABI is some royal road to crime. However, Brain Injury Australia considers a position that there is no relationship between brain injury and subsequent offending behaviour insupportable from the available evidence. At the same time, Brain Injury Australia is disturbed by an emerging strain in criminology - sometimes referred to as “neurojurisprudence” – that seeks to reduce all offending to the operation of a dysfunctional brain: “because all behaviour emerges from the brain, the individual brain, in isolation, is the most relevant site for understanding criminal behaviour”.**¹³¹ A “disease theory” of crime runs the risk both of viewing all people with an ABI as criminals-in-the-making and offenders with an ABI as only medically treatable. And while some medications – for example, the use of anti-depressants, anti-convulsants, psychostimulants and beta-blockers to reduce impulsivity, anger and aggression¹³² – may hold positive prospects for some prisoners at risk of re-offending, Brain Injury Australia would resist the criminal justice system reaching for pharmacological quick fixes to criminogenic need.¹³³

Models attempting an explanation of the relationship between ABI and offending behaviour abound. Brain Injury Australia believes offending typically has no single cause, but likely combines social and biological factors. The author of a 1999 review of four large follow-up studies of survivors of head injury concluded “to the extent that head injuries tend to happen preferentially to people with premorbidly impulsive and often violent behavioural lifestyle patterns (i.e. high risk), it is not surprising that superimposed head injury to the brain would serve to intensify and exacerbate this pattern; a vicious cycle if ever there was one – those most prone to sustain head injuries are those most likely to have the worst reactions.”¹³⁴ (Interestingly, for the 85 juvenile justice detainees who reported head injury, in the New South Wales Study referred to above, the “only two independent risk factors” were histories of gambling and “moderate to severe anger”.¹³⁵) Regardless of whether head injuries are “additive”¹³⁶ to social risk factors, or lower the “threshold”¹³⁷, for violent offending, it is clear – in keeping with the Council of Australian Government National Disability Strategy’s “focus on early intervention”¹³⁸ - that **services and supports should be concentrated on children and adolescents with a history of head injury. And juvenile justice detainees: 38% of respondents to the 2009 NSW Inmate Health Survey had been in juvenile detention, 13% on five or more occasions. “Unlike most neurobehavioural consequences of TBI that improve over time, irritability, aggression and other behaviour problems may worsen, both in children and adults...Furthermore, the few children with relatively ‘pure’ pre-frontal injuries who have been described in the literature have, with few exceptions, developed increasing behaviour problems over the years after their injuries.”**¹³⁹ A five-year follow up study of 42 people with severe head injuries found their threats or gestures of violence increased from 15% in the first year post-injury to 54% after 5 years. Ten per cent of the group had been physically violent with a relative within one year, and 20% within 5 years, and 7% had contact with the criminal justice system in the first year after injury, increasing to 31% after 5 years.¹⁴⁰ Brain Injury Australia notes the results of the 2009 NSW Inmate Health Survey, where nearly half (47%) of head injuries resulting in a loss of consciousness sustained by participants were reported to have occurred ten or more years earlier, 22% between five and ten years earlier.¹⁴¹ Where the neurobehavioural consequences worsen - and thus the criminogenic needs of prisoners with an ABI increase - with time, it serves to reinforce National Disability Strategy’s “focus on early intervention”¹⁴² as a crime prevention strategy.

9. "DIVERSION"

Figure C.1 Flows through the criminal justice system^{a, b, c}



"Estimates consistently indicate a disproportionately large number of offenders with a cognitive impairment or mental illness, or both, when compared with the number of people with these conditions in the general population. While there are various theories to suggest why people with a cognitive impairment or mental illness might become enmeshed in the criminal justice system, it is commonly agreed that it is not the impairment or mental illness itself that makes a person more prone to criminal activity. Rather, it is the cumulative effect of numerous social disadvantages arising from their impairment or illness that may make these groups more susceptible to become involved in crime, disadvantages such as limited educational and employment opportunities, social isolation, greater visibility to the police, lack of support services and difficulties in getting access to these services. Diversion is one way by which the law can try to break this cycle of involvement in the criminal justice system and ensure that that system is not used as a substitute for proper social services to deal with people whom society finds inconvenient."¹⁴³

Figure C. 1 depicts an array of points where an accused person or an offender with an ABI might be diverted from “flows through the criminal justice system”. Firstly, in determining whether to lay charges police may exercise their discretion by taking into account a person’s impaired capacity arising from their ABI, for example. Secondly, in determining whether to proceed with the charges, the person or their lawyer may make submissions to the prosecuting authority asking the charges be withdrawn based on the person’s mental or cognitive impairment, including where that impairment arises from ABI. Thirdly, the effects of ABI (or other cognitive impairment or mental illness) may be taken into account when determining whether to grant bail and in determining the conditions of that bail. Fourthly, in determining whether the person has the capacity to participate meaningfully in court proceedings (referred to as a person’s “fitness to be tried”). Fifthly, in determining a person’s guilt: generally, a person cannot be found guilty of an offence unless the prosecution can prove beyond reasonable doubt both that the person committed the acts that constitute the offence for which the person was charged and that the person intended to commit the offence (or was reckless as to the consequences of their action). “The law has long recognised that in certain circumstances a person may commit the act or acts giving rise to the charge but, due to an ‘abnormality of mind’ they did not or could not form the intention to commit the offence and therefore should not be convicted of the offence. This gave rise to defences to criminal charges based on a person’s reduced capacity to form an intention or inability to control their behaviour. Such defences include a person being not guilty by reason of mental illness, not guilty simply because the prosecution cannot prove they intended to commit the crime, or not guilty due to automatism (where they could not control their physical actions.”¹⁴⁴ Lastly, when determining the sentence to impose on a person courts are required to take into account a range of factors. These may include: the level of the person’s culpability (for example, was the offence well-planned or spontaneous); general deterrence (where the punishment implied by the sentence will serve to deter others from committing a similar offence); and specific deterrence (where the punishment of person serves to deter that person from re-offending). Depending on the jurisdiction, a person’s ABI may be taken into account here as well.

As part of the preparation of this paper, law firm Blake Dawson examined all Australian jurisdictions for any special considerations that may be available to people with an ABI charged with criminal offences. The survey was confined to local or Magistrates’ Court - where the overwhelming majority of criminal matters are finalized; 97% of the 653,136 heard during 2008-2009.¹⁴⁵ It concluded; **“only a few Australian jurisdictions expressly recognise ABI as a form of cognitive or mental impairment for the purposes of criminal proceedings, and in the remaining jurisdictions significant uncertainty exists in relation to whether a person with an ABI can benefit from the existing allowances made in the criminal law for people with mental impairment, illness or disability. This uncertainty stems largely from the variety of terms and definitions used to describe mental impairment at various stages of criminal proceedings and across jurisdictions. Many jurisdictions adopt definitions of mental impairment based on common understandings of mental illness, which do not cover ABI. This results in exclusion of people with ABI from any alternate pathways that exist for people with mental impairment in such jurisdictions.”**¹⁴⁶ Moreover, **“The criteria for diversion and reduction of culpability were largely developed to address the issues raised by intellectual disability and mental illness. ABI is often conflated with mental illness and, more often, with intellectual disability. The danger of this in the criminal law is that laws which were crafted on the basis of the features of mental illness and/or intellectual disability may exclude people with an ABI who may have an equal claim to special consideration.”**¹⁴⁷

In relation to the first two potential avenues for diversion for people with an ABI, described above, none of the State or Territory police forces approached by Brain Injury Australia collected information about their contacts with the public, by disability type.¹⁴⁸ Neither did any of the State or Territory legal aid commissions, from where the bulk of legal representation for offenders with an ABI would derive.

▪ Bail

When a person is charged with a criminal offence initially the police, and later the court, must decide whether the person should be released on bail or held in custody while their matter is determined by the court. In assessing whether bail should be granted, courts primarily have regard to the likelihood of the accused appearing in court, whether or not the accused is likely to break the law while on bail and the protection and welfare of the community - that the accused is not a danger to the public, witnesses or themselves. If a person is released into the community, bail conditions may be imposed to increase the likelihood of the person appearing in court to answer the charge against them. For example, a bail condition may be imposed to require a third party to lodge a sum of money which they lose if the defendant does not attend court, or requiring the accused to report regularly to police to ensure the person remains within the jurisdiction. The court may also impose conditions designed to reduce the risk of reoffending such as a curfew or a requirement that the accused attends rehabilitation.

The bail Acts of Victoria, Western Australia, South Australia, the Australian Capital Territory and Tasmania “do not explicitly provide for consideration of the accused’s cognitive impairment, ABI, mental illness or intellectual disability in deciding whether or not to grant bail... Where the provisions do extend to people with an ABI, the conditions on which bail may be granted may result in the imposition of inappropriate requirements, for example, a requirement to seek medical treatment for a person whose ABI is stable and no longer amenable to medical treatment.”¹⁴⁹ While the New South Wales Bail Act (1978) sets out “criteria to be considered in bail applications”, they will only extend to an accused person with an ABI who also “has an intellectual disability or is mentally ill”.¹⁵⁰ Queensland’s Bail Act (1980) allows for a “person with an impairment of the mind” to be released without bail into the care of another person who ordinarily has care of the person or with whom the person resides, or the court may permit the person to go at large. It defines “an impairment of the mind” as attributable to an intellectual, psychiatric, cognitive or neurological impairment or a combination of these and results in a substantial reduction in the person’s capacity for communication, social interaction or learning and the person needing support. “The section may, then, apply to a person with ABI.”¹⁵¹ Courts in the Northern Territory are permitted to consider whether a person is “incapacitated by...injury” or otherwise in danger of physical injury or in need of physical protection in assessing bail applications.¹⁵² An accused person with an ABI could argue they be granted bail due to their disability rendering them especially vulnerable if imprisoned. Magistrates also have the power to order bail assessment reports from Northern Territory Community Corrections, part of the Department of Justice. For the jurisdiction with both the highest per capita imprisonment and recidivism rates as well as the highest apparent prevalence rates for ABI, such prospects for diversion hold out some promise.¹⁵³ However, when asked by Brain Injury Australia how many people with an ABI were able to access these services, the Department of Justice responded “we do not collect any data related to ABI. There is only anecdotal information.”¹⁵⁴

The lack of positive *inclusion* of people with an ABI in Australia’s bail acts is as regrettable as any of its absences in legislation. However, there is the distinct potential that the effect of the criminal justice system’s lack of awareness and understanding of the disability when combined with experience of the cognitive and behavioural effects typical of ABI might result in the positive *exclusion* of people with an ABI from sympathetic bail considerations. For example, “Northern Territory practitioners have indicated to us that an ABI may increase the likelihood a person will be refused bail, especially if their condition causes challenging, violent or antisocial behaviour, or increases their likelihood of recidivism.”¹⁵⁵ Victoria Legal Aid notes: “when people are charged with criminal offences, police provide them with copies of their charge sheets and a court date. Because of the memory and organisational problems commonly associated with ABI, persons in this situation are likely to misplace this paperwork and fail to appear at the required time. As a consequence of this, warrants for their arrest are issued. When the police locate the person with an ABI they are arrested and the warrant is executed. The police then have the choice of whether to grant the person bail or remand them in custody until their court date. They client may also face additional charges of failing to appear on bail. This means that, even though a person with an ABI may be facing less serious charges, their inability to keep court dates may end up in them serving time in prison.”¹⁵⁶

▪ “Fitness to be tried”

There is a general presumption that every accused person is fit to stand trial. The defence, the prosecution or the judge can call into question that presumption. A person is unfit to stand trial if the person is generally, or at some time during the trial will be, unable to: understand the nature of the charge; enter a plea or exercise the right to challenge jurors; understand the nature of the trial; follow the course of the trial; understand the effect of any evidence that may be given in support of the prosecution; or give instructions to his or her legal practitioner. In practice, the threshold for these standards is low and Brain Injury Australia understands that practitioners regularly take instructions from clients with mild mental illness or intellectual disabilities.

Though the link between cognitive impairment and the standards for fitness differs between Australian jurisdictions, people with an ABI may fail to meet the minimum standard of fitness described above. This could be due to some typical effects of ABI, including: difficulty processing information; inability to understand abstract concepts; impaired decision-making ability; memory loss or impairment (which may impede not only the defendant’s ability to recall the events the subject of the charge, but also their ability to follow the trial); deficits in spoken or received language; problems learning new information; and dependence (the failure to assume responsibility for one’s actions).

While many defendants with an ABI will exhibit these effects, many of the contributors to this paper indicated the following; “obtaining a neurological or neuropsychiatric diagnosis of ABI can be difficult, time-consuming and costly. Without such evidence, especially in lower courts, it is unlikely that fitness would be raised or considered unless the person is completely incoherent or unable to instruct their legal representatives.”¹⁵⁷ Neuropsychologists contacted by Brain Injury Australia offered costings ranging between \$250 and \$2,500 for a variety of assessments depending on whether the provider was government or private and on whether the client was represented by legal aid.

If the person remains unfit to stand trial after twelve months, some courts have the option of either releasing the accused unconditionally, or holding a “special hearing”.¹⁵⁸ The consequences of the charges being proven in a special hearing are similar to the consequences of successfully relying on the defence of mental impairment, discussed below. “In both cases, the judge would be likely to put the accused on an indefinite supervision order (which may involve being placed into custody or detained at a hospital). Despite the statutory time limits that apply to this particular mechanism for dealing with mental impairment, our consultations with criminal law practitioners in various Australian jurisdictions indicated that some cases are delayed for much longer while the accused undergoes involuntary mental health treatment.”¹⁵⁹

Contributors to this paper raised a range of concerns relating to determinations of “fitness to be tried” for people with an ABI. The NSW Chapter of the Australian and New Zealand Association of Psychiatry, Psychology and Law (ANZAPPL NSW) has pointed up deficiencies in NSW’s *Mental Health (Forensic Provisions) Act 1990* - the relevant legislation governing the law and procedures where questions of “fitness to be tried” arise in that state’s District or Supreme Courts. If an accused person with an ABI is found unfit under the terms of the Act they are referred to NSW’s Mental Health Review Tribunal for its determination whether “during the period of 12 months after the finding of unfitness”, the accused may “become fit to be tried”.¹⁶⁰ If not, the Tribunal “must notify the Director of Public Prosecutions of this determination who invariably then directs that a ‘special hearing’ be conducted as to whether or not the person has committed the offence with which they are charged.”¹⁶¹ If the Court then finds that the accused person has committed the offence “on the limited evidence available (that is, the Crown evidence without the accused’s instructions), then consideration must be given by the Court as to whether the Court will impose a sentence and if so, must nominate a term, referred to as a ‘limiting term’. This is ‘the best estimate of the sentence the Court would have considered appropriate if the special hearing had been a normal trial of criminal proceedings against a person who was fit to be tried for that offence and the person had been found guilty of that offence’”.¹⁶² If a “limiting term” has been set by the Court, the accused is again referred to the Tribunal for determination as to whether “the person is suffering from mental illness, or the person is suffering from a mental condition for which treatment is available in a mental health facility.”¹⁶³ The Tribunal is then required to determine whether “the person is suffering from a mental illness or a mental condition for which treatment is available in a mental health facility and whether or not the person objects or does not object to being detained in a mental health facility.”¹⁶⁴ ANZAPPL NSW notes this process; “has no application to a person who is unfit because of a brain injury but is not mentally ill. They go through a cumbersome and confusing process for no apparent purpose.” Furthermore, “there is no power in the legislation to give consideration as to an appropriate placement for a person with an acquired brain injury in a facility which is not a mental health facility. Thus, the Court has little alternative other than to impose a custodial sentence in a gaol, even though the Court may not be of the view that the imposition of a gaol sentence is the appropriate course.”¹⁶⁵

It has been Brain Injury Australia’s experience that **a general advocacy for diversion - as an alternative to overly punitive and generally disability-unaware practices in the criminal justice system - begs an array of questions. They include: whether people with an ABI are eligible under the provisions of relevant legislation; that access to existing programs of diversion is often conditional upon the accused accepting a guilty plea; and whether programs of diversion, where available, are appropriate or relevant for people with an ABI. A number of contributors noted “diversion is still punitive”¹⁶⁶ in its approach.**

"C. is a 30 year old, single Pitjantjajara man and long-term resident of Alice Springs. Prior to his imprisonment, he lived on the fringes of the community with some minimal support from various family members. He has been assessed as globally cognitively impaired. The actual cause is not clear, but is possibly attributable to unmanaged epilepsy and chronic alcohol abuse... C. has an offending history dating from 2007 and has been identified as significant risk of serious harm to others. In December 2007, C. was found 'unfit to plead' in the Alice Springs Supreme Court where he was appearing on charges of assault and placed into detention on a Custodial Supervision Order for twelve months. C. is now into his fourth year of imprisonment under Section 43CZ of Part IIA of the Northern Territory Criminal Code... C. has no idea why he is in prison and at each annual review of his Custodial Supervision Order thinks he is to be released. C., like others on such orders is housed in the G Block of the Alice Springs Correctional Centre – a highly restrictive and oppressive block. The prison authorities do their best to provide for C. offering minimal programmed activity. Out of prison activities have been promised to the Court by the Department of Health and Families but have never eventuated."¹⁶⁷

Brain Injury Australia is a member of the Aboriginal Disability Justice Campaign (ADJN); "a coalition of individuals and agencies concerned about the incarceration of Aboriginal people with a cognitive impairment in the Northern Territory"¹⁶⁸ – the jurisdiction with both the nation's highest, and fastest growing, imprisonment rate; rising 41% from 469 to 663 prisoners per 100,000 during the last decade.¹⁶⁹ Eighty-one per cent of its prisoners are Indigenous. The campaign is focused on the needs of at least half a dozen Aboriginal prisoners - like "C.", above – all of whom have been deemed "unfit to plead" and are subject to indefinite detention in the maximum security section of the Alice Springs Correctional Centre. "Northern Territory prisons are being used as an accommodation option solely because there are no community-based secure treatment options. There is no legislative framework that enables the balancing of the rights of the individual and the protection of the community leaving the courts no choice other than to make prison-based supervision orders."¹⁷⁰ The Northern Territory Government's Department of Health and Families has scheduled construction to commence on two "Secure Care Group Homes" - in Darwin and Alice Springs - in June and July 2011, respectively. The "facilities will support 8 children/young people who have experienced significant trauma in their lives" and "8 adults who have an intellectual disability or other cognitive impairment."¹⁷¹ In the meantime, the ADJN notes an additional 130 Aboriginal people under guardianship in the Central Desert Region "with 60 applications waiting to be processed. At the high-needs end of this spectrum is a small group of 12 to 14 Aboriginal people who are beyond the reach of the few existing services, because they are considered a significant risk of serious harm to others and whose behaviours bring them into contact with the criminal justice system. There is also a group of people who are recidivist offenders constantly coming into contact with the criminal justice system, who show behaviours of concern and who are not receiving appropriate levels of support needed to manage them in a least restrictive manner."¹⁷² Brain Injury Australia understands 29 people are currently imprisoned in Western Australian on, in effect, indefinite remand – 13 of whom have been deemed unfit to plead. A further 17 are in jail despite having been found not guilty due to mental impairment (see below).¹⁷³ The ADJN warns "the number of such disabled people in prison will increase significantly",¹⁷⁴ especially where an accused person – whose "fitness to be tried" is in doubt - might be encouraged to plead guilty rather than risk potentially indefinite prison-based supervision.

Brain Injury Australia is generally concerned that a nationwide tide of deinstitutionalisation – that resettled people with a disability back into community settings, begun 30 years ago by David Richmond's report for the New South Wales Government - is being reversed. And that due to the lack of community options, the numbers of prisoners with an ABI, intellectual or psycho-social disability denote "re-institutionalisation" by stealth by state and territory governments. At the same time, Brain Injury Australia acknowledges contributors to this paper who felt, for some people with an ABI, that the neurobehavioural effects of the disability, as well as their overall health, improved in prison. "These individuals...find the structured life without any responsibilities in the prison easier than living outside. They are the ones who say - 'I do prison easy – I do outside hard.'¹⁷⁵ "Many people with an ABI, who live a cyclical life of crime find comfort in the stability and routine of jail...Therefore they seek ways to return to jail."¹⁷⁶ "The irony and tragedy of this situation is that M.'s health and welfare indicators have never been as good as they are now that he is in prison."¹⁷⁷

▪ The defence of mental impairment

The defence of mental impairment is a modernisation of the insanity defence; where a “defect of reason, from a disease of the mind” may prevent a person from “knowing the nature or quality of their allegedly criminal actions, or knowing that what they were doing was wrong.”¹⁷⁸ Though both were developed in response to mental illness, the use of the defence has been expanded to include other forms of offenders’ impaired capacity to understand or regulate their conduct. The *Commonwealth Criminal Code Act 1995* is considered model legislation for all Australian jurisdictions. Its definition of mental impairment includes “brain damage”, implying specific recognition of ABI. The defence comprises a three-limbed test of criminal responsibility if, at the time, the accused was experiencing a mental impairment such that he/she: did not know the nature and quality of the offending conduct; or did not know that the conduct was wrong; or was unable to control the conduct.

The defence is more readily available to offenders with an ABI in Western Australian, the Australian Capital Territory and the Northern Territory¹⁷⁹ - whose criminal codes copy the Commonwealth model by including “brain damage” within their definitions of mental impairment - and in South Australia, where a defence of “mental incompetence” is subject to a three-limbed test similar to the Commonwealth Criminal Code Act. Victoria’s defence of mental impairment “is intended to adopt and replace the common law defence of insanity without substantively altering it.”¹⁸⁰ And unlike the Commonwealth code, Victoria’s *Crimes (Mental Impairment and Unfitness To Be Tried) Act 1997* does not include the “unable to control the conduct” test. Blake Dawson notes; “in the Magistrates’ Court, if a person is found not guilty because of mental impairment for a summary offence or an indictable offence heard summarily, the court must discharge the person. Practitioners that we have consulted have indicated that, in practice, this makes it virtually impossible to successfully raise the defence of mental impairment in the Magistrates’ Court in Victoria.” The statutory defence in New South Wales relies on “mental illness” rather than mental impairment, specifically “a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence of [symptoms such as] delusions, hallucinations, serious disorder of thought form, a severe disturbance of mood, and/or sustained or repeated irrational behaviour indicated by the presence of any one or more of the [previously listed] symptoms.”¹⁸¹ Moreover, the defence is only available in the state’s District and Supreme Courts. The Tasmanian Criminal Code’s retention of the term “insanity” is “likely to make it more difficult for a person with ABI to use the defence...unless they have complex and multiple mental conditions contributing to such a mental state.”¹⁸²

As with questions of “fitness to be tried”, where a defence of “mental impairment” may be available to an offender with an ABI and that defence proves successful, Brain Injury Australia retains profound concerns about the options available to courts in such circumstances. The prosecution may withdraw the charges. Courts have the discretion to release the accused unconditionally but this is unlikely to occur except in exceptional circumstances. “Supervision”, “care” or even “treatment” orders, “most often used to facilitate mental health treatment”,¹⁸³ are commonly the only available options, inappropriate for a person with an ABI without a mental illness pertinent/ relevant to the offending. “Practitioners and stakeholders that we consulted in the preparation of this paper indicated that the risk of long-term detention or supervision often outweighed the benefits of raising mental impairment at any stage other than sentencing or diversion. Some jurisdictions provide that custodial treatment should only be imposed if there are no practical alternatives, but it is difficult to know whether all appropriate alternatives are apparent to the court when imposing supervision orders on people with an ABI.”¹⁸⁴

▪ Sentencing

The capacity of Australian courts to include an offender’s ABI as mitigation in sentencing is equally patchy. The understanding of mental and intellectual “impairments” or “conditions” in Queensland, Western Australian, Tasmanian and the Australian Capital Territory’s legislation is “arguably wide enough to cover ABI.”¹⁸⁵ Victoria’s *Sentencing Act* makes specific provision only for mental illness and intellectual disability. Though “disability” is undefined, New South Wales’ legislation affords mitigation where the offender “was not fully aware of the consequences of his or her actions because of his or her...disability”.¹⁸⁶ While the Northern Territory’s *Sentencing Act* applies mandatory sentencing to certain violent offences under its Criminal Code, the court “must have regard to the offender’s character, age and intellectual capacity in sentencing and also to any aggravating or mitigating factors concerning the offender”,¹⁸⁷ potentially inclusive of ABI.

South Australia is the only jurisdiction to positively include ABI within its sentencing legislation. Its courts have the discretion to dismiss charges or find a defendant with a “mental impairment” guilty of an offence without

conviction or penalty, provided that the offender: suffers from a mental impairment that explains and extenuates the offending conduct; has completed or is satisfactorily participating in an intervention program; recognises their mental impairment and is making a conscientious attempt to overcome behavioural problems associated with it; and that their release would not represent an unacceptable risk to the safety of a particular person or the community. Its *Criminal Law (Sentencing) Act* defines “mental impairment as an impaired intellectual or mental function resulting from mental illness, an intellectual disability, a personality disorder, or a brain injury or neurological disorder (including dementia).”¹⁸⁸ Blake Dawson notes: “the requirement that such people complete satisfactory intervention programs could also benefit people with ABI. Specifically, supervised behaviour management, or supervised access to support services, may assist in addressing many of the symptoms that people with ABI face. The difficulty, however, is that people with ABI often have permanent disablements which may require ongoing management. While a shorter term program may benefit the person with ABI for the duration of the program, once completed, the benefits may not be fully realised as ongoing support is required.”¹⁸⁹ The ready availability of such “intervention programs” notwithstanding, Blake Dawson concludes: “the broad range of sentencing options available in South Australia may offer the most appropriate model for dealing with people with ABI in sentencing.”¹⁹⁰ **Overall, “while the recognition of mental illness and cognitive impairment as a mitigating factor at common law extends to people with ABI, the lack of knowledge of ABI in the criminal justice system as means that it is uncertain that a person’s ABI would be appropriately identified and addressed.”¹⁹¹**

▪ “Therapeutic jurisprudence”

“For many years judges, lawyers and justice system officials have been aware in individual cases of how the legal process impacts upon the wellbeing of those involved - such as where a judge allows a witness a short adjournment to collect herself after a difficult time in the witness box or where a lawyer settles a case on the client’s instructions as the client can no longer stand the stress of litigation. But the approach was piecemeal. Until recently there has been no general theory concerning the impact of legal processes upon participant wellbeing and its implications for attaining justice system objectives. This gap has been filled by therapeutic jurisprudence.”¹⁹² Programs of diversion along such therapeutic lines are available in all States and Territories. However, “not all jurisdictions provide diversion that is specific to or appropriate for people with ABI.”¹⁹³

Australia’s three specialist mental health tribunals do not extend their eligibility criteria to include ABI. To qualify for diversion to Queensland’s Mental Health Court, a person with ABI would also have to demonstrate either a mental illness or an intellectual disability, the former of which the *Mental Health Act* defines as “a condition characterised by a clinically significant disturbance of thought, mood, perception or memory”.¹⁹⁴ Offenders with an ABI may be eligible for Tasmania’s Mental Health Diversion Program if they have a concurrent mental illness. But they become ineligible if they wish to rely on the defences of unfitness to be tried or mental impairment. Like Victoria’s Assessment and Referral Court List, referred to below, participation in the program is conditional upon the offender’s admission of guilt. While offenders with an ABI, but without a concurrent mental illness, will be ineligible for the Australian Capital Territory’s Mental Health Tribunal, they may qualify under the Tribunal’s provisions relating to “mental dysfunction...a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion”.¹⁹⁵ In the Northern Territory, “there are currently no diversion programs that specifically target people with cognitive impairment.”¹⁹⁶ Offenders with an alcohol or other drug-related ABI may be diverted for treatment and rehabilitation through the Alcohol Court or CREDIT [Court Referral and Evaluation for Drug Intervention and Treatment] program for illicit drug users, but the Northern Territory Government was unable to provide “any data related to ABI. There is only anecdotal information.”¹⁹⁷ While offenders with an ABI are “not excluded per se” from the Alcohol Court, “we do not assess clients for ABI...This is an area we have identified as an unmet need.”¹⁹⁸ It is similarly unclear whether adult offenders with an ABI are eligible for behaviour management under Western Australia’s Intellectual Disability Diversion Program – a joint initiative between the Department of Justice and the Disability Services Commission. Eligibility criteria include “adults with other intellectual impairment” alongside intellectual disability. Like Tasmania’s Mental Health Diversion Program and Victoria’s Assessment and Referral Court List, referred to above, entry to the Program depends on the offender’s intent to plead guilty.

Similar to New South Wales' Community Justice Program, described below, the Intellectual Disability Diversion Program only extends to offenders whose disability occurred before the age of 18, although "the strict definition of intellectual disability recently adopted by the Commission, has not been adopted by the [Program] and it retains a broader and more flexible assessment for eligibility. For example, those who acquire a brain injury in adulthood may still be eligible to participate in the program — although priority will generally be given to those whose disability is manifest prior to the age of 18."¹⁹⁹ **An age cut-off of 18 years to a range of services and supports described throughout this paper further restricts access for people with an ABI, where the overwhelmingly majority of these injuries occur in adult life. Thirty per cent of hospitalisations for TBI during 2004-2005 involved people aged between 18 and 34 years, alone.²⁰⁰ The median age for stroke in Australia is 80 years. While data for the age of onset of alcohol and other drug-related ABI is unavailable, it would be safe to assume that disability is confined mostly to adults.**

To qualify for diversion under the provisions of New South Wales *Mental Health (Forensic Provisions) Act 1990*, the defendant needs to be: developmentally disabled; "suffering from mental illness"; or "suffering from a mental condition for which treatment is available in a mental health facility."²⁰¹ While a person with an ABI could be considered to have a "mental condition" - "a condition of disability of mind not including either mental illness or developmental disability of mind" - for the purposes of the *Act*, it is "unlikely to be a condition for which treatment is available in a mental health facility. Hence most people with ABI will fall outside the only provision for diversion from the criminal justice system on the basis of mental illness or cognitive impairment in the New South Wales local courts."²⁰² This is amply demonstrated by **data obtained by Brain Injury Australia from the New South Wales Department of Justice and Attorney General. While 56 out of the 702 offenders diverted from four local courts over a three-year period under the *Mental Health (Forensic Provisions) Act* had an ABI, only 6 "had an ABI only". The remainder also demonstrated a "psychiatric", intellectual or "other cognitive" disability.²⁰³ Overall, a "small percentage"²⁰⁴ of defendants appearing before local courts in New South Wales were dealt with under the diversionary provisions of the *Act*; only 3,941 (1.6%) of the 241,896 charges finalised during 2007.**

In its submission to the New South Wales Law Reform Commission's review of the criminal law and procedure applying to people with "cognitive and mental health impairments",²⁰⁵ NSW Health – the agency responsible for the administration of the "treatment" determined under the diversionary provisions of the *Act* – "supports a separate defence of cognitive impairment which would provide a clear recognition of the circumstances and needs of people with developmental disability, intellectual disability, brain injury and dementia when they interact with the criminal justice system... However, further consideration is required as to the processes that will follow if a person is found not guilty by reason of cognitive impairment. Will such a person be liable for detention following a finding of not guilty by reason of cognitive impairment and if so, where will they be detained and for how long will they be detained?"²⁰⁶ In its submission to the same review, Corrective Services NSW not only supports the replacement of "mental condition" in the *Act* with a "more general term such as 'cognitive impairment'"²⁰⁷ but also argues that the "use of the term 'developmentally disabled...essentially limits the use of the provisions of the *Act* to those individuals who have a disability that was evident prior to the age of eighteen years. The restrictive nature of this term excludes individuals with a brain injury that was acquired in adulthood or low cognitive functioning that did not present until after the developmental period. The age of onset in these cases is not indicative of the impact the condition has on the individual and therefore should not be a cause to deny an individual access to diversionary measures where there is clearly a need for an alternative method of disposal of a matter that will more appropriately address the needs of the individual."²⁰⁸ The New South Wales Law Reform Commission suggests "if a person's criminal responsibility is seriously impaired because of a reduced cognitive functioning, it should not make him or her any more or less deserving of a diversionary order depending on whether he or she was born with a cognitive impairment, or it developed before adulthood, or it resulted from injury or illness in his or her adult years."²⁰⁹

Diversion for people with an ABI may be available through either the Criminal Justice Diversion Program or the Special Circumstances List operated by the Magistrates' Court of Victoria. The Court has also recently initiated an Assessment and Referral Court List, inclusive of offenders with an ABI. A magistrate may adjourn proceedings for a period of up to 12 months to enable offenders to participate in a program of "appropriate health, welfare and disability services that are tailored to their particular needs."²¹⁰ To be eligible for the List, the accused "must admit responsibility for the offence"²¹¹ and has "not been charged with a criminal offence that does not involve serious violence or serious sexual assault".²¹² Even though the list is being piloted until 2013 and is only available in certain courts and to a limited number of participants, Blake Dawson found it "sets a good example for other jurisdictions; however it remains only a part of the holistic, communitywide support that people with ABI and other cognitive impairments require."²¹³

R e c o m m e n d a t i o n 3 :

Brain Injury Australia recommends that the Australian Government make both a reference to the Australia Law Reform Commission and representations to the Standing Committee of Attorneys-General to investigate uniform model legislation - in bail, “fitness to plead”, the defence of mental impairment, sentencing, and “therapeutic jurisprudence” – that is genuinely inclusive of people with an ABI. This will serve to fulfill both the Australian Government's obligations as a State Party to Article 13 (“Access to justice”) of the UNCRPD and COAG's commitment under “Policy Direction 5” of the National Disability Strategy; to “more effective responses from the criminal justice system to people with disability who have complex needs or heightened vulnerabilities”.

10. “OFFENDER REHABILITATION”

“The typical non-head-injured offender is subjugated to incarceration and criminal rehabilitation. The head-injured individual may also need incarceration and criminal rehabilitation; however, subjecting these people to incarceration and criminal rehabilitation without giving them cognitive rehabilitation is unjust and cruel.”²¹⁴

Apart from that operated by Corrections Victoria at Port Phillip Prison, “there are no programs that are designed to identify and provide in-prison rehabilitation to ABI prisoners. By default, prisoners with such severe ABI that they demonstrate symptoms of major mental illness may get mental health services, although such services are inappropriate for managing ABI.”²¹⁵ Just as with access to diversion, detailed above, people with an ABI may only become eligible for programs of offender rehabilitation if they can demonstrate a concurrent mental illness or intellectual disability, “although such services are inappropriate for managing ABI. For instance, medication may be offered to people who reveal impulsive and agitated behaviour, without regard to the cause of that behaviour.”²¹⁶ Even where an ABI is self-reported or identified by staff, corrective services agencies rarely retain that participant information since it is unrelated to program eligibility. And since none “screen or formally assess for ABI”²¹⁷ program outcomes measures (where taken) that may be relevant to the disability are not available.

For prisoners with an ABI in Western Australia who may also be eligible for the Department of Corrective Services’ “Intellectual Disability Diversion Program”, its “Legal and Social Awareness”, “Sex Offender with Intellectual Disability” or “Building on Aboriginal Skills” programs, or the “Transitional Accommodation and Support Service” which “provides pre- and post-release services for offenders with a cognitive disability”, the Department “does not have a systematic way of identifying the outcome or effectiveness of program interventions or service provision for prisoners with an ABI.”²¹⁸ Even where efficacy or outcomes measures may be available, they are inaccessible to many corrective services agencies because an external agency or another government department delivers the programs. In South Australia, “prisoners and offenders with disabilities can be referred to the Management Assessment Panel (MAP) for consideration of additional resources and services.”²¹⁹ But because the Panel is “managed through an external agency, the Exceptional Needs Unit (ENU)”, the Department for Correctional Services “does not evaluate the Panel”²²⁰ for purposes of measuring, for example, reductions in re-offending and re-incarceration for participants. Since Victoria’s “Cognitive Skills” and “Violence Intervention” programs were moved to the Department of Human Services, Corrections Victoria “does not have...information” about their accessibility or outcomes for prisoners with an ABI.

Brain Injury Australia has been able to obtain additional information about prisoners with an ABI from Corrective Services NSW. Between 2000 and 2011, its Statewide Disability Services received 1348 referrals “for offenders thought to have an ABI or dementia.”²²¹ Fifty-eight per cent had their “ABI/ TBI confirmed”, only 49% were “assessed – no impairment” and 465 are “not yet assessed.”²²² “The number of referrals does not reflect those people who have had a lifetime history of head injury, but rather predominantly reveals those offenders who appear to have difficulty adjusting to a correctional environment and have been referred...as staff are concerned about issues of vulnerability.”²²³

In December 2009, Corrective Services NSW introduced the “Acquired Brain Injury Questionnaire”, used to “screen offenders referred for head injury.”²²⁴ Most of the 138 respondents reported multiple head injuries, 86% from assaults, 80% from motor vehicle accidents, 62% from falls, 61% from “alcohol blackouts”, 33% from overdoses and 30% from suicide attempts. Seventy-five per cent of respondents reported “41 or less” head injuries, 50% “17 or less”. Notwithstanding that the “Acquired Brain Injury Questionnaire” screens solely for “head injury”, alongside much higher rates of multiple head injuries combined with longer periods of loss of consciousness, they also reported much higher rates of “symptoms following acquired brain injury” than the 2009 NSW Inmate Health Survey’s sample, referred to above. Fifty-six per cent of respondents to the “Acquired Brain Injury Questionnaire” reported “personality change” compared to 6% of those who completed the Inmate Health Survey. Seventy-five per cent reported problems with “impulsivity”, 62% with “anger management” and 50% with “understanding other people’s behaviour”.²²⁵

As with every other state and territory, New South Wales does not offer “programs specifically for offenders with acquired brain injury...Where possible, offenders are placed in mainstream programs.”²²⁶ Prisoners with an ABI who are “unable to participate in mainstream programs may be eligible to complete programs that have been adapted for people with disability.” Corrective Services NSW runs these “adapted” programs from four Additional Support Units located within two of the state’s prisons. Program content includes “emotional regulation” and “self-regulation”, the latter aiming to address “offending behaviours that are related to sexual offending.”²²⁷ Sixteen prisoners with an ABI attended the Units’ programs in 2009-2010. Even though the Units “have been in place in one form or another since around 2000”, Corrective Services NSW could not provide “any outcome figures from programs. There are pre- and post- test[sic] that indicate specific learning related to the programs has taken place, but it is much too soon to provide any recidivism data.”²²⁸ Almost 60 per cent of offenders in New South Wales convicted in 1994 were reconvicted within 15 years. Significantly, in relation to TBI, assault had the second highest rate of “reconviction for the same offence” after “traffic and vehicle regulatory offences”.²²⁹

Ageing, Disability and Home Care – now a division of NSW’s Department of Family and Community Services – provides a Community Justice Program “of accommodation and support services for people with intellectual disability exiting the criminal justice system.” The division’s 2008-2009 Annual Report stated “early analysis shows a reduction of over 60 per cent in re-offending” in program participants. The “analysis was done based on re-incarceration recorded in Police Records relying on an analysis of file information.”²³⁰ As with the overwhelming majority of offender rehabilitation programs that target offenders with an intellectual disability or mental illness, “no clients have entered the [Community Justice Program] based on having an ABI without a concurrent [intellectual disability]...In fact, anecdotally I suspect many have received significant head trauma...With respect to exploring the number who have a concurrent ABI, unfortunately we do not collect this data.”²³¹ Eligibility for the Program is determined by conformity to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition’s (DSM-IV) definition of “mental retardation”; “an [Intelligence Quotient] below 70 with 2 adaptive functioning deficits.”²³² **On that basis, the Community Justice Program would be inaccessible to 40% of the 756 offenders who had their “ABI/ TBI confirmed” by Corrective Services NSW’s Statewide Disability Services, above, but also recorded a “Full Scale IQ” of over 80 points. The eligibility of the further 31% who had their “ABI/ TBI confirmed”, but scored in the “Borderline Range” – between 70 and 80 points – would also be in doubt. Moreover, conformity to the DSM-IV’s definition includes an age cut-off; “whilst some of our clients may have developed their intellectual disability through head trauma, this would have occurred before age 18. Thus, from a diagnostic point of view, they would be considered as having an Intellectual Disability and not an ABI.”²³³**

Brain Injury Australia asked Justice Health in New South Wales whether juvenile detainees were questioned about histories of head injury or other ABI as part of either its “initial risk assessment” or “further comprehensive assessment”, what information it retained from the responses, and how many detainees had been referred for further (neuropsychological) assessment as a result. Brain Injury Australia also asked whether – and how many - detainees with a history of head injury or other ABI had accessed services provided by Justice Health’s “Adolescent Community and Court Team”, “Community Integration Teams” or “Adolescent Community Justice Health Services” and, if so, what efficacy or outcomes measures were used.

Even though Justice Health has conducted two surveys of young people in custody that found more than one-third reported histories of one or more head injuries with loss of consciousness, and commissioned research into young people on community orders that returned even higher rates of head injury (41%, see above) and funded a study that found “head injuries increase disinhibition of aggressive impulses...which raises the risk of severe violence within an offence pattern,”²³⁴ after 17 years of operation, it “is not in a position to provide a response to [Brain Injury Australia’s] individual questions”.²³⁵ It does, however, “provide a holistic range of health and interventions to all individuals in the custodial environment”.²³⁶ Research from NSW’s Bureau of Crime Statistics and Research, referred to above, found almost 80 per cent of juvenile offenders convicted in 1994 were reconvicted within 15 years. Significantly in relation to TBI, assault had the second highest rate of “reconviction for the same offence” after “theft and related offences”.²³⁷

R e c o m m e n d a t i o n 4 :

Brain Injury Australia recommends that the Australian Government direct the National Corrections Advisory Group and the National Forensic Disability Working Group to formulate both a nationally consistent definition of, as well as disability-specific and disability-relevant performance indicators for, offence-related programs. This will serve to fulfill both the Australian Government's obligations as a State Party to Article 31 ("Statistics and data collection") of the UNCRPD as well as COAG's commitment to "good data" under the National Disability Strategy.

Brain Injury Australia is less concerned here about arbitrary hair-splitting around program eligibility than governments’ strict adherence to diagnoses in determining access to services. Such an adherence is quaint, at best, when the reform agenda in disability focuses on assessments of eligibility based primarily on need. Brain Injury Australia understands that Australian governments are currently considering a draft “National Crime Prevention Framework”. The Framework should include “offence-related programs” and in keeping with “Policy Direction 5” of the National Disability Strategy – “more effective responses from the criminal justice system to people with disability who have complex needs or heightened vulnerabilities” – access to such programs should be regardless of disability type, external cause or age. Brain Injury Australia is bewildered that, after 16 years, the Council of Australian Governments-commissioned *Report on Government Services* – an annual “measure...[of] data on the equity, efficiency and cost effectiveness of government services” – has yet to arrive at a definition of “offence-related programs”. The programs are “an indicator of governments’ objective of providing program interventions to reduce the risk of re-offending including providing offence related programs that address criminogenic behaviour and, for prisoners released from custody, maximising their prospects for successful reintegration as law-abiding citizens into the community.”²³⁸ Without a definition, “data for this indicator were not available” either, inclusive of “equity, access...for people under the responsibility of corrective services”, which “has[sic] been identified as a key area for development in future reports.”²³⁹ The “development of meaningful and nationally comparable indicators...to bring together data on offence-related programs from eight quite separate jurisdictions to produce nationally comparable data is no easy matter.” Besides, “data systems that would support a performance indicator have not yet been established in any jurisdiction.”²⁴⁰ Outcome measures as broad as recidivism rates for offenders with the ABI are perhaps even further away, while “no jurisdiction systematically tests and/or identifies prisoners/offenders with acquired brain injury in their databases.”²⁴¹ In the meantime, Brain Injury Australia is disappointed that a large Criminology Research Council consultancy examining “adult offender treatment... identifying those programs that have been shown to work” did not “specifically focus on this high needs group.”²⁴²

When pressed to explain the void of services and supports specific to the needs of offenders with an ABI, many contributors to this paper wrote of “therapeutic nihilism”²⁴³ - a “nothing works [with ABI]” attitude among staff of adult corrections and juvenile justice, that prisoners with an ABI are “‘too hard’ a client group”²⁴⁴. This paper demonstrates not only that very little has been tried (to conclude “nothing works”) but also that what services and supports are available target intellectual disability and mental illness. There is no lack of evidence for the efficacy of offence-related programs generally.

A recent “review of systematic reviews” of the “hundreds of experimental and quasi-experimental studies of correctional interventions” found “every meta-analysis of large samples of studies comparing offenders who receive rehabilitation treatment with those who do not has found lower mean recidivism for those in the treatment groups. Moreover, the least of those mean reductions is greater than the largest mean reductions reported by any meta-analysis of sanctions [fines, incarceration, intensive supervision, drug testing, electronic monitoring etc.] In addition, nearly all the meta-analyses of studies of specific rehabilitation treatments or approaches [multisystemic therapy, cognitive-behavioural therapy, alcohol and other drug treatment etc.] show mean recidivism reductions, and the great majority of those are greater than the largest reductions found in any meta-analysis of sanctions.”²⁴⁵ The authors conclude **“the greatest obstacle to using rehabilitation treatment effectively to reduce criminal behaviour is not a nothing-works research literature with nothing to offer but, rather, a correctional system that does not use the research available and has no history of doing so.”**²⁴⁶

“The rehabilitation perspective embodies an assumption that the correctional system is expected to do more than exact just deserts from those who have harmed others - it is expected to reduce crime and foster public safety. To achieve this goal, correctional programs must reduce the potential for the offenders under their charge to reoffend when they are released from supervision or custody...At present, much of what is done within corrections is not based on sound evidence but, rather, on custom, bureaucratic convenience, and political ideology with results that have [been] called ‘correctional quackery’.”²⁴⁷

The nihilists, referred to above, may argue that *any* intervention with rehabilitative intent is likely to reduce recidivism more than doing nothing and ask for positive evidence for behavioural interventions specifically for offenders with an ABI. Over the last six years, Canada’s “Evidence-Based Review of moderate to severe Acquired Brain Injury” (ERABI) has examined over 28,000 titles in the ABI research literature. It found evidence of positive effects on behaviour post-ABI (importantly, after randomised controlled trials²⁴⁸) from courses in anger management, a cognitive behavioural therapy-based “coping skills group”,²⁴⁹ and from “Natural Setting Behaviour Management”.²⁵⁰ A Cochrane Review of four randomised interventions for aggressive behaviour in people with learning difficulties found “there is some evidence that behavioural and cognitive behavioural treatments are efficacious on their own in the long-term management of outwardly-directed aggression...[They] are relatively resource-intensive but it can be argued that they are preferable to the use of antipsychotic drugs which have significant side-effects.”²⁵¹ A recent systematic review of 65 studies involving 172 experimental participants found “traditional contingency management procedures and positive behaviour support procedures can be said to be evidence-based treatment options”²⁵² for behaviour disorders after TBI. “Contingency management procedures” involve rearranging the environment to reinforce appropriate behavioural patterns while providing negative reinforcement for inappropriate behaviours. “Positive behaviour support” - sometimes referred to as “positive behavioural interventions and supports” - emerged from the controversies surrounding the use of aversive (punishing) consequences with people with developmental disabilities and “challenging behaviour” - “an approach that blends values about the rights of people with disabilities with a practical science about how learning and behaviour change occur.”²⁵³ Positive behaviour support programs involving offenders in the United States and United Kingdom²⁵⁴ have not only demonstrated long-term behavioural change that is sustainable post-release but have also proven cost-effective. During 1996-1997, the New York State Neurobehavioural Resource Project “cost [US]\$144,000 and resulted in savings of \$1,486,000 (based on conservative calculations by external New York State Health Department auditors.”²⁵⁵

Brain Injury Australia notes that prisoners are “excluded”²⁵⁶ from health services funded under Medicare. Responsibility for the provision – and payment – of prisoners’ healthcare rests with the state or territory in which they are incarcerated. “Disentitlement to community-based comprehensive insurance schemes impacts on access to tertiary care, and the seeking of ‘second’ opinions. Disentitlement to health insurance places additional burdens on prisoners’ families.”²⁵⁷ A number of contributors to the paper pointed out “the health cost of prisoners is a significant burden for the...taxpayer at a time when the state government is curtailing expenditure in the public sector.”²⁵⁸ **This can result in corrective services pursuing prisoner screening narrowly focused on “acute medical concerns”²⁵⁹ ignoring chronic - and more costly - concerns relating to, for example, a prisoner’s history of ABI. “Once in the penal system there are few mechanisms to ‘catch’ these individuals...I have to make the presumption that politically, at least, brain injury is perhaps just not very appealing or palatable, especially when the offence committed involves violence”.**²⁶⁰ The costs of crime, in 2005 terms, were estimated at just under \$36 billion per annum. Assault – both the most common cause of ABI in prisoners and their most common offence – accounted for \$1.4 billion.²⁶¹ Australian governments spent \$2.8 billion on corrective services during 2009-2010, equivalent to \$207 per prisoner per day.²⁶²

R e c o m m e n d a t i o n 5 :

Brain Injury Australia recommends that the Australian Government and COAG - through the CDSMC, the Corrective Services Administrators' Council and Australasian Juvenile Justice Administrators - ensure that eligibility and access to offence-related programs are based primarily on need, and without regard to disability type, external cause or age. This will serve to fulfill both the Australian Government's obligations as a State Party to Article 13 ("Access to justice") of the UNCRPD and COAG's commitment under "Policy Direction 5" of the National Disability Strategy; to "more effective responses from the criminal justice system to people with disability who have complex needs or heightened vulnerabilities".

11. TRAINING:

"My name is Carl and I have a severe ABI. Can you tell me how I can have a notice card or some publication noting I have an ABI? Reason is I was walking in a shopping district and police stopped me and thought I was drunk, but I was just tired and stumbling at times. Thank you."²⁶³

Article 13 of the United Nations Convention on the Rights of Persons with Disabilities includes a commitment from "States Parties" to "promote appropriate training for those working in the field of administration of justice, including police and prison staff...in order to help to ensure effective access to justice for persons with disabilities". As part of the preparation of this paper, Brain Injury Australia approached state and territory police forces and corrective services to ascertain what disability awareness-related training they offered and whether it was inclusive of ABI. **Where training in ABI was available, it was patchy and inconsistent. Some jurisdictions offered training in disability only to trainee, and not serving, police and corrections officers. Most relied on internal staff to deliver the training. None was able to specify the source information on which any training in ABI is based.** Some training seemed ambitious. Western Australia's Department of Corrective Services provides "specific disability awareness training to help [all new prison officers] identify and manage prisoners with intellectual impairment". The "one hour session" includes: "explanation of the causal effects - result of accident, assault, birth defects[sic] and drug abuse"; "impact of the injury/impairment on the person - learning disabilities, cognitive recognition[sic] etc."; "dealing with persons in the workplace"; and "covers the course programs adapted for persons affected - Sex Offenders Program, Anger Management, Life Skills and others".²⁶⁴

"...I have been told by a very reliable source that prison officers scoffed at training in Asperger's syndrome and gave a young inmate with the disorder 'a good flogging' to teach him appropriate behaviour."²⁶⁵

Of all jurisdictions, the training available to Victoria Police and Corrections Victoria staff appears to be the most evolved. Over the last year, partly utilising the preliminary results from the Arbias/ La Trobe University research it commissioned, referred to above, Corrections Victoria has delivered 18 half-day training sessions in ABI to 540 prison and community corrections staff.²⁶⁶ Victoria Police's "Mental Health Strategy" in "providing policing services to people with, or affected by, mental disorders" - with "less apparent...conditions..such as with autism or acquired brain injury" - provides training to both "recruits and probationary constables" as well as "operational members".²⁶⁷ The former group receives training from; Victoria Police "law instructors on identifying mental illness, relevant legislation, policy and procedures" and a "mental health professional on clinical recognition of mental illness, communication and risk management of situations". After graduating, probationary constables receive additional training from Victoria's Office of the Public Advocate, from "disability services" and "mental health professionals".²⁶⁸ "Supplementary notes" provided with the training "describe mental illness, intellectual disability, acquired brain injury, and dementia." A two-day "Operational Safety Tactics Training" for "operational members" has included a "four-hour mental health module" comprising "scenarios, presentations by expert, role playing, advice on communication strategies and information sources".²⁶⁹

"Offenders with impaired cognitive function tend to plead guilty on the advice of inexperienced Legal Aid lawyers who are ignorant of medical and/or psychological factors that might be relevant to the offending behaviour. Therefore the court accepts the guilty plea and hands out a sentence."²⁷⁰

Brain Injury Australia interprets the “including” from Article 13 of the UNCRPD (“promote appropriate training for those working in the field of administration of justice, *including* police and prison staff”) as intending to capture a workforce at all points between first contact with law enforcement and corrections, such as court staff, legal officers, magistrates and judges. Indeed “Policy Direction 3” of COAG’s National Disability Strategy - “People with disability have access to justice” - states “greater awareness is needed by the judiciary, legal professionals and court staff of disability issues.” Brain Injury Australia has been unable to examine what training on ABI might be included in the continuing professional development of legal officers through, for example, the Australasian Institute of Judicial Administration, the Law Council of Australia or the various state and territory legal aid commissions, bar associations and law societies. But, as with this paper’s reflections on screening for ABI and on diversion, Brain Injury Australia notes the following contribution in regards to training: “it’s critical, but only if downstream services exist. I would currently not want our staff trained, as it would only result in more highly frustrated clinicians who would watch their ABI clients back step into ever-increasing restrictions and management, through lack of specialist services and be powerless to stop it and the resulting decline in their clients’ mental health.”²⁷¹

Brain Injury Australia and its Member Organisations share the UNCRPD’s commitment to training in the criminal justice system. We agree with COAG that the criminal justice system needs “greater awareness” of disability. However, raising disability awareness also raises expectations that disability services and supports will be available to match. Australian governments’ reporting on *training* to both/ either of the NDS and UN CRPD cannot be decoupled from the provision of the additional disability services necessary to respond to increased awareness. In a context of generally low levels of community awareness about ABI, Brain Injury Australia and its Member Organisations would be concerned to ensure that all information contained in training is accurate and current. For the purposes of the reporting requirements of both the NDS and UN CRPD, Brain Injury Australia and its Member Organisations are best placed not only to verify that information but to supply training in ABI as well.

R e c o m m e n d a t i o n 6 :

Brain Injury Australia recommends that the Australian Government and COAG - through the CDSMC and in consultation with Brain Injury Australia and its Member Organisations – develop and deliver a nationally consistent curriculum of training in ABI for all criminal justice system personnel. This will serve to fulfill the Australian Government’s obligations as a State Party to Article 13 (“Access to justice”) of the UNCRPD, specifically to “promote appropriate training for those working in the field of administration of justice, including police and prison staff”.

12. POSTSCRIPT

“The Australian penal system, with a 2-year recidivism rate of about 40%, and about half of prisoners having been previously imprisoned, is failing. Prisoner health must be seen to encompass both inmates and those recently released. It should be seen to include justice issues that influence health: is the quantum of punishment appropriate; are there alternatives to incarceration; are rehabilitation and education programs available? Programs that smooth the reintegration of prisoners into society are urgently required.”²⁷²

In 2008, Brain Injury Australia asked Corrections Victoria to “sponsor” an agenda item on the needs of prisoners with an ABI to be placed on that November’s meeting of the Corrective Services Administrators’ Council (CSAC) working group (comprising the heads of corrective service agencies in each jurisdiction and the officers in charge of community-based corrective services). Corrections Victoria’s briefing paper included the following “draft resolutions”; “that state and territory jurisdictions share research findings conducted on offenders with an ABI” and “that a National working party, including correctional jurisdictions, ABI service providers, stakeholders and advocacy services be convened to inform both day-to-day management of offenders and differentiated rehabilitation responses.” Neither resolution was adopted but the CSAC resolved to “maintain a watching brief over the needs of prisoners in this group.”²⁷³ The CSAC has not communicated with Brain Injury Australia since that meeting.

ENDNOTES:

¹ “Disabled Justice: The barriers to justice for persons with disability in Queensland”, Foreword by Kevin Cocks, Director Queensland Advocacy Incorporated, Phillip French, Disability Studies and Research Institute for Queensland Advocacy Incorporated, May 2007, p.3 Cf. Victoria’s “Disability Act 2006 also establishes special sentencing provisions for people with an intellectual disability involved in the criminal justice system. For example, once an adult with an intellectual disability has been found guilty of an offence, the Court may use the Sentencing Act 1991, Part 3, Division 6: Special conditions for intellectually disabled offenders, which offers the court additional sentencing options for people with an intellectual disability, specifically, a plan of available services. (DHS, 2007 p29; DHS, 2006). An example of a targeted intervention is provided by the Australian Community Support Organisation (ACSO) who amongst other services provide a problematic sexual behaviour program for persons over 12 years who have an intellectual disability and are at risk of committing or have committed sex offences. VCASP [Victorian Coalition of ABI Service Providers] contends that at a minimum people with an ABI who are involved in the criminal justice system in Victoria should have access to a comparable system to that which currently exists for intellectual disability, and argues that this requisite of legislative and policy reform is central to the rights of people with ABI and to any future success in reducing numbers of people with ABI involved in the criminal justice system. VCASP suggests that this system should be configured in recognition of the following evidence and principles.”, VCASP Criminal Justice Sub-Committee, Marc Paradin (VCASP Policy Officer) Kerry Stringer (VCASP Chairperson) , p.4

² Corrections Victoria’s Joint Treatment Program at Port Phillip Prison. Brain Injury Australia acknowledges that Corrections Victoria has a range of other programs that may be suitable for offenders with an ABI in “pilot” or “adapted” phase: a “cognitive skills program in Community Correctional Services aimed at offenders with a cognitive impairment”; “development of transitional accommodation and support options to assist the transition and integration of prisoners with a cognitive impairment into the community”; an “ABI Correctional Service Model in the North West Region, for offenders and prisoners with an ABI”; a “drug and alcohol program to offenders on community-based orders with a cognitive impairment”; “implementation of a central contact point for case management information on ABI offenders entering the prison system”; and “development and implementation of a long-term evaluation framework to assess the impact of disability-specific correctional services on prisoners with a cognitive disability.” Personal communication email Peter Persson, Manager, Disability Policy, Corrections Victoria

³ United Nations Convention on the Rights of Persons with Disabilities, Article 13 (“Access to Justice”)

⁴ Participation restrictions are “problems an individual may experience in involvement in life situations” such as attending school or participating in recreation. (Australian Bureau of Statistics’ 2003 Survey of Disability, Ageing and Carers)

⁵ Australian Institute of Health and Welfare (AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE), Children with disabilities in Australia, Canberra, 2004, Bulletin 55 and Disability Updates: Children with Disabilities (Bulletin no.42), Australian Institute of Health and Welfare, Canberra, 2006

⁶ “Survey of Disability, Ageing and Carers”, Australian Bureau of Statistics, 2009.

⁷ The Australian, online edition, April 19 2009.

⁸ The use of ABI here, rather than TBI alone, is deliberate. There is strong evidence that stroke – the largest “subgroup” of ABI – also tracks social disadvantage. A recent Medical Journal of Australia study pooled data from over 3,000 stroke patients from Perth, Melbourne and Auckland, New Zealand. “The crude annual stroke incidence rate was higher among patients from the most deprived areas...compared with those from the least deprived areas...Overall, the age-standardised incidence rate per 100 000 person-years was 70% higher...among the most deprived group compared with the least deprived group.”, “Socioeconomic disparities in stroke rates and outcome: pooled analysis of stroke incidence studies in Australia and New Zealand” Emma L Heeley et al., Medical Journal of Australia, 2011; 195 (1), p. 10-14

⁹ Michael McCrea, “Mild Traumatic Brain Injury and Postconcussion Syndrome: The New Evidence Base for Diagnosis and Treatment, Oxford Workshop Series: American Academy of Clinical Neuropsychology, 2007” quoted in “Prevalence of traumatic brain injury in incarcerated groups compared to the general population: A meta-analysis”, Thomas Farrer, Dawson Hedges, Progress in Neuro-Psychopharmacology & Biological Psychiatry 35, 2011, p. 390–39

¹⁰ “Each State and Territory has provided us with detailed information on more twenty different variables that are relevant to the measurement of social disadvantage. This information has been combined with data more readily available from the Australian Bureau of Statistics....This research investigation [was] completed by Emeritus Professor Tony Vinson on behalf of Jesuit Social Services and Catholic Social Services Australia.” <http://www.australiandisadvantage.org.au/>

¹¹ “This may be due to a higher concentration of disadvantaged persons in rural areas, where average travelling speeds may be greater.” The Level of Disadvantage of Lifetime Care Scheme Participants, Report by Victor Korabelnikoff, Scheme Performance Branch, June 2011, p. 4

¹² Cited in “Counting the cost: estimating the number of deaths among recently released prisoners in Australia”, Stuart A Kinner et al., Medical Journal of Australia 2011, 195, p. 64–68

¹³ Prevalence refers to the frequency with which a certain medical condition or disability is found in specific population at a specific time. It helps to show the extent and importance of a problem, such as the load it may place on health or other government service systems.

¹⁴ “Prevalence of Traumatic Brain Injury in an Offender Population: A Meta-Analysis”, Eric J. Shiroma et al., Journal of Correctional Health Care, 2010, 16, p. 148

¹⁵ Ibid., p.148

¹⁶ “World Prison Brief”, International Centre for Prison Studies, London, US prison population, total (including pre-trial detainees/remand prisoners) 2,292,133 at 31.12.2009 (U.S. Bureau of Justice Statistics)

¹⁷ Prison population total, UK; England and Wales (including pre-trial detainees/remand prisoners); 84,922 at 1.4.2011 (national prison administration - not including juveniles in Secure Training Centres and Local Authority Secure Children’s Homes) Prison population total (Northern Ireland, including pre-trial detainees/remand prisoners); 1,615 at 28.3.2011. Prison population total (Scotland)(including pre-trial detainees / remand prisoners) 7,968 at 1.4.2011 (national prison administration)

¹⁸ Prison population total (including pre-trial detainees / remand prisoners) 29,700 at 30.6.2010 (Australian Bureau of Statistics) Prison population total (NZ) (including pre-trial detainees / remand prisoners) 8,892

at 8.10.2010 (chairman of Parole Board

¹⁹ Farrer and Hedges, op.cit., p.391

²⁰ Ibid., p.392

²¹ "Traumatic brain injury rates and sequelae: A comparison of prisoners with a matched community sample in Australia", Iain Perkes et al., *Brain Injury*, February 2011; 25(2), p. 131–141

²² *Ibid.*, p.140

²³ Personal communication email Lynne Wilkinson, Executive Officer National Corrections Advisory Group. "Corrections Victoria (CV) uses a screen - Victorian Intervention Screening Assessment Tool (VISAT) - which has a range of questions that provide information about the possibility of acquired brain injury. Whilst CV has commenced a service response as described above, how this information can be used systematically requires further consideration." Personal communication email Peter Persson, Manager, Disability Policy, Corrections Victoria

²⁴ "Information on individuals with borderline intellectual impairment (an IQ between 70 and 80) is not routinely collected. Therefore, estimates of the prevalence of intellectual disability using custodial databases are likely to underestimate the burden of disability among prisoners...The reception assessment typically includes questions on previous and current conditions and illnesses, current medications, drug and alcohol use, a brief mental health screen and a risk assessment screen. A physical examination, which may include blood and urine tests, is also conducted. Basic demographic information is recorded and may be collected during the reception assessment or copied from custodial databases. Given the amount of information collected at reception, and the fact that this information is routinely collected on all prison entrants, the reception assessment has the potential to offer a great deal of useful information on the health of people who enter prisons...However, in most jurisdictions this data is collected manually and is not stored in an electronic format (the Northern Territory is the only jurisdiction that uses an electronic reception form, although Western Australia plans to implement an electronic form in 2007). Therefore, while reception assessments collect a great deal of valuable information at the individual clinical level, the information remains relatively inaccessible. An additional hurdle is the lack of uniformity and consistency in the way data are gathered.", Belcher J and Al-Yaman F, "Prisoner health in Australia: contemporary information collection and a way forward.", Australian Institute of Health and Welfare, p.24.

²⁵ *Ibid.*, p.14. Injury "unspecified". "Recent" is undefined in the Australian Institute of Health And Welfare's report. At the time of the report, ACT had no adult prison, but two remand and one periodic detention centre.

²⁶ "The Health of Australia's Prisoners 2009", Australian Institute of Health and Welfare, Canberra, 2010, p.33

²⁷ "Confusion exists regarding head injury...and TBI. HI is a non-specific and antiquated term, which includes clinically evident external injuries to the face, scalp, and calvarium, such as lacerations, contusions, abrasions, and fractures, and may or may not be associated with TBI. TBI injury is more properly defined as an alteration in brain function manifest as confusion, altered level of consciousness, seizure, coma, or focal sensory or motor neurologic deficit resulting from blunt or penetrating force to the head. In mild TBI, subtle behavioural and neuropsychological changes may be the only symptom(s)" (Bruns & Hauser 2003). Quoted in Helps Y, Henley G & Harrison JE, "Hospital separations due to traumatic brain injury, Australia 2004–05", Adelaide, Australian Institute of Health and Welfare, p. 2

²⁸ Indig, D et al., "2009 NSW Inmate Health Survey: Key Findings Report", Justice Health, Sydney, 2010, p.16

²⁹ *Ibid.*, p.64

³⁰ Cassidy, J.D. et al. "Incidence, Risk Factors and Prevention of Mild Traumatic Brain Injury: Results of the WHO Collaborating Centre Task Force on Mild Traumatic Brain Injury", *Journal of Rehabilitation Medicine*, 2004, 43, p. 28-60. Cf. "It is estimated that 70%–85% of all traumatic brain injuries fall into the mild category. While they rarely require inpatient rehabilitation, patients commonly report cognitive and behavioural changes from which they recover within 3–6 months; 10%–15% remain symptomatic in the longer term with a persisting post-concussion syndrome: physical complaints including headache, cervical pain, vestibular symptoms; changes in taste and hearing; difficulty with attention and memory; and irritability, insomnia and sleeping difficulties. Interpersonal relationships and work may also be affected. This large group of people with TBI can face many years of impairment, possibly affecting health, education, occupation, and social and emotional functioning. Treatment involves patient and family education, reassurance and psychological support."

³¹ "Practice Essentials Rehabilitation Medicine 4: Rehabilitation after traumatic brain injury", Fary Khan, Ian Baguley and Ian Cameron, *Medical Journal of Australia*, 2003, 178, p.293

³² Indig et al. *op.cit.*, p.66

³³ *Ibid.*, p.66 "These rates of persistent sequelae are lower than those reported in a study of 200 men entering the NSW criminal justice system in 2003 and 2004 (Schofield et al., 2006), among whom 82% reported a history of head injury, 79% of which involved a loss of consciousness. Among participants who had experienced a head injury, 52% reported unresolved consequences of that injury, including 45% who continued to suffer neurological effects, 32% who still experienced psychological symptoms, and 17% who reported ongoing social sequelae."

³⁴ *Ibid.*, p. 63

³⁵ NSW Bureau of Crime Statistics and Research Contemporary Issues in Crime and Justice Number 107 March 2007 The relationship between head injury and violent offending in juvenile detainees Dianna T Kenny and C J Lennings, The University of Sydney, p.11.

³⁶ "The incidence, causes, and secular trends of head trauma in Olmsted County, Minnesota, 1935–1974", John F. Annegers et al., *Neurology*, 1980, Vol. 30, No. 9, p.912-919

³⁷ *Ibid.*, p.64

³⁸ Indig et al., *op.cit.*, p. 65

³⁹ *Ibid.*, p.66

⁴⁰ *Ibid.*, p.63

⁴¹ NSW Inmate Health Survey: Key Findings Report. Justice Health. Sydney, p.16

⁴² "The Health of Australia's Prisoners 2009", Canberra, Australian Institute of Health and Welfare 2010, p.53

⁴³ "The World Health Organization's Alcohol Use Disorders Identification Test was used to assess the risk posed by IHS participants' self-reported alcohol consumption in the year prior to their current imprisonment. The AUDIT categorises alcohol consumption into 'safe,' 'hazardous' and 'harmful' levels, using a cut-off score of 8 to identify hazardous drinking, 16 to identify harmful drinking and 20 to identify dependent drinking.", "NSW Inmate Health Survey: Key Findings Report", Justice Health. Sydney, p.16

⁴⁴ "Acquired Brain Injury in the Victorian Prison System", Martin Jackson, La Trobe University, Glen Hardy, arbias Ltd, Corrections Victoria, Department of Justice, Corrections Research Paper Series Paper No. 04, April 2011, p. 8

⁴⁵ *Ibid.*, p.6; "Applying the ABI prevalence rate identified in the current study to the Victorian prison population as a whole indicates that, as at 30 June 2010, approximately 1,774 male prisoners and 103 female prisoners potentially had an ABI (106 and seven of whom respectively were likely to have a severe ABI)." p. 25 cf. The Victorian Prisoner Health Study (2003), found

that 66 per cent of male prisoners and 41 per cent of female prisoners, had experienced a head injury resulting in unconsciousness. Of these, 41 per cent of women and 23 per cent of men reported ongoing side effects, such as memory loss, poor concentration and personality change.” Victorian Prisoner Health Survey, February 2003

⁴⁶ *Ibid.*, p.6

⁴⁷ *Ibid.*, p.6

⁴⁸ Perhaps surprisingly, women reported greater numbers of assaults (23.3% versus 15.6%) and motor vehicle accidents (17.4% versus 10.1%) than men. “Of significance is the near total lack of reporting of TBI as a single risk factor/trigger in male prisoners (only eight per cent) compared to female prisoners who reported TBI as a single trigger for ABI in 45 per cent of cases. This finding highlights that when TBI is identified as a risk factor for ABI for male prisoners it is usually in conjunction with another risk factor.”, *ibid.*, p.15

⁴⁹ *Ibid.*, p.12

⁵⁰ French, *op.cit.*, p.101

⁵¹ “People with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System: Impact of Acquired Brain Injury”, Report prepared for Brain Injury Australia and the Brain Injury Association of New South Wales, Leanne Dowse, Melissa Clarence, Eileen Baldry, Julian Trofimovs and Sharleen James, April 2011

⁵² Inmates can be separated from the mainstream prison population by either “segregation” or “protection”. Generally, an inmate is held in segregation to protect others from the inmate. The aim of protective custody is to protect the inmate from other inmates.

⁵³ Dowse et al, *op.cit.*, p.40. “Interestingly self-harm is one of the few parameters which occurs at significantly higher rates in those with an mental health issue combined with ABI, rather than an [Borderline Intellectual Disability/Intellectual Disability].”

⁵⁴ A type of systematic bias which occurs when the way a survey respondent answers a question is affected not just by the correct answer, but also by the respondent’s memory.

⁵⁵ Indig et al., *op.cit.*, p.64

⁵⁶ *Ibid.*, p.45, 46

⁵⁷ *Ibid.*, p.65

⁵⁸ Butler, T at al., “The 2004 Australian prison entrant’s blood-borne virus and risk behaviour survey”, Australian and New Zealand Journal of Public Health, 31, 2007, 44-50.

⁵⁹ The Report on Government Services, 2010-2011, Productivity Commission, Table 8A.14

⁶⁰ Personal communication email Dr. Astrid Birgden

⁶¹ A variety of ABI screening have been developed, or are under development, by Corrective Services NSW, NSW Legal Aid, Corrections Victoria/ arbias/ La Trobe University, QLD Corrective Services.

⁶² Corrections Victoria, *op.cit.*, p.21

⁶³ “The Approach to Performance Measurement”, Productivity Commission, n.d.

⁶⁴ Personal communication email Professor Tony Butler.

⁶⁵ “Prisoner health in Australia: contemporary information collection and a way forward”, (introduction by Professor Ted Wilkes), Belcher J and Al-Yaman F, Australian Institute of Health and Welfare, Canberra, 2007, p.vii

⁶⁶ “Prisoners in Australia, 2010”, Australian Bureau of Statistics, Canberra, 2011

⁶⁷ Taylor, N, “Juveniles in detention in Australia, 1981-2007”, Australian Institute of Criminology Monitoring Reports No. 5, 2011

⁶⁸ “Hospitalisation for head injury due to assault among Indigenous and non-Indigenous Australians, July 1999-June 2005”, Lisa M Jamieson, James E. Harrison and Jesia G. Berry, Medical Journal of Australia, Volume 188, Number 10, 19 May 2008

⁶⁹ Indig D, McEntyre E, Page J and Ross B., “2009 NSW Inmate Health Survey: Aboriginal Health Report.” Justice Health, Sydney, 2011

⁷⁰ “Psychological and cognitive assessment of Indigenous Australians”, Kylie Dingwall, Sheree Cairney, Australian and New Zealand Journal of Psychiatry, 2010, 44, p.22

⁷¹ “Juvenile justice in Australia 2008–09”, Australian Institute of Health and Welfare, Canberra, 2011, p. 9

⁷² *Ibid.*, p.9

⁷³ *Ibid.*, p.4

⁷⁴ “These figures include estimates from Western Australia and the Northern Territory, who did not supply Juvenile Justice National Minimum Data Set data to the Australian Institute of Health and Welfare’s report.”, “Juvenile justice in Australia 2008–09”, Australian Institute of Health and Welfare, Canberra, 2011

⁷⁵ “Prisoners in Australia, 2010”, Australian Bureau of Statistics, Canberra, 2011

⁷⁶ “Between 1995 and 2006, the rate of recorded assault rose by almost 50 per cent. Rates of aggravated assault increased by 46 percent - 41% for males and 61% for females. Rates of non-aggravated assault rates rose by only seven percent - 3% for males and 19% for females. (Aggravated assault refers to an assault involving any of the following aggravating circumstances: causing serious bodily injury; carried out in company; carried out using a weapon; carried out with the intent of preventing apprehension or committing a felony; or committed with the intent to recklessly endanger life or cause injury. Non-aggravated assault refers to an assault not involving any of these aggravating circumstances, above.”, “Trends in violent crime”, Samantha Bricknell (Trends and Issues in Crime and Criminal Justice, no. 359), Canberra, Australian Institute of Criminology, June 2008.)

⁷⁷ Indig, D et al., “2009 NSW Young People in Custody Health Survey: Full Report”, Justice Health and Juvenile Justice, Sydney, 2011, p.77-78.

⁷⁸ Kenny, D.T. and Nelson, P. K., “Young Offenders on Community Orders: Health, Welfare and Criminogenic Needs”. Sydney, Australia: Sydney University Press, 2008, ch.5, p.20

⁷⁹ Australian Institute of Health and Welfare 2011, *op.cit.*, p.1

⁸⁰ Indig et al., *op.cit.*, p.130

⁸¹ *Ibid.*, p.129

⁸² Kenny et al., *op.cit.*, ch. 8, p. 15

⁸³ Indig et al., *op.cit.*, p.134

⁸⁴ Personal communication email Richard Balfour

⁸⁵ Available via; www.braininjuryaustralia.org.au

⁸⁶ “Australian hospital statistics 2006–07”, Australian Institute of Health and Welfare, Canberra, 2008

⁸⁷ Data from Network Management, NSW Health’s Brain Injury Rehabilitation Directorate.

⁸⁸ *Ibid.*, p.159

⁸⁹ *Ibid.*, p.157

- ⁹⁰ Kenny et al., *op.cit.*, p. 7.7
- ⁹¹ Personal communication email Vicki Johnson
- ⁹² “Early Head Injury And Attention-Deficit/Hyperactivity Disorder: Retrospective Cohort Study”, Heather T Keenan et al., *British Medical Journal*, 2008, 337, p.1
- ⁹³ “Premorbid Prevalence of ADHD and Development of Secondary ADHD after Closed Head Injury”, Gerring J.P. et al., *Journal American Academy of Child and Adolescent Psychiatry*, 1998, p. 647-54, “Child and Adolescent Traumatic Brain Injury: Correlates of Injury Severity”, Max JE et al., *Brain Injury*, 1998, p. 31-40
- ⁹⁴ “Behavioural interventions for children and adults with behaviour disorders after TBI: A systematic review of the evidence”, Mark Ylvisaker, *Brain Injury*, 2007, Vol. 21, No. 8, p.769, 770.
- ⁹⁵ Headway Ireland, “Challenging Behaviour following an Acquired Brain Injury”
- ⁹⁶ Dikmen et al. “One year psychosocial outcome in head injury”, *Journal of the International Neuropsychological Society*, 1995, 1, p. 67-77 and Dikmen et al. “Psychosocial outcome in patients with moderate to severe head injury: 2-year follow-up”, *Brain Injury*, 1993, Vol. 7, No. 2, p. 113-124
- ⁹⁷ Challenging Behaviours Project: Prevalence, course, comorbidity and burden Brain Injury Rehabilitation Directorate Report Agency for Clinical Innovation, NSW Health, July 2010, p.1
- ⁹⁸ *Ibid.*, p.viii
- ⁹⁹ *Ibid.*, p.11
- ¹⁰⁰ *Ibid.*, p.18
- ¹⁰¹ *Ibid.*, p.18
- ¹⁰² Ylvisaker et al., *op.cit.*, p. 771
- ¹⁰³ “Long-Term Outcomes After Traumatic Brain Injury: Following Up A Consecutive Series at 20-26 Years Post-Trauma Final Report to Motor Accidents Authority Of New South Wales”, R Tate et al., p.25
- ¹⁰⁴ Personal communication email with Mark Sabaz, Brain Injury Rehabilitation Directorate
- ¹⁰⁵ Brain Injury Rehabilitation Directorate, *op.cit.*, p. ix
- ¹⁰⁶ *Ibid.*, p.ix, x
- ¹⁰⁷ *Ibid.*, p.99-101
- ¹⁰⁸ Dowse et al., *op.cit.*, p.40
- ¹⁰⁹ Defined as “patients discharged from non-federal South Carolinas EDs [emergency departments] or hospitals with a TBI-related ICD-9-CM [International Classification of Diseases, 9th edition, Clinical Modifications] code”.
- ¹¹⁰ “Association of Medically Attended Traumatic Brain Injury and In-Prison Behavioural Infractions: A Statewide Longitudinal Study”, Eric Shiroma et al., *Journal of Offender Rehabilitation*, v22 n3-4, 2010, p11-19
- ¹¹¹ Personal communication email Vidula Garde
- ¹¹² Dowse et al., *op.cit.*, p.28
- ¹¹³ Personal communication email Vicki Johnson
- ¹¹⁴ Dowse et al., *op.cit.*, p.30. Offences were classified under the Australian Standard Offence Classification (ASOC) index.
- ¹¹⁵ “Sex Offending as a Psychosocial Sequela of Traumatic Brain Injury”, Simpson, Grahame et al., *Journal of Head Trauma Rehabilitation*, December 1999, Volume 14, Issue 6, p. 567–580. It studied 445 clients at a brain injury rehabilitation centre and found 29 (6.5%) had committed sexual offenses after the brain injury. The offenses involved mainly touching, followed by exhibiting and sexual aggression. In the absence of prior sexual offense history and alcohol abuse in the majority of cases, the authors concluded that the traumatic brain injury may have been a significant etiological factor underlying the sexual offenses. They further concluded that sexual offenses are a significant problem in a minority of traumatic brain injured clients. Cf. Langevin, R. (2006). Sexual offenses and traumatic brain injury. *Brain and Cognition*, 60, 206-207.
- ¹¹⁶ Indig et al., *op.cit.*, p.151
- ¹¹⁷ The frontal lobe is located directly behind the forehead and in front of the parietal lobes and above and in front of the temporal lobes.
- ¹¹⁸ The limbic system includes brain structures such as the hippocampus, amygdala, anterior thalamic nuclei, septum, limbic cortex and fornix. It supports a variety of functions including emotion, behaviour, long term memory, and the sense of smell.
- ¹¹⁹ Ylvisaker et al., *op.cit.*, p.151
- ¹²⁰ “Frontal lobe injuries, violence, and aggression: a report of the Vietnam Head Injury Study”, Grafman J et al., *Neurology*. 1996 May;46(5):1231-8. “As well-matched as the control group was VHIS given the amount of thought and work went into the study, for example, did not report on prior history of aggression, substance misuse, stability of employment, socioeconomic status, the presence of psychiatric symptoms or disorders other than depression, or criminal charges or other legal involvement. Without such data, it remains unclear how much of the increases in aggressive behaviour found can be specifically attributed to focal frontal lobe injury.”
- ¹²¹ “Neuropsychiatry of frontal lobe dysfunction in violent and criminal behaviour: a critical review”, *Journal of Neurology Neurosurgery and Psychiatry*, Brower MC, Price BH, 2001, p.722
- ¹²² “Neurological disorders and violence: a systematic review and meta-analysis with a focus on epilepsy and traumatic brain injury” Seena Fazel et al., *Journal of Neurology*, p.3
- ¹²³ Timonen M, Miettunen J, Hakko H, et al. The association of preceding traumatic brain injury with mental disorders, alcoholism and criminality: the Northern Finland 1966 Birth Cohort Study. *Psychiatry Research* 2002;;113:217-226
- ¹²⁴ “Self-reported traumatic brain injury in male young offenders: A risk factor for re-offending, poor mental health and violence?”, W. Huw Williams et al., *Neuropsychological Rehabilitation*, November 2010, p.8
- ¹²⁵ McKinlay A., Horwood, L.J., Fergusson, D., MacFarlane, M., “Are children who experience Traumatic Brain Injury more likely to engage in criminal behaviour during their adult lives?”, conference presentation, Australian Society for the Study of Brain Injury, 5-7 May, (Abstract) *Brain Impairment*, 2010.
- ¹²⁶ Personal communication email Audrey McKinlay.
- ¹²⁷ “Blows to the head during development can predispose to violent criminal behaviour: rehabilitation of consequences of head injury is a measure for crime prevention”, Jose Leon-Carrion and Francisco Javier Chacartegui Ramos, *Brain Injury* 2003, Vol. 17, No. 3 : Pages 207-216
- ¹²⁸ “The relationship between head injury and violent offending in juvenile detainees”, Dianna T Kenny and C J Lennings, NSW Bureau of Crime Statistics and Research - Contemporary Issues in Crime and Justice Number 107, March 2007, p.11
- ¹²⁹ *Ibid.*, p.1

¹³⁰ *Ibid.*, p.12

¹³¹ "Violence on the Brain: A Critique of Neuroscience In Criminal Law", Amanda C. Pustilnik, Wake Forest Law Review, Vol. 44 2009, p.188

¹³² The Evidence-Based Review of moderate to severe Acquired Brain Injury (ERABI) – "a joint project involving researchers in London, Ottawa and Toronto, Ontario, Canada...summarized over 28,000 titles and 7,000 abstracts for more careful assessment." It includes a section; "Challenging Behaviours Pharmacological Treatments for Agitation and Aggression". Australian researchers have conducted a trial using selective serotonin reuptake inhibitor (SSRI) anti-depressants to reduce impulsivity. "Reducing impulsivity in repeat violent offenders: an open label trial of a selective serotonin reuptake inhibitor", Tony Butler et al., Australian and New Zealand Journal of Psychiatry, 2010, 44, p. 1137 – 1143; "...The link between serotonergic dysfunction and impulsive-aggression has prompted researchers to speculate that: '...an inverse relationship between central serotonergic system function and impulsive-aggressive behaviour has been accumulating for several decades...We observed a 35% decrease in impulsivity between baseline and the three-month follow-up according to the Barratt Impulsivity Scale. Whether or not such a change would translate into a reduction in offending over a sustained period needs to be examined by an adequately powered randomised control trial with a placebo group." (p. 1141)

¹³³ "Criminogenic needs include antisocial attitudes and peer associations, lack of self-control and self-management skills, drug dependencies, and other such malleable characteristics associated with criminal offense rates." "The Effectiveness of Correctional Rehabilitation: A Review of Systematic Reviews," Mark Lipsey and Francis Cullen, *The Annual Review of Law and Social Science*, 2007, p.310

¹³⁴ "Major syndromes of aggressive behaviour following head injury: An introduction to evaluation and Treatment", Laurence Miller, *Cognitive Rehabilitation*, vol. 8, 1990, p.16

¹³⁵ Kenny and Lennings, *op.cit.*, p. 7 (Anger was measured on the Adolescent Psychopathology Scale.)

¹³⁶ Raine A, Brennan PA, Farrington DP, Mednick SA, editors. "Biosocial Bases of violence", New York, Plenum", 1997. (The additive model is based on the observation that the presence of both neurological problems and adverse family environments is a better predictor of violence than either alone.)

¹³⁷ Susman, E.J. and Finkelstein, J.W., "Biology, development and dangerousness", in G-F. Pinar and L. Pagani (Eds), *Clinical Assessment of Dangerousness: Empirical Contributions*, Cambridge University Press, New York, 2007, pp. 22-46.

¹³⁸ "2010–2020 National Disability Strategy: An initiative of the Council of Australian Governments", p.20

¹³⁹ Yylvisaker et al., *op.cit.*, p. 771

¹⁴⁰ Brooks N et al. "The five year outcome of severe blunt head injury: a relative's view", *Journal of Neurology Neurosurgery and Psychiatry*, 1986, 49, 7, p. 764–70.

¹⁴¹ Indig et al., *op.cit.*, p.64

¹⁴² 2010–2020 National Disability Strategy An initiative of the Council of Australian Governments, p.20

¹⁴³ NSW Law Reform Commission, "Consultation Paper 7 (2010) - People with cognitive and mental health impairments in the criminal justice system: diversion", p.5

¹⁴⁴ "Memorandum: People With Acquired Brain Injury Facing Criminal Charges in the Lower Courts In Australia", Blake Dawson, February 2011, p.3

¹⁴⁵ Australian Bureau of Statistics, *Information on Criminal Courts Australia 2008-2009*, Criminal Courts, Australia

¹⁴⁶ Blake Dawson, *op.cit.*, p.48

¹⁴⁷ *Ibid.*, p.7

¹⁴⁸ "No police departments reported that they collect information related to cognitive disability or mental health status of either victims or offenders.", *Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues*, Australian Human Rights Commission, Sydney, March 2008, p.77

¹⁴⁹ *Ibid.*, p.9

¹⁵⁰ Bail Act, 1978; S32 [1] "Criteria to be considered in bail applications"

¹⁵¹ Blake Dawson, *op.cit.*, p.12

¹⁵² Bail Act (NT) s 24(1)(b)(iv).

¹⁵³ Report on Government Services 2011, Productivity Commission

¹⁵⁴ Personal communication email Rosemary O'Reilly-Martinez, Court Clinician, Court Support Services, Department of Justice, Darwin; "We are not to comment on all of [Department of Justice]. In the Court Diversions Programs we do not collect any data related to ABI. There is only anecdotal information."

¹⁵⁵ Blake Dawson, *op.cit.*, p.11

¹⁵⁶ "Acquired brain injury and the justice system: Victoria Legal Aid's observations of clients' experiences", personal communication email

¹⁵⁷ Blake Dawson, *op.cit.*, p. 26

¹⁵⁸ Special hearings "vary between jurisdictions: 2.2 Where a defendant is found to be unfit to stand trial, and likely to remain so for a period of 12 months or more,¹ the court must conduct a special hearing to determine whether or not, on the limited evidence available, the defendant committed the offence charged.² The prosecution must prove the accused person's guilt beyond reasonable doubt,³ and the hearing must be conducted as nearly as possible as if it were a trial of criminal proceedings.⁴ The defendant must be represented by a legal practitioner unless the court otherwise allows." Blake Dawson, *op.cit.*, p.5

2.3 "At the special hearing, the defendant is presumed to have pleaded not guilty.⁶ He or she is entitled to give evidence⁷ and "may raise any defence that could be properly raised if the special hearing were an ordinary trial of criminal proceedings." *Ibid.* p.28

¹⁵⁹ See, for example, Crimes (Mental Impairment and Unfitness To Be Tried) Act 1997 (Vic), ss 18, 23; Criminal Code Act (NT) s 43X. Blake Dawson, *op.cit.*, p. 26,27

¹⁶⁰ "Mental Health (Forensic Provisions) Act 1990", Section 16 – "Functions of Tribunal on referral after inquiry"

¹⁶¹ Personal communication email NSW Chapter of the Australian and New Zealand Association of Psychiatry, Psychology and Law (ANZAPPL),

¹⁶² *Ibid.*

¹⁶³ "Mental Health (Forensic Provisions) Act 1990", Section 24 – "Consequences of nomination of limiting term"

¹⁶⁴ *Ibid.*

¹⁶⁵ ANZAPPL, *op.cit.*

¹⁶⁶ Personal communication email Linda Steele

¹⁶⁷ Personal communication email ex Patrick McGee, Coordinator, Aboriginal Disability Justice Campaign

¹⁶⁸ "ADJC is currently composed of a broad range of individuals and agencies, including Northern Australian Aboriginal Justice Association; Central Australian Aboriginal Justice Association; Darwin Community Legal Centre; People with Disabilities Australia; Aboriginal Disability Network; Maurice Blackburn Legal Firm of Melbourne; Blake Dawson Legal Firm of Sydney; Brain Injury Australia; Synapse of Queensland; National Council of Intellectual Disability; the Alice Springs office of the Northern Territory Public Guardian; and Northern Territory Council of Social Services.", *ibid.*

¹⁶⁹ Australian Bureau of Statistics, "Prisoners in Australia, 2010"

¹⁷⁰ *ibid.*

¹⁷¹ "Secure Care Services Fact sheet – May 2011, accessed via www.health.nt.gov.au on 17 May, 2011

¹⁷² Personal communication email Patrick McGee, Coordinator, Aboriginal Disability Justice Campaign

¹⁷³ Transcript ABC TV Lateline, 18 April 2011

¹⁷⁴ *ibid.*

¹⁷⁵ Personal communication email Vidula Garde

¹⁷⁶ Personal communication email Nicole Lucas, Brain Injury Association of New South Wales

¹⁷⁷ Personal communication email Patrick McGee

¹⁷⁸ Blake Dawson, *op.cit.*, p.13

¹⁷⁹ Blake Dawson notes in regards to the Northern Territory: "The defence is complicated by various parallel provisions of the Mental Health and Related Services Act 1998 (NT), which are relevant to an accused with a mental impairment. These provisions relate to mental impairments arising out of mental illness or mental disturbance. People with ABI are explicitly excluded from the definition of mental illness in this Act as the relevant provisions of this particular statute state that "a person is not considered to have a mental illness merely because he or she...has acquired brain damage". The express exclusion of ABI from the definition of mental illness, while being accurate from a definitional point of view, is unfortunate from a policy perspective. Because of this exclusion, a person with ABI will also need to demonstrate some form of mental illness or mental disturbance to be eligible for the following mechanisms. However, these mechanisms might still be of relevance to many people with ABI, as people with ABI often also suffer from other mental impairments such as mental illness." *ibid.*, p.23

¹⁸⁰ Blake Dawson, *op.cit.*, p.18/19

¹⁸¹ Mental Health Act 2007 (NSW) s 4(1)

¹⁸² Blake Dawson, *op.cit.*, p. 24

¹⁸³ *ibid.*, p.14

¹⁸⁴ *ibid.*, p.14

¹⁸⁵ *ibid.*, p.35

¹⁸⁶ Crimes (Sentencing Procedure) Act 1999 (NSW), s 21A(3)

¹⁸⁷ Sentencing Act 1995 (NT), s 5(2)(e) and (f)

¹⁸⁸ Criminal Law (Sentencing) Act 1988 (SA), s 19C(5)

¹⁸⁹ Blake Dawson, *op.cit.*, p.33

¹⁹⁰ *ibid.*, p.36

¹⁹¹ *ibid.*, p.30

¹⁹² "The Concept of Therapeutic Jurisprudence", Australasian Therapeutic Jurisprudence Clearinghouse <http://www.aija.org.au/research/australasian-therapeutic-jurisprudence-clearinghouse.html>

¹⁹³ Blake Dawson, *op.cit.*, p.37

¹⁹⁴ Mental Health Act 2000 (Qld), s 12

¹⁹⁵ Mental Health (Treatment and Care) Act 1994 (ACT), s 3

¹⁹⁶ Jennifer Devlin, Judy Clisby, Submission: Senate Select Committee on Mental Health (2005) Community Visitor Program at 28 January 2011. Cited in Blake Dawson, *op.cit.*, p.46

¹⁹⁷ Personal communication email Rosemary O'Reilly-Martinez, Court Clinician, Court Support Services, The Department of Justice, Northern Territory Government, Darwin.

¹⁹⁸ *ibid.*

¹⁹⁹ 'Equality before the Law Bench Book', quoted in personal communication e-mail from Dani Connolly, A/Senior Policy Officer (Justice), Disability Services Commission Western Australia

²⁰⁰ Personal communication email Geoff Henley, Research Associate, Australian Institute of Health and Welfare National Injury Surveillance Unit, Research Centre for Injury Studies, Flinders University. ("This includes "primary" cases - where the Principal Diagnosis is an intracranial injury - "secondary" cases - where the Principal Diagnosis code is for another injury – and "other" case - where the Principal Diagnosis code does not include an injury code, but where S06 appears as an Additional Diagnosis code.")

²⁰¹ Mental Health Act 2007 (NSW)

²⁰² Blake Dawson, *op.cit.*, p.45

²⁰³ Personal communication email Jenna Macnab, NSW Department of Justice and Attorney General

²⁰⁴ NSW Law Reform Commission: Consultation Paper 5 (2010) - People with cognitive and mental health impairments in the criminal justice system: an overview, p.47

²⁰⁵ NSW Health submission to the NSW Law Reform Commission's review of the criminal law and procedure applying to people with cognitive and mental health impairments, p.6

²⁰⁶ *ibid.*, p.6

²⁰⁷ Corrective Services NSW submission to the NSW Law Reform Commission's review of the criminal law and procedure applying to people with cognitive and mental health impairments, p.24

²⁰⁸ *ibid.*, p.6

²⁰⁹ New South Wales Law Reform Commission Consultation Paper 7 (2010) "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion", p.27

²¹⁰ "Assessment and Referral Court (ARC) List", Magistrates' Court of Victoria, April 2010

²¹¹ Criminal Procedure Act 2009 (Vic).

²¹² Magistrates' Court of Victoria, *op.cit.*

²¹³ Blake Dawson, *op.cit.*, p.47

²¹⁴ "The role of head injury in cognitive functioning, emotional adjustment and criminal behaviour", Michael Sarapata et al. Brain Injury, 1998, Vol. 12, No. 10, p.835

- ²¹⁵ Personal communication email with Dr. Chris Lennings. Brain Injury Australia notes that, partly in response to the findings of the arbias/ La Trobe research, that Corrections Victoria has employed an “acquired brain injury clinician” as part of an “eighteen-month pilot”(Personal communication email Jo Famularo, Corrections Victoria).
- ²¹⁶ Ibid.
- ²¹⁷ Personal communication email with Jackie Tang, Deputy Commissioner, Offender Management and Professional Development, Department of Corrective Services, Western Australia
- ²¹⁸ Ibid.
- ²¹⁹ Department For Correctional Services Annual Report 2009-2010, p.45
- ²²⁰ Personal communication email from Dr. Anne Marie Martin, Executive Director, Offender Development Department for Correctional Services
- ²²¹ Personal communication email Dr. Phillip Snoyman, A/Principal Officer Disabilities, Statewide Disability Services
- ²²² Ibid.
- ²²³ Ibid.
- ²²⁴ Ibid.
- ²²⁵ Ibid.
- ²²⁶ Ibid.
- ²²⁷ Ibid.
- ²²⁸ Ibid.
- ²²⁹ “Re-offending in NSW”, Jessie Holmes, NSW Bureau of Crime Statistics and Research Bureau Brief, Issue paper no. 56 February 2011, p.1
- ²³⁰ Personal communication email Matt Frize, Team Leader, Practice Development Community Justice Program, Office of the Senior Practitioner, Ageing, Disability & Home Care, NSW; “In the general offender population, the most common measures are risk assessment scales since offences and offenders are heterogeneous categories, meaning you need to examine a number of factors. Generally, services work towards addressing those changeable factors on such measures, with lower subsequent scores suggesting reduced risk and thus improved outcome.”
- ²³¹ Ibid.
- ²³² Ibid.
- ²³³ Ibid.
- ²³⁴ Kenny and Lennings, op.cit., p.25
- ²³⁵ 4 March, 2011 letter from Julie Babineau, Chief Executive, Justice Health.
- ²³⁶ Ibid.
- ²³⁷ “Re-offending in NSW”, Jessie Holmes, NSW Bureau of Crime Statistics and Research Bureau Brief, Issue paper no. 56 February 2011, p.1
- ²³⁸ Report on Government Services 2011, Productivity Commission, Canberra, 8:22
- ²³⁹ Ibid., 8:22
- ²⁴⁰ Personal communication email Lynne Wilkinson, Executive Officer National Corrections Advisory Group
- ²⁴¹ Ibid.
- ²⁴² Personal communication email Karen Heseltine
- ²⁴³ Personal communication email Dr. Olav Neilssen
- ²⁴⁴ Personal communication email Linda Steele
- ²⁴⁵ Lipsey and Cullen, op.cit., p.297, 314
- ²⁴⁶ Ibid., p.315
- ²⁴⁷ Lipsey and Cullen, op.cit., p.298
- ²⁴⁸ Study subjects, after assessment of eligibility and recruitment, but before the intervention to be studied begins, are randomly allocated to receive one or other of the alternative treatments under study. After randomization, the two (or more) groups of subjects are followed up in exactly the same way, and the only differences between the interventions they receive should be those intrinsic to the interventions being compared.
- ²⁴⁹ “Who benefits? Outcome following a coping skills group intervention for traumatically brain injured individuals”, Katie Anson and Jennie Ponsford, Brain Injury, 2006, Vol. 20, No. 1 , p. 1-13
- ²⁵⁰ “The Natural Setting Behaviour Management (NSBM) program is an education and intervention program delivered in the community to address the long-term needs of caregivers and persons with brain injury with significant behavioural dysfunction. The education module provides generic information about neurobehavioural problems and their relationship to brain injury as well as practical behaviour management strategies. In the intervention module, specific techniques in behavioural assessment and management are taught to caregivers and applied to their individual situation with maximal involvement of the person with brain injury. The overall goal is to promote generalizable skills in the caregiver systems that are associated with long-term maintenance of behavioural gains in the natural community environment.” A Natural Setting Behaviour Management Program for Persons With Acquired Brain Injury: A Randomized Controlled Trial, George J. Carnevale et al., Archives of Physical Medicine and Rehabilitation Vol 87, October 2006. Evidence-Based Review of Moderate to Severe Acquired Brain Injury, Volume 6, 2010
- ²⁵¹ “Behavioural and cognitive-behavioural interventions for outwardly-directed aggressive behaviour in people with learning disabilities (Review)”, Hassiotis AA, Hall I, The Cochrane Library, 2009, Issue 3, p.13. (“The Cochrane Collaboration, established in 1993, is an international network of more than 28,000 dedicated people from over 100 countries. We work together to help health care providers, policy makers, patients, their advocates and carers, make well-informed decisions about health care, based on the best available research evidence, by preparing, updating and promoting the accessibility of Cochrane Reviews – over 4,600 so far, published online in The Cochrane Library.”)
- ²⁵² Mark Ylvisaker et al. “Behavioural interventions for children and adults with behaviour disorders after TBI: A systematic review of the evidence,” Brain Injury, July 2007; 21(8), p. 769
- ²⁵³ Horner R.H. “Positive behaviour supports; Focus on Autism and Other Developmental Disabilities”, 2000, p.97
- ²⁵⁴ Personal communication email Dr Jonathan Rogers, St. Mary’s Hospital, St George Health Care Group, Cheshire. Dr. Rogers is Head of the Hospital’s Forensic Neurorehabilitation program.
- ²⁵⁵ “Reflections on Dobermanns, poodles, and social rehabilitation for difficult-to-serve individuals with traumatic brain injury”, Ylvisaker M, Feeney T, Aphasiology, 2000, 24, p.421

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- ²⁵⁶“Prisoner health care provision: Reflections from Australia”, Michael Levy, *International Journal of Prisoner Health*, March 2005, 1:1, p.68
- ²⁵⁷ *Ibid.*, p.68
- ²⁵⁸ Personal communication email Richard Balfour
- ²⁵⁹ Personal communication email Peter Marshall, Manager, Crisis Support Unit, ACT Corrective Services: “Simple answer to the screening that is done here, is that a few questions are asked by mental health staff in their induction interview, and by generalist nurses in their induction interview. But only to identify whether there are any current acute medical concerns (e.g. recent head injury, or longer term medical sequelae such as seizures). I don’t know why the mental health workers ask about head injuries, as they do nothing with the information. We are all well aware that people with ABI fall through the cracks, as they do not meet the criteria to be a client/consumer of ACT Mental Health, and nor do they meet the criteria to receive a service from the disability department, Disability ACT (unless the ABI occurred as a youngster and they therefore meet the criteria for Intellectual Disability).”
- ²⁶⁰ Personal communication email Dr Jonathan Rogers, *op.cit.*
- ²⁶¹ “Counting the costs of crime in Australia: a 2005 update”, Kiah Rollings, Research and Public Policy Series, No. 91, Australian Institute of Criminology.
- ²⁶² Productivity Commission, *op.cit.*
- ²⁶³ Personal communication email
- ²⁶⁴ Personal communication email with Jackie Tang, Deputy Commissioner, Offender Management and Professional Development, Department of Corrective Services, Western Australia
- ²⁶⁵ Personal communication Meg Perkins
- ²⁶⁶ Personal communication email Peter Persson, Manager, Disability Policy, Corrections Victoria
- ²⁶⁷ “Peace Of Mind: Providing policing services to people with, or affected by, mental disorders - Strategic Directions Paper”, Corporate Sponsor: Commander Ashley Dickinson, April 2007, p.16 “This definition [mental disorders] is intended to reflect the range of behaviours that police encounter (but are not expected to diagnose) and the range of disorders that affect people at any age (eg. children and adolescents, adults and older persons). The definition also encompasses standard legal, clinical and social definitions of mental illness and intellectual disability.” (p.2)
- ²⁶⁸ *Ibid.*, p.39
- ²⁶⁹ “The Victoria Police Mental Health Strategy; Now and Then”, Powerpoint, February 2011, slide 13
- ²⁷⁰ Personal communication email Meg Perkins
- ²⁷¹ Personal communication email Dr. Dion Gee, Senior Forensic Psychologist, Forensicare, Acute Assessment Unit (Melbourne Assessment Prison)
- ²⁷² “Why are prisoners dying after they’re released?”, Annette G Katelaris, *Medical Journal of Australia*, 2011, 195, p.59
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