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Brain injury and the criminal justice system
Workshop Report 2016

Prepared by:
NHMRC Centre of Research Excellence in Offender Health,
Kirby Institute, UNSW Australia and Brain Injury Australia

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Table of Contents

Executive Summary

This Workshop on people with a brain injury and the criminal justice system arose out an ongoing conversation between its three co-organisers – Nick Rushworth Tony Butler and Peter Schofield. It followed work in the New South Wales justice system examining the role of traumatic brain injury in offending behaviour, and recognising that this issue is often overlooked in the justice system. The Workshop brought together over one hundred local, national and international participants representing law enforcement, the judiciary, advocacy, consumers, and academia. The aim of the workshop was to identify areas requiring attention with regard to the identification and management of those with brain injury at all levels of the justice system, and develop an action plan to address these issues.

Participants identified eight main areas of interest using a deliberative methodology that involved all attendees. These were: the need to develop standardised screening questions for brain injury at first contact the criminal justice system; improving data quality and information systems to identify brain injury; law reform; educating criminal justice system stakeholders about brain injury; the need to develop different models for responding to people with brain injury; pathways for people with a brain injury; and developing a person-centred approach encompassing a community-based prison model.

Main actions arising from the Workshop included developing standardised screening questions for brain injury at first contact with the criminal justice system, establishment of a cross-sectoral working group to improve access to data on people with brain injuries, a review of relevant legislation to include brain injury, introduction of a diversion system for people with brain injury coming into contact with the criminal justice system for minor offences, brain injury education and awareness training for those involved in the criminal justice system, development of holistic support for those with a brain injury, and the development of a community-based prison model to assist in social integration and empowerment.

It is anticipated that this Report will act as a reference point for this important issue in Australia and lead agencies to respond to the recommendations. This will lead to best practice and a justice system that responds appropriately and humanely to those with

brain injury across all levels of the justice system ranging from the police who often have first contact with this group to those who enter the nation's correctional facilities. To assist in research translation, workshop attendees are encouraged to continue to engage with their newly established collaborations and to promote the outcomes and actions arising from the workshop among their extended networks.

Brain injury and the criminal justice system workshop report

1. Background

Traumatic brain injury is a significant public health problem which disproportionately affects subgroups of the population, such as those who come into contact with the criminal justice system, with as many as 80% of adult prisoners report a history of traumatic brain injury.[1] Evidence suggests that the consequences of brain injury for psychological and physical well-being, for thinking and behaviour, may increase the risk of offending. Notwithstanding these alarming statistics, brain injury and its related disabilities receive relatively little recognition in the criminal justice system. Nationally, there is no standardised process for screening of those who come into contact with the criminal justice system. In some Australian jurisdictions, screening for brain injury occurs on reception to prison. A brief overview of current screening reception screening processes can be found in Appendix One.

In light of this, a national workshop was held to discuss the interaction between people with a brain injury and the criminal justice system with the aim of identifying areas requiring attention with regard to the identification and management of those with acquired brain injury at all levels of the justice system, and develop an action plan to address these issues. This report provides an overview of this path-breaking workshop that was held with over 90 invited attendees from a wide variety of backgrounds, at the Kirby Institute, UNSW Australia in June 2016.

[1] Schofield et al. (2006). Traumatic brain injury among Australian prisoners: Rates, recurrence and sequelae. Brain Injury, 20, 499-506.

2. Workshop overview

On the 27th June 2016, the National Health and Medical Research Council Centre of Research Excellence in Offender Health and Brain Injury Australia, with the support of the NSW Lifetime Care and Support Scheme, hosted a one-day interactive national workshop devoted to discussing the interaction between people with a brain injury and the criminal justice system. This is the first time a national group has set out to discuss this important, but neglected issue.

The workshop was opened by Dr Mukesh Haikerwal, Director of Brain Injury Australia and former president of the Australian Medical Association. Prior to this, Professor Tony Butler, Program Head of the Justice Health Research Program and Chief Investigator of the CRE in Offender Health at the Kirby Institute conducted initial introductions and a Welcome to Country was performed by Dr Peter Yanada McKenzie, respected Elder of the La Perouse Community. The workshop was facilitated by Dr Stephen Mugford of Kinnford Consulting.

The open space workshop generated substantial interest from invited stakeholders and was attended by people from health, the judiciary, law, corrections, advocacy, and those with the lived experience of brain injury. A list of workshop attendees can be found in Appendix Two.

2.1 Workshop activities

The workshop was structured into three principal activities. The aim was to engage participants in a lively active workshop that would:

- Encourage the sharing of ideas and information;
- Promote networking and the building of ties; and
- Consider issues on which the group might be able to make recommendations or formulate plans for action.

The three activities are described in more detail below.

1. Opening "speed-geeking" session

The opening session used the 'speed-geeking' technique to share information and ideas from a number of experts in a conversational manner rather than a sequence of 'talking heads' as in a traditional plenary format. Workshop participants were divided into 10 groups whereby eight experts[2] moved in sequence through the table chain, spending seven minutes at each location (the two sessions without a 'geek' were devoted to further introduction/reflection discussions). This method was utilised to increase group engagement based on two separate principles: first, that attention spans are usually limited and frequently talking head presentations ignore this; second, that humans are 'wired' more for conversational attention than listening to speeches.[3]

At the event, this method appeared to be very effective: everyone had a chance, in a small group setting, to listen to a variety of short, expert presentations that offered views and information that might otherwise not have been available.

2. Interactive ideas generation exercise

This simple interactive rating exercise involved workshop participants writing onto an index card their answer to the following question:

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[2] 'Speed geeks':

1. Prof Lyn Turkstra (University of Wisconsin-Madison) – An introduction to brain injury.
2. Judge Hyman (Superior Court for the State of California, retired) – Brain injury and the law, therapeutic jurisprudence.
3. Prof Tony Butler (Kirby Institute, UNSW Australia) – Traumatic brain injury among prisoners.
4. A/Prof Peter Schofield – Traumatic brain injury and offending behaviour.
5. Doddy – A consumer's perspective.
6. Dr Susan van den Berg (NSW Department of Corrective Services) – Challenges and considerations for managing offenders with a brain injury.
7. Scott Avery (First Peoples Disability Network) – Indigenous specific challenges for offenders with a brain injury.
8. Tania Evers (Frederick Jordan Chambers) – A lawyer's perspective.

[3] Garrad, S and Pickering, M.J, (2004), "Why is conversation so easy?" Trends in Cognitive Sciences, 8, 8-11.

Given what you already know, and what you have heard today, (and recognising that this is still 'early days', of course), if you had to choose RIGHT NOW one, and only one, policy direction or idea for improving how we handle brain injury in the criminal justice system, what would you choose?

Participants were then asked to pair off, swap cards and together rate the idea on each of the cards they held, before swapping partners and repeating the exercise in a total of five rounds. There was a total of seven points available to be shared between each pair of ideas during each round (e.g. 4/3, 5/2). The maximum total score an idea could obtain is 35.

The exercise enabled ideas that received wide support to rise up the numeric rankings, while 'weaker' ideas drifted down. At the completion of the exercise, a plenary 'count-down' session in which the highly rated ideas were read out loud to the group. Following this, all cards were collected and the high scoring ideas were sorted and grouped thematically to determine the overall themes the group showed interested in and were supportive of.

On the day, this exercise created a considerable buzz both literally and figuratively.

3. Open space workshop activity

The open space activity formed the main component of the day. At the beginning of this session, workshop participants were invited to post large wall posters around the room advertising ideas for discussion group topics that they had formulated and were prepared to host. Once all ideas were posted, the facilitator assisted in consolidating similar topics, reducing the number of posters, and asked everyone to add their name to the remaining ideas to indicate their support for the topic. Topics which attracted only a small number of interested people were removed, and the remaining consolidated into seven core themes.

Those who successfully nominated topics were asked to take on three responsibilities:

a. To ensure the discussion was chaired and all voices heard. He or she was to delegate the role of the chair if there was a good chair candidate in the group who agreed to do this task;
b. To ensure the discussion points were scribed by a delegate. The scribe needed to provide some clear notes that could be written up and circulated to the broader group at the end of the day. Notes could be recorded electronically (e.g. on a laptop) to reduce transcription; and
c. To ensure that a simple method of reporting back to the larger group was created, for example a flipchart with a few key points or, if working electronically, a PowerPoint presentation with a few slides.

Each group was asked to consider the following: what is being proposed, when things are expected to happen, what will be done and how will it be done using what resources. At the conclusion of the discussion, each group reported back on what it had discussed and concluded.

3. Outputs and Outcomes

3.1 The interactive ideas generation exercise

Out of a possible score of 35, two ideas scored very highly at 27, while a third scored 24. The four top rated themes that emerged from this round of reflection were:

A. ***The need for standardised screening questions for brain injury for use by criminal justice system frontline workers*.**

   This topic had one of the two top scoring cards at 27. It also had four other cards that scored 20 or more.

B. ***The need for better support features for people living with a brain injury*.**
   This topic also had a top scoring card at 27 and had two other cards that scored 20 or more.

C. ***The desirability of improving education for professionals on brain injury in law and criminal justice*.**
   This topic had the third highest scoring card at 24. It also had four other cards that scored 20 or more.

D. ***The need to reform various parts of legislation to accommodate those with brain injury*.**
   This had one card that scored 22 along with two other cards of 20 or more.

   Note: Two cards that linked the need for better screening data and for support were also recorded, each scoring 21 and these sat between themes A and B.

This short, high intensity activity served well to surface some key themes that, as one might expect resonated throughout the day. Moreover, by asking people the central question about what they would advocate, the ground was established for a more practical, policy-oriented discussion (as opposed to a more abstract or research oriented discussion). This reflected the intent of the organisers to emphasise practical action rather than consider 'further research'.

3.2 The Open Space Workshops

After a lively process of posting ideas, sorting ideas, signing up, and prioritising, seven clear ideas emerged. The following ideas formed the basis of the open workshop group activities:

1. Development of standardised screening questions for brain injury at first contact with the criminal justice system
2. Improved data quality and information systems to identify brain injury
3. Brain injury and law reform
4. Educating criminal justice system stakeholders about brain injury
5. Need for different models for responding to people with a brain injury
6. Integration/intervention pathways for people with a brain injury
7. Person-centred approach – development of a community-based prison model

At the end of a substantial period of discussion (about 1½ hours), each of the groups reported back to the plenary. Group presentations were voice recorded (to the extent that the room allowed) and written materials were gathered and in several cases participants were kind enough to email detailed notes.

Group presentations

The summaries below were compiled from participant group notes, and supplemented where necessary by the voice recordings. It follows that much of the material is quoted rather than written by the report author who, in this sense has played a compiler role. The varied methods of recording and reporting have, of necessity, meant that the reports that follow are also somewhat heterogeneous.

3.2.1 Group 1: Development of standardised screening questions for brain injury at first contact the criminal justice system

Group Members: Amanda White (Dr Susan Pulman & Associates); Dr Dion Gee (Australasian Psychology Services); Rebekah Loukas (arbias Ltd.); Kay Sloan (New Zealand Corrections Health Service); Michelle Wareham (Victoria Police); Tim Dorey (Victoria Police); Pamela Snow (La Trobe University); Maggie Killington (Repatriation General Hospital & Flinders University).

Group Proposal: To develop standardised screening questions for brain injury at first contact with the criminal justice system. We envisaged the purpose of the screening questions is to 'flag' individuals who may have a cognitive impairment, brain injury, behavioural difficulties etc., and to prompt further investigation and/or assessment to enable an adequate response to the person's needs.

Aim: To facilitate access to fair and equitable justice.

When you expect things to happen? At the first opportunity that the person comes into contact with the criminal justice system at each point of contact e.g. police at the time of arrest/arrival into custody and prior to interview; first interaction with solicitor/duty lawyer/legal aid; first arrival into correctional facility. Ideally the goal is for the screening questions to have been asked prior to a person being in custody and/or a correctional facility. (Note, this point was also raised by the Group 2 in regards to access and availability of diagnostic information.)

It is suggested that if this brain injury flag was able to be passed on to other relevant bodies/agencies (for example, if police tell legal representative and corrective services), this may help prevent individuals falling through the gaps, prompt further assessment and planning for interventions and provide consistency in client information and hopefully

reduce wasteful repetition of assessments etc., due to poor communication between professionals and agencies.

Where you see activity taking place? Wherever the interaction with the criminal justice system takes place e.g. police station, court house cells, and correctional centres.

Who will do what? Screening questions about possible acquired brain injury will be asked by any professional (e.g. police, lawyer, social worker) who comes into contact with an individual at a point in the criminal justice system, i.e. this can be asked by non-clinicians as well as clinicians. It is proposed that this should form part of the standard procedure for first contact with an individual just as one would clarify their personal details e.g. name, date of birth, and ask routine questions about mental health and drugs and alcohol for example.

The reason it was proposed to have the screening questions asked by all persons is to promote the notion that finding out about a client's brain injury is everyone's responsibility.

Why do you propose this course of action? See above aims/purpose. This would ensure a higher rate of reliability in the responses attained, as studies show self-report in this group using standardised questions about *traumatic* brain injury, for example, are fairly accurate.[4] The standardised questions can also assist with research endeavours and documenting the prevalence of brain injury for use by organisations such as the NSW Bureau of Crime Statistics and Research. Such research organisations could utilise this information which then can be presented to policy makers, politicians, media etc. to help enact changes around identification, assessment and later intervention.

How it will be done using what resources: This question was viewed as too complex to answer in the day's session. Resource suggestions included using arbias Ltd. screening

[4] Schofield et al. (2010). Are prisoners reliable survey respondents? A validation of self-reported traumatic brain injury (TBI) against hospital medical records. Brain Injury, 25, 74-82.

questionnaire; a questionnaire trialled in New Zealand corrections by Kay Sloan and colleagues, which has been derived from two validated screening tools, the Traumatic Brain injury Questionnaire (TBIQ) and the Ohio State University TBI Identification Method (OSU TBI-ID). The group felt that the idea of prompting simple standardised questions to flag a possible brain injury across disciplines may be of interest to groups such as the Corrective Services Administrative Council. It is thought that this group has the potential capacity to coordinate this across various groups and to facilitate the sharing of the information of the brain injury flag, similar to flags for patients with mental health issues.

3.2.2 Group 2: Improved data quality and information systems to identify brain injury

Group Members: Chair: Mukesh Haikerwal (Brain Injury Australia); Tony Butler (Kirby Institute); Peter Schofield (HNE Health); Leanne Dowse (UNSW); Adrienne Withall (UNSW School of Public Health); Tom Turnbull (Correct Care Australasia); Monica Cations (UNSW Australia).

This group started with the ambition to integrate all relevant sources of data for brain injury and discuss what are the issues involved in 'tracking' using a variety of sources? The group distinguished using data for research purposes from the use of data to provide services and for administrative ends. The group had a wide variety of experiences that ran across these different areas.

A core issue that emerged was the linking of data across a range of services as it is recognised that people with a brain injury are multisystem service users, showing up the areas of health, corrections, police, disability, housing, Centrelink, aged care and whole range of other public sector agencies.

What are the key issues and impediments in allowing data to be shared across those areas? One problem is that the important ethical clearance procedures are fragmented across the health, justice and other public service sectors meaning researchers cannot streamline their

access requests resulting in significant delays in gaining access to worthwhile data. Privacy issues were also seen as potentially hampering in regards to access to information for both research and service provision purposes. There are also issues with the identification (or mapping) of what data might be available for people with a brain injury, let alone who these data sources might be linked to.

There are ethical issues as well as intersecting legislative and privacy issues. Western Australia with its 'livelinks' data was seen as admirable, especially since each Australian jurisdiction has a different set of rules.

The group felt clear gains would arise if there was a proper cost-benefit analysis of access to comprehensive data, with regard both to better provision of services to users in general and also by fitting of individual users to particular services would be beneficial. Failure of some sectors to recognise a brain injury disadvantages the person and sharing their status (with appropriate safeguards) might help overcome this.

How to resolve these matters? A way forward would be to establish a working group that could straddle sectoral boundaries and encompass a range of service, legal, privacy and research topics. Mapping available information would benefit service providers and consumers alike. Having to reinvent the wheel for every such effort is nugatory and frustrating.

It was suggested that links between justice and health could be facilitated by the use of the unique individual health identifier which has existed in legislation since 2010 but is not being used. Many of the group members were (until now) unaware of this identifier and its potential. This untapped resource could easily be used across multiple sectors and assist linkages. The health identifier is potentially of considerable use given the high use of aliases among recidivist offenders as a mean of 'tricking' the judicial system.

Right to anonymity: The Productivity Commission is currently conducting an enquiry into the availability and use of public and private sector data. It seemed a really good idea for members of this group to consider making a submission to that.

The group saw that law reform in various areas was also important.

The group also noted that there is a lot going on in various areas: the National Disability Insurance Scheme was provided as a really good example, where this agency is creating a new set of identifiers, assessments and rules independently of others. The group also expressed concern around the reoccurring separation and fragmentation of data holdings, which was viewed as a major challenge to add to those inherent in the various jurisdictional/sectoral differences.

The group concluded, that if you can get good data, it is interesting that government agencies actually come looking for help because they too are finding this difficult.

3.2.3 Group 3: Brain injury and law reform

Group Members: Chair - Tania Evers (Frederick Jordan Chambers); David Gibson (Victorian Legal Aid); Russell Goldflam (NT Legal Aid); Sarah Piggott (Tasmanian Legal Aid); Andrew English (South Australian Legal Aid); Emma Aldersea (Slater & Gordon); Lee Knight (Kirby Institute); Sally Ringrose (Community Restorative Centre) NSW; Andrew Ellis (Justice Health & Forensic Mental Health Network); Paul Crean (Slater & Gordon); Dianna Kenny (University of Sydney); Yasmin Hunter (NSW Department of Justice); Joseph Briggs (Legal Aid QLD).

Summary:

1. Adopt a uniform definition of mental impairment including cognitive disability, intellectual disability, brain injury and mental illness.

2. Set up a statutory office to oversee people who fall into this category and who will become subject to either supervision orders or some form of custody; overview all legislation and adopt the best legislative models.
3. Introduce a uniform diversion system in response to minor offences similar to the model of Section 32 of the NSW Mental Health (Forensic Provisions) Act 1990 but extended to include brain injury. Include also the proposals of the NSW Law Reform Commission.
4. Set up an independent review body similar to the NSW's Mental Health Review Tribunal.
5. Appoint a legal advocate to assist each person with a brain injury who comes into the criminal justice system.
6. Sign Optional Protocol to the Convention against Torture [and other Cruel, Inhuman or Degrading Treatment or Punishment]. (This is much broader than the basic provision we have signed).
7. Set up wrap-around release services along the model of the Community Restorative Centre (NSW).

Issues raised:

- Review of the Mental Health (Forensic Provisions) Act 1990 and related legislation with respect to brain injury, as it is not currently included.
- Change legislation to include and recognise brain injury and set up diversion processes.
- Make the legal system accessible for people with a brain injury by ensuring:
    - the provision of legal advocates; and that
    - people with disabilities are not subject to onerous orders or prison terms or inpatient stays due to lack of support services.

Review:

- Mental Impairment legislation, fitness to plead; differences between states; forensic mental health orders; treatment facilities.

    - States and Territories have different approaches
- Assessment, mental impairment – broad enough to cover brain injury
- Brain injury versus mental impairment (curable) versus intellectual disability (static): different procedure for each category?

Ideas:

- Establishment of Uniform Code of mental health/impairment.
    - Criminal Code? Not realistic
    - When jurisdictions are considering drafting mental health legislation that a definition of mental impairment that encapsulates brain injury be included
- Independent Review Tribunal: mental health facility versus jail
    - Availability of alternative treatment centre
    - NSW Mental Health Review Tribunal – where federal offence, off to Attorney-General for final decision

- Diversionary court programs to include brain injury – expand the definition to enable the dealing with summary offences for a wider variety of impairments; not restricted to those with a mental illness.
    - E.g. Section 32 NSW Mental Health (Forensic Provisions) Act 1990
    - Law Reform Commission NSW – currently looking at this

- Legal Advocate/Assistant Communicator – for those with brain injury, recurrent offenders.
    - To assist with language “interpretation” of police speak
    - Adapting the criminal justice/legal system to meet needs of vulnerable person

- Service provision post prison for those with co-morbidity: social disadvantage factors, low income, trauma, lack of control of behaviour, drugs, alcohol -brain injury, mental illness, mental impairment. Ability to access services, undertake case management.

- Mandate an after-care agency upon release from prison to ensure that they are not released to nothing with no service provision
    - Both juvenile and adult custodial systems
    - Time set
    - (not successful in the Northern Territory - mandatory alcohol offences)
- Wrap-around release services – better than the current parole system that doesn't provide that (punitive, lack of trust, anxiety producing experiences for the person with a disability). If found unfit, nowhere to go, won't be released.
    - Along model of NSW Community Restorative Centre
    - Engagement of clients with non-parole punitive has higher incidence of engagement
- No services for those on short term sentences that aren't subject to parole who reoffend and do the revolving door of reoffending.
- Information sharing between corrective services and health to facilitate continuation of health care.

- Referral pathways – somewhere to divert people to (intellectual disability versus brain injury): split money between mental forensic health and corrective services? Favour who is getting best results in decreasing recidivism.

- Funding for these changes? Should be split between corrective services (Justice) and forensic mental health (Health) and Disability Services – both to take responsibility for solving the problem.
    - Political sway for votes

- Statutory office of oversight of people in custody or subject to orders made by a court that subjects person with disability to curtailment of their freedom identified with brain injury (WA and NSW have a similar type of role).

- Conduct a review of mental health systems in each state to determine what works, and identify the best to suggest a national legislative system agreed to by Council of Australian Governments?
- Adopt uniform definition of mental impairment
  - Cognitive disability
  - Intellectual disability
  - brain injury
- Appointment of advocate – (Intellectual Disability Rights Service just lost their funding …) to interface between those who have just been released from prison at the service provision end rather than at the court end, case management
- Non-custodial supervision orders vs custodial supervision orders
  - Unacceptable risk, used on people with cognitive impairment

- Encourage Australia to sign Optional Protocol to the Convention against Torture [and other Cruel, Inhuman or Degrading Treatment or Punishment] – which sets minimum standards of detention.

- Changes to the Bail Act – e.g. non association order of children attending same school.

3.2.4 Group 4: Educating criminal justice system stakeholders about brain injury

Group Members: Samantha Grant (Inspire Rehab & Psychology); Armin Alimardani (UNSW Australia); Judge Eugene M Hyman (Former Superior Court for the State of California); Adam Spicer (SA Prison Health Service); Alexandra Culloden (Public Health Association of Australia); Leanne Togher (University of Sydney).

This group wanted both to ensure that all people working in the criminal justice system have knowledge of brain injury and also, in a more focused way, help those who have front line contact (i.e. police) to see quickly that someone may have some form of brain injury. The group emphasised that part of their effort is to help people to see that brain injury matters and if this can be linked in useful ways to moments when the issue might be 'front of mind' then some gain in understanding can be made. This can even extend to retrospective understanding, such as in a coronial inquiry.

The group identified a long list of potential audiences for the education messages, from the police all the way through to lawyers, prosecutors, judges, correctional staff and probation staff. They also considered where it could happen ranging from police training academies through to law schools to colleges etc. The group identified barriers, such as people thinking they do not need this sort of education because they already know enough. This, along with pre-judgements about what they consider to be anti-social behaviour can be a powerful block because there's often a reluctance to accept that behaviour that is disliked, or people who are not warmed to might be framed and understood differently.

So what should be in awareness training? What is and is not a brain injury; what causes brain injury; potential indicators and risk factors; what might be in a screening tool; and alternative explanations for behaviour that might be confused with brain injury. Specific features to be covered might include impulsivity, memory problems, and poor emotion regulation. The group thought a human dimension – people with a brain injury telling their own stories—might be a rich resource.

They also considered how best to communicate effective strategies for interaction and what particular restrictive factors (such as evidence reliability) are preventing the impact of brain injury on key aspects of the criminal justice process.

The group considered law societies and similar bodies as a route to reach lawyers, and were particularly keen to consider some mandatory components to be added to the continuing, professional education syllabus as well as extending the reach of this professional education to ensure a wider range of legal practitioners were exposed to the material. With respect to the judiciary, the heads of various groups might be the way in, while at the other end of the chain the Council of Australian Law Deans might be a good contact point. It would be worth talking to the police unions about the impact on police safety of not dealing with this problem and to the commissioners of police about the safety and effectiveness of officers if nothing is done about this issue.

Some States and Territories are doing disability justice strategy development and implementation work, and education could fit in very nicely to that as a core component.

In terms of funding, the National Disability Insurance Agency was identified as having funds for training and development and there might also be a nice link in with domestic violence prevention work. Links to existing resources included:

- Online training
    - www.abistafftraining.info or www.tbistafftraining.info
    - arbias Ltd.
- Brain Injury Association of Tasmania training modules
- iCARE
- Diverge (Victoria)
- Enabling Justice Program (Victoria)
- Expansion of existing mental health liaison staff training for police and ambulance services

- Office of Public Advocate (Victoria) fact and info sheet on what to do if you suspect someone has a cognitive impairment
- Brain Injury identification card signed by a General Practitioner and Police Commissioner (Tasmania)

3.2.5 Group 5: Need for different models for responding to people with brain injury and traumatic brain injury

Group Members: Stuart Browne (Royal Rehab); Dr Maggie Killington (Repatriation General Hospital & Flinders University); Bernadette Armstrong (Brightwater Care Group).

This group started with what they saw as the compelling need to deal better with people with brain injury. The starting point for the imperative was seen to be the costs of the status quo – the economic and human costs of criminal justice management. Large numbers get funnelled into the criminal justice system, often at quite a young age, and then become entrenched therein with complex and compounding needs. Research has quantified the enormous financial costs this creates and there is a parallel set of human costs.

The group saw an urgent need for national leadership backed by commitments in individual jurisdictions that together could create a better response to this very vulnerable group. Those who sustain a brain injury and are also from disadvantaged backgrounds in particular often just 'fall through the cracks' and end up in the criminal justice system just because there is no community support that would have prevented that outcome and no proper community understanding of their impairment.

There was seen to be a need for proper funding and it seems that the cost-benefit analysis referred to by Group 2 would support that as a wise use of resources.

What would a different model look like? A person-centred, integrated, non-punitive model of holistic support. A key feature that would underpin this model is trust, so it needs to be established first in parts of the community or organisations that already have on-going trust.

The group started looking first at post-release models, thinking about how this might be linked into the prison experience and to transitional support. They also considered an early intervention model, thinking about linking together education, health and community services as well as police and courts but always with a holistic, 'wrap around' model that responded to the needs of the person rather than defined in terms of specific pathology because so often brain injury is not separate from other issues, in short 'need, not diagnosis' would be the theme.

There was also a need for this to be connected to remand because in NSW in particular where there have been changes to the Bail Act, many of those inside prison are on remand and are not serving a sentence. It is important to reach all groups, not just those who have been convicted. Therapeutic support is crucial and referral pathways and transitional support are vital.

Not everyone with a brain injury necessarily links themselves to disability services. They may have specialist support but not be linked to more general services that would help them. A broader integrated model would help with this need.

The group included some with direct experience of the NSW's Community Justice Program, Integrated Services Program and much of the discussion about what was needed found that these already contained useful models to intervene in the cycle of reoffending which are well evaluated and shown to be successful. But these are vulnerable to lack of ongoing funding as a result of the new focus on the National Disability Insurance Scheme.

3.2.6 Group 6: Integration/intervention pathways for people with a brain injury

Group Members: Claire Gaskin (Justice Health & Community Mental Health Network); Lyn Turkstra (University of Wisconsin-Madison), Chloe Hall (Tasmanian Prison Service), Elaine Heaney (The Law Society of NSW); Gillian Cohen (Domestic Violence NSW Service Management); Melissa Hughes (Inspire/Neurofensics); Chris Lennings (LSC Psychology); Ngila Bevan (People with Disability Australia).

The problem

- No follow-through on recommendations
- Hard to get professionals/service providers into the prison environment for administrative reasons, risk, and not wanting to assess because it obliges treatment

What we are proposing?

Determine intervention by stage at which services need to be deployed: diversion, sentenced prisoners, pre-release, post-release.

1. For diversion:
    - Once Section 32 NSW Mental Health (Forensic Provisions) Act 1990 allows for inclusion of brain injury, then community providers need adequate resources to offer services; we need an advocate placed in the court system to link people to appropriate providers in the community, whether those are private or public
    - i.e., our group isn't proposing anything specific for this stage

2. For sentenced prisoners:
    - A specialist team: a disability-specific clinician who coordinates with discipline-specific providers (e.g., occupational therapy, speech therapy) to adapt programs for people with brain injury or identify other resources needed;

- To get this, start with a working group with Corrective Services NSW, to identify numbers of people with disabilities (using screening tool created by the screening group) and needs, then figure out how to create the team;
- Build on previous efforts for specialised units for individuals with intellectual disabilities – not that people with brain injury should be treated as individuals with intellectual disability, but rather than program structure ideas from one might be useful for the other; and
- We think Corrective Services NSW would welcome these efforts!

3. For Pre-Release:
    - Bring community-based services into the prison and vice versa – i.e., connect prisoners with community-based services; and
    - Re-integration pathway that allows this two-way interaction, and focuses on disability-related integration rather than typical re-integration for post-prison life.

4. For post-release:
    - Identify an advocate whose role is to pull together all services, and also identify mentors - e.g., individuals with shared experience;
    - The most important part of the post-release pathway is follow-up;
    - Housing is a key concern: we recognize that community accommodation options are very limited for all individuals post-release, and also that individuals with brain injury might have a history of violence that limits their community living options;
    - Educate parole and probation officers about providing positive supports for people with brain injury in the community; and
    - Support family involvement.

5. At all stages:
    - Need to base intervention on best evidence;
    - The evidence is out there. We need a strategy for translating those into a custodial setting;
    - There are experts who know this information (e.g., (International Traumatic Brain Injury Cognitive Rehabilitation Guideline) guidelines involving Monash University) – we need to bring them together with legal advocacy groups (e.g., Legal Aid, Disability Initiative) and corrective services, particularly parole boards, tribunals; and
    - Not sure who to lobby to make sure this gets done.

How we will measure success?

- Outcome measures such as employment, access to insurance, cost (e.g., is it more cost-effective to provide services than to re-incarcerate); and
- Note: if we move people from Corrective Services NSW to NSW Health, NSW Health won't be happy if they don't have sufficient funding.

Where do you see activity taking place?

- As listed earlier: in prisons, in the community

Who will do what?

- Individuals responsible are as listed earlier (e.g., disability representative, parole officers)
- Elaine Heaney offered help from the Law Society Disability Committee to draw up a more detailed action plan based on our ideas and draft a policy statement

Why do you propose this course of action?

- Because resources, services, and guidelines exist but are not applied in a coordinated and systematic fashion

How will it be done using what resources?

- See earlier note re: who will do what.

3.2.7 Group 7: Person-centred approach – development of a community-based prison model

Group Members: Thalia Anthony (UTS); Brett Collins (Justice Action); Kat Armstrong (WIPAN); Lana Sandas (WIPAN); Brigid Henley (Jesuit Social Services).

Proposal on 'Person-Centred Approach' (prisons – but note that this is something that is compatible with other aspects of the community and addressing disempowerment of people with acquired brain injury in decision making regarding)

<u>Key themes of discussion</u>

Development of community-based prison model – building a community in the prison

- Context of approach
    - Inmates are often isolated
    - No access to internet, by and large, by prisoners
    - Limited access to education
    - Lack of empowerment in decision making in relation to their environment
    - These factors increase alienation that aggravate features of brain injury

- Premises of our approach to build a prison community
    - Promotes social integration
    - Consistent with trauma-informed perspectives and therapeutic justice approaches
    - Fosters reintegration of inmates into the outside community

- Therefore, corrections communities would help foster a supportive environment for inmates with TBI

Features of this community model

- The key feature is the empowerment of inmates in relation to their environment and thus extending the limited role of the extant Inmate Development Committees in relation to decision making
- Inmate communities would be structured according to a municipality or local council infrastructure with potentially representatives from each wing
- Council representatives could be elected by inmates, perhaps with affirmative action protocols to have representation of certain groups
- Its jurisdiction would be in relation to relevant localised prison decisions (e.g. in relation to types of facilities available (esp. technology), work, education, communication with media, putting rubber stops on prison doors to stop clanging, services or programs available, including self-initiated groups – e.g., peer-support groups around mental health, rehab groups led by prison mentors, mothers' support groups in prison)
- This so-called corrections community council has to be integral to running of prisons

What is required for the establishment of the corrections community council?

- This democratisation would require prison officers and administrators to listen to prisoners
- Delegates or representatives would require training in community development
- Meetings of the quasi-municipality council would be held consistently and with clear processes determined by this corrections community council

What is needed for the council to be effective?

- Will by officers, administrators
- Bottom-up drive by inmates
- More time out of prison cells (cannot create a community in individual cells)

- Computers to communicate with other inmates in cells, if not also on the outside

Is this utopian? When can it happen?

- There is some evidence of effective communitarian models in Canberra and overseas
- We all know the importance of communities given the growth of social media
- This can happen now if we want it to.

Conclusions

This interactive one-day national workshop brought together a broad range of stakeholders for the first time in Australia to discuss brain injury within the context of the criminal justice system. Overall, workshop participants identified many opportunities, falling under seven core areas of importance, with the aim of improving the outcomes for people with brain injury who come into contact with the criminal justice system. Ranging from educating those working in the criminal justice system about brain injury to a review of the Mental Health Act 1990 to include brain injury – the discussion groups provided practical examples of how to address such gaps for example in screening, service provision, and data availability. Going forward, it is hoped that some of the newly formed connections and networks arising out of the workshop will continue to pursue the ideas raised to bring about real change for those who have a brain injury and find themselves in contact with the criminal justice system.

Appendix One: Jurisdictional screening for brain injury on reception to prison

	Australian Capital Territory	New South Wales	Northern Territory	Queensland	Western Australia	South Australia	Victoria	Tasmania
Prisoner population (June 2015, ABS)	396	11,797	1,593	7,318	5,555	2,732	6,219	519
Number of Correctional Centres	1	35	2	13	16	9	13	5
Does your jurisdiction collect information (screen) about histories of head injury as part of the reception assessment to prison?	No	Head injury is not a specific topic of enquiry in current prison reception screening processes.	The reception process is a full health screen focusing on acute care needs, STI screening and planning for adult health checks or care plans for chronic conditions if inmates have existing chronic conditions. If a past head injury was noted in the history and a concern it would be followed up, but we do not collect information about histories of head injuries as targeted information.	QCS screens prisoners on reception using a four item version of the HASI (HQ) to identify those who may require further assessment regarding cognitive impairment, which may in turn identify offenders with an acquired brain injury. Health services are provided in publicly run prisons in QLD by QH. QH advise they do not have standardised screening processes for history of head injury.	??	Limited information is collected. Specific questions asked include: **NEUROLOGICAL** Q. History of significant head injury? Q. With Loss Of Consciousness (LOC)? Q. Impaired comprehension? **SELF HARM** Q. Previous self-harm with loss of consciousness?	Not specifically. Past medical history is generally asked. Patient would need to volunteer details or clinician would need to have a suspicion on presentation.	Yes. Q. Have you had a head injury resulting in unconsciousness? A. Yes, No, Unknown
If yes, does this screen seek further information regarding the severity of the head injury, and if so how is this done?	N/A	N/A		If it is identified that a prisoner has previously suffered a head injury, further information is accessed through self-report by the prisoner in the first instance.		Only as above regarding LOC for both if they answer yes to head injury or self-harm.		Upon RN/MO initiative, collateral is sought

	Australian Capital Territory	New South Wales	Northern Territory	Queensland	Western Australia	South Australia	Victoria	Tasmania
If screening does occur, does this lead to further action such as follow up assessment (specify)?				Prisoners may be identified as requiring neurological assessment via a range of means, including problematic behaviour, or capability issues identified through program participation. Some psychological assessment may occur via QCS psychology staff. Cases are also referred to QH for consideration. In some instances referrals are made to externally contracted specialised psychological and psychiatric services for further assessment. QH advise that where a head injury is identified, a neurological assessment would be conducted. Depending on the skill set of the practitioner this can potentially range from standard neurological assessment such as GCS/AVPU/ Orientation /Mini-Mental State Determination would be made if any confound factors would also be present such as drug/alcohol		If yes for LOC in both above cases, this is flagged on admission and they must be booked for MO review. Mostly this is a significant delay though.		Only in severe cases

				usage Previous acquired brain injury Existing medical conditions for example Wernicke's/ Korsakoffs, dementia etc. If the prisoner was determined to be physically stable, collateral would then be sought from any treating medical officer/centre to allow for further determination of care pathways. If the prisoner was determined to be physically compromised they would be transported for further treatment/investigation based on the findings.				

	Australian Capital Territory	New South Wales	Northern Territory	Queensland	Western Australia	South Australia	Victoria	Tasmania
Does your jurisdiction have ready access to the following?		CS NSW employs psychologists, some of whom have expertise in neuropsychological assessments. Neurologists and neuropsychiatrists are only involved when a referral is made from health staff within JH&FMHN (they are external specialists).		Access to these specialised roles occurs through QH or through QCS referral to neuropsychiatrists or neuropsychologists (occurs rarely, usually in the most extreme cases).				
Neurologists	Yes		Not locally, fly in from interstate.			By OPD only, long public hospital wait for low acuity.	Yes, through St Vincent's Hospital Melbourne. Patient transported in person to SVHM, or via telehealth consult	No
Neuropsychiatrists	Yes		No			Not really, may be organised in special circumstances. I have not seen one in the year I have been with SAPHS.	Yes, through Community Brain Disorders Assessment & Treatment Service (CBDATS) – Austin Health Will visit prison patient in prison after referral: http://www.austin.org.au/bdp/contact/ http://www.austin.org.au/bdp/bdpcs/	No
Neuropsychologists	Yes		No			Not really, can be organised in special circumstances.	There is a full-time Forensicare employed Neuropsychologist based at Metropolitan Remand Centre	No

Appendix Two: List of attendees

Name	Affiliation
Emma Aldersea	Slater & Gordon Lawyers
Armin Alimardani	UNSW Australia
Marinos Anastas	Community Restorative Centre
Dr Thalia Anthony	University of Technology Sydney
Bernadette Armstrong	Brightwater Care Group
Kat Armstrong	Women in Prison Advocacy Network
Scott Avery	First Peoples Disability Network
Robin Banks	Equal Opportunity Tasmania
Ngila Bevan	People with Disability Australia
Joe Briggs	Legal Aid Queensland
Dr Stuart Browne	Royal Rehab
Prof Tony Butler	Kirby Institute
Deborah Byrne	Brain Injury Association of Tasmania
Monica Cations	UNSW Australia
Gillian Cohen	Domestic Violence NSW Service Management
Brett Collins	Justice Action
Amanda Coultas-Roberts	Legal Aid New South Wales
Paul Crean	Slater & Gordon Lawyers
Dr Kay Cuellar	Office of Dr the Hon Vanessa Goodwin MLC, Tasmania
Alex Culloden	Public Health Association of Australia
Tim Dorey	Victoria Police
Prof Leanne Dowse	UNSW Australia
Dr Andrew Ellis	Justice Health & Forensic Mental Health Network
Andrew English	Legal Services Commission of South Australia
Tania Evers	Frederick Jordan Chambers
Karen Farley	Legal Aid Western Australia
Don Ferguson	Lifetime Care
Dr Claire Gaskin	Justice Health & Forensic Mental Health Network
Dr Dion Gee	Australasian Psychology Services
David Gibson	Victoria Legal Aid
Russell Goldflam	Northern Territory Legal Aid Commission
Tracey Graham	icare
Luke Grant	Corrective Services New South Wales
Samantha Grant	Inspire Rehab and Psychology
Prof David Greenberg	Justice Health & Forensic Mental Health Network

Name	Affiliation
Dr Mukesh Haikerwal	Brain Injury Australia
Chloe Hall	Tasmanian Prison Service
Mary Hawkins	National Disability Insurance Agency
Elaine Heaney	The Law Society of New South Wales
Brigid Henley	Jesuit Social Services
Judge Graeme Henson	Chief Magistrate of New South Wales
Anthony Holton	New South Wales Ombudsman
Dr Melissa Hughes	Inspire/Neuroforensics
Yasmin Hunter	NSW Department of Justice
Judge Eugene M Hyman	Superior Court for the State of California, County of Santa Clara
Jocelyn Jones	National Drug Research Institute
David Kennedy	Australian Community Support Organisation
Prof Dianna Kenny	University of Sydney
Dr Maggie Killington	Repatriation General Hospital & Flinders University
Lee Knight	Kirby Institute
Dr Marlene Kong	Kirby Institute
Dr Chris Lennings	LSC Psychology
Rebekah Loukas	arbias Ltd.
Dr Michael Levy	Justice Health Services, Australian Capital Territory
Dr Michelle Maitz	New South Wales Health
Dr Ruth McCausland	UNSW Australia
Prof Skye McDonald	UNSW Australia
Loretta Moore	Department of Family and Community Services
Robina Moubarak	NSW Health
Dr Yega Muthu	University of Technology Sydney
Karen Nankervis	Department of Communities Queensland
Dr Paul Nelson	Bureau of Crime Statistics and Research
Samantha Newman	Queensland Corrective Services
Carol Nikakis	Victorian Association for the Care and Resettlement of Offenders
Bridget O'Keefe	Mental Health Commission
Michelle Perrin	Queensland Forensic Mental Health Service
Emma Phillips	Queensland Advocacy Incorporated
Sarah Piggott	Legal Aid Commission of Tasmania
Dr Mark Rallings	Queensland Corrective Services

Name	Affiliation
Sally Ringrose	Community Restorative Centre
Nick Rushworth	Brain Injury Australia
Lana Sandas	Women in Prison Advocacy Network
A/Prof Peter Schofield	Neuropsychiatry Service, Hunter New England Health
Dr Grahame Simpson	Griffith University
Dr Melanie Simpson	Kirby Institute
Adam Spicer	South Australia Prison Health Service
Kay Sloan	Department of Corrections, New Zealand
Dr Pamela Snow	La Trobe University
Kelly Swan	New South Wales Ombudsman
Nicole Telfer	Synapse
Prof Leanne Togher	University of Sydney
Prof Julian Troller	UNSW Australia
Dr Lyn Turkstra	University of Wisconsin-Madison
Dr Tom Turnbull	Correct Care Australasia
Dr Susan van den Berg	Corrective Services New South Wales
A/Prof Handan Wand	Kirby Institute
Michelle Wareham	Victoria Police
Dr Amanda White	Dr Susan Pulman & Associates
Dr Adrienne Withall	UNSW Australia