Issues and inequities facing people with acquired brain injury in the criminal justice system

Report prepared for
Victorian Coalition of ABI Service Providers Inc. (VCASP)

Victorian Coalition ABI Service Providers

September 2012

By Suzanne Brown and Glenn Kelly

Diverge Consulting Inc.

diverge.org.au

This Publication: November 2012

VCASP Inc.
PO Box 900, Northcote VIC 3070
27 Hope Street, Brunswick VIC 3056

Issues and inequities facing people with acquired brain injury in the criminal justice system

Report prepared for
Victorian Coalition of ABI Service Providers Inc. (VCASP)

September 2012

By Suzanne Brown and Glenn Kelly

Diverge Consulting Inc.

diverge.org.au

Contents

1. Project description

This project had the overarching aim of collating information from a variety of sources to establish an evidence base regarding people with acquired brain injury (ABI) and their experience in the criminal justice system (CJS) in Victoria, Australia.

It was considered particularly important to put a 'spotlight' on this group and portray the characteristics and circumstances of people with ABI who come in contact with the law.

A review of relevant Australian and international literature was undertaken to identify common themes and core issues. The findings of a number of seminal studies have been highlighted in this report. In addition, interviews with 'hands-on' service providers, working with the identified client group on a daily basis, identified key issues and strategies that could potentially result in better outcomes.

This report was funded by Victorian Coalition of ABI Service Providers Inc. (VCASP) who contracted Diverge Consulting to produce it. The project was not resourced to enable it to be exhaustive – it is expected that VCASP will use the content of this report plus other information to construct informed submissions to assist Government to develop effective service responses to people affected by ABI.

VCASP

The role of VCASP is to represent the views of the Victorian Acquired Brain Injury (ABI) sector in presenting the needs of people with ABI and their carers to all relevant policy and funding bodies.

Diverge

Diverge is a not-for-profit organisation whose mission is to assist people with brain injury, their carers, and the wider community to better understand and manage behaviour change.

2. Why ABI is significant in the CJS

2.1 ABI is known to be prevalent in the CJS

Research has indicated that a large proportion of people in the criminal justice system have ABI. A recent study of Victorian prison populations found evidence that over 30% of female prisoners and 40% of male prisoners had ABI (Jackson & Hardy, 2010).

There is evidence to suggest that available statistics understate the true prevalence due to underreporting, particularly by those with more mild injuries (Rushworth, 2011).

A number of studies that included loss of consciousness and mild traumatic brain injury (TBI) have reported substantial prevalence rates of approximately 60% - 90% among prison populations (Schofield et al., 2006; Slaughter, Fann, & Ehde, 2003; Williams et al., 2010).

It is clear that there is a high prevalence of prisoners with ABI, and when one also considers the prevalence of persons with intellectual disability (ID) and mental illness (MI) within prisons (Taylor, 2012; Villamanta Disability Rights Legal Service, 2012), it is arguable that employees of the Department of Justice work as much in a disability system as a justice system.

2.2 ABI is over represented in the CJS

It is well established that people with disabilities are over represented in the criminal justice system as suspects, defendants, offenders and victims of crime (French, 2007; McGuire, 2012).

The prevalence of ABI in the general population is estimated to be approximately 2% (Australian Institute of Health and Welfare, 2007). In contrast, as noted above, the prevalence of ABI in prisons is considered to be 30-40%. The data indicates that there is a disproportionate number of persons with ABI in the CJS.

Despite the high numbers of offenders with ABI, this group is often out of the spotlight, and appears to be considerably disadvantaged and under resourced. Census data shows that the number of people with ABI in the general community is comparable to those with intellectual disability (Australian Institute of Health and Welfare, 2007, 2008). There is, however, a marked gulf between the systemic assistance for persons with ABI and those with intellectual disability.

2.3 Disability, disadvantage and marginalisation

People with cognitive impairment continue to be disadvantaged in Australian society, and often are caught in a cycle of poverty, low education, unemployment, inappropriate housing, social isolation, insufficient services and support, vulnerability and community prejudice (McGuire, 2012; Victorian Law Reform Commission, 2007).

People with ABI who come into contact with the criminal justice system typically have very complex life circumstances. Many present with multiple and complex needs, and may be experiencing co-existing mental illness, alcohol or drug dependence, health complaints, breakdown of the family unit or unstable accommodation (Australian Institute of Health and Welfare, 2010). There is also evidence to suggest that complex circumstances can be precipitated and exacerbated by contact with the criminal justice system (McGuire, 2012; Victorian Law Reform Commission, 2007).

The Victorian Law Reform Commission (2007) noted that cognitive impairment can lead to criminalisation of a person because the offences an individual is charged with may relate to behaviour associated with their disability. There are varying views regarding whether there are causal links between ABI and offending behaviour. Evaluation of that research is not within the scope of this paper. It is, however, important to highlight that the cognitive-behavioural changes that commonly follow ABI, such as disinhibition and impaired impulse control, poor social judgement, irritability, low-frustration tolerance, anger and aggression, can be factors that increase the risk of committing criminal acts (Miller, 1999).

Cognitive impairments that impact on an individual's everyday functioning can lead to behaviour that falls outside societal norms and contravenes the law. Poor memory and executive function may result in a person forgetting to pay for purchases or neglecting fines and being legally pursued. Impulsive behaviour may compel someone to put a grocery item in their bag, or grab untended cash or property, and subsequently be charged for theft. Disinhibited behaviour in a community setting, such as swearing, undressing or urinating in public, may result in charges for offensive behaviour. People with ABI have signed contracts that they have not fully understood, such as equipment rental agreements, mobile phone offers, loans or a house mortgage, and failed to comply with the agreement, resulting in prosecution for fraud. Reduced frustration tolerance, susceptibility to stress and poor anger management can result in heated social exchanges, misconduct or assault (as either a perpetrator or victim). These difficulties can create a cycle where a person is charged, convicted and sentenced, rather than treated, rehabilitated and supported in the community (French, 2007; Synapse, 2012).

2.4 Recidivism

The research literature indicates that people with cognitive impairment can be vulnerable to having repeat contact with crime (French, 2007). “People with cognitive impairment often face greater difficulties in dealing with the criminal justice system than other groups” (p.200; Victorian Law Reform Commission, 2007). Both individual and systemic barriers present significant challenges, and unfortunately this can lead to a cycle of recidivism. The individual may have limited understanding of their legal rights, lack confidence and be easily intimidated, respond impulsively without thinking strategically through the issues, have trouble controlling their emotions, or have difficulty communicating. The ‘system’ may fail to identify that the person has a cognitive impairment, may be prejudiced or fail to provide a fair and equitable response with respect to dealing with disability issues, be unable to arrange affordable legal services as needed, or not provide adequately trained staff with knowledge and appropriate procedures for dealing effectively with persons with cognitive impairment. These barriers can affect the outcome of legal proceedings and lead to high rates of recidivism.

2.5 Limited research

Research regarding ABI and offending behaviour in the justice context is very limited. There are few comprehensive sources of data about this group. This can be attributed to a range of factors. Firstly, a person entering the CJS may not be identified as having ABI by police or other justice workers. Secondly, persons with severe ABI engaging in offending behaviour may be diverted away from the CJS. Thirdly, much of the existing research on disability and justice has focused on persons with mental illness or intellectual disability, or under the broad term of cognitive impairment. Only in recent years has the issue of ABI within the CJS been more closely investigated. The next section outlines some of those findings.

3. A profile of people with ABI in the CJS

The purpose of this section is to characterise people with ABI in the criminal justice system, and also indicate how they differ from those in the general population. The precise characteristics of the group of interest differ across reports depending on the sample and inclusion criteria, and particularly the definition of ABI used. Definition issues will be briefly considered, then clients from several key Australian studies or samples will be described.

3.1 Definition of ABI

Acquired brain injury (ABI) is the term used to describe all kinds of brain injury that occur after birth. This includes injury to the brain caused by trauma (as can occur in a motor vehicle accident or assault), cerebrovascular accident (stroke), hypoxic event (as can occur in near drowning, heart attack, and drug overdose), and chronic alcohol and substance abuse. Whether degenerative neurological conditions (such as Alzheimer's Disease) are included in the definition is a point of debate in the field, but the Australian Institute of Health and Welfare include this in their definition of ABI. Detailed discussion of the challenges in defining ABI can be found in Dowse, Clarence, Baldry, Trofimovs, and James (2011) and Fortune and Wen (1999).

One of the difficulties that face planners in health and related sectors who need to respond to ABI is that there is not a reliable or direct mapping of the cause of ABI to its sequelae. Common sequelae of ABI can include physical and sensory impairments, communication and cognitive deficits, emotional and mental health problems (commonly depression and anxiety), and changes in personality and behaviour. The level of impairment can differ markedly from one individual to the next.

Not all people diagnosed with having had an ABI need extensive or ongoing service system support. Of those who do, they are not a uniform group with uniform needs, meaning that individualised and specialised support is needed. Furthermore, much of the research literature regarding the client group considered 'brain injured' comes from samples of people who have had traumatic brain injury (TBI) because they present to the hospital system, and have clearly defined indicators of severity of injury (such as a Glasgow Coma Scale score or duration of Post Traumatic Amnesia). It is unclear how readily findings from TBI can be extrapolated to the various other kinds of ABI.

Because defining and responding to ABI is not a straightforward task, a host of dilemmas arise. For example, determining precisely the prevalence of ABI in the general population (or the criminal justice system) is difficult because, for example, people with ABI from substantial alcohol use or from sports injuries may not present to the health

system and fail to be accounted for. People injured early in life may be labeled and treated as intellectually disabled. When self-reports of primary disability are relied upon (e.g., as in the National census), respondents with ABI may describe themselves as physically disabled rather than cognitively impaired or brain injured. In Government agencies such as the Department of Human Services, eligibility for services or quantity of resources needs to be matched to the extent of impairment; but ABI and its sequelae are not easily conveyed or reflected in a single score as is traditionally done for intellectual disability; using a full scale IQ score of <70).

It is common now to use the term "cognitive impairment" to indicate a reduction in an individual's thinking ability, whether the cause of this is ABI, intellectual disability or mental illness. In this report we have attempted to identify ABI as a diagnosis and causal factor wherever possible, because in Victoria service options and funding systems are often based around that diagnosis or cause of the cognitive impairment.

3.2 Australian data

In order to build a profile of people with ABI in the criminal justice system, this project focused on a few key studies that presented data sets from Australian cohorts. These are presented below.

3.2.1 Mental health disorders and cognitive disabilities in the criminal justice system

A report released in 2011 described a group of people with complex needs and their involvement with community services and the criminal justice system in New South Wales (Dowse et al., 2011). This was a revealing study because it combined records across health and justice systems. All those involved in the study had known diagnoses and had been in prison.

The total sample of more than 2000 people had the following profile of primary diagnoses: Intellectual disability (n=680), Borderline intellectual disability (n=783), Mental illness (n=965), Substance abuse disorder (n=1276), and No diagnosis (n=339). Of these, 511 individuals (18.7% of the total sample) were considered to have an ABI (identified as such in the disability database, or, in an inmate survey, reporting head injury with loss of consciousness plus sequelae). The authors were able to compare the ABI group with a non-ABI group.

Table 3.1 shows that, in the ABI group, substance abuse, personality disorder, and mental illness (broadly defined) were quite common, as they were in the non-ABI group. Almost a third of the ABI sample was indigenous.

Table 3.2 indicates the presence of ABI across all other identified primary disability groups in the sample. The data shows that ABI is more prevalent in the "complex groups" that have multiple comorbidities.

Table 3.1. ABI cohort description

Characteristic	Non-ABI group	ABI group
Age		36.7 years (mean)
Gender=male	89%	91%
Indigenous	25%	30%
Substance use disorder or history of substance abuse	55%	58%
Personality disorder	23%	16%
Psychiatric disorder (includes anxiety, affective and psychotic disorders)	34%	37%
Mental health disorder (includes psychiatric disorders, substance use disorders, and personality disorders)	69%	73%

Table 3.2. The percentage of individuals with ABI in each study group

Within this subgroup →	Was this proportion of ABI
MI	26.0
ID	21.4
BID	22.5
MI & ID	30.5
MI & BID	31.6
AOD & MI	14.6
AOD & ID	29.6
AOD & BID	28.8
AOD & PD	13.3
No MH ID	15.9

Note. MI= History of mental illness. ID=intellectual disability (IQ score <70). BID=borderline intellectual disability (IQ score=70-80). AOD= History of substance use (alcohol and other drugs). PD=personality disorder.
Darker shading highlights higher proportions.

Dowse et al. (2011) compared the ABI and non-ABI groups within each of the other key diagnostic groups (ID, MI, and so forth). Details of any statistical analyses were absent, but apparent differences across groups included:

Criminal Justice Contacts

Individuals in the ABI group:

- were more frequently victims of crime and persons of interest than the non-ABI group
- had a higher rate of police contact than those without ABI

- most commonly committed theft and road traffic vehicle regulatory offences (40% of offences); these were also the most common convictions
- were more likely to have alcohol as a contributing factor to offending (18.5% of police contacts) than the non-ABI group (13.6%)
- were more likely to engage in alcohol-related offences when they also had ID or BID
- The data suggested that a high usage of alcohol by the ABI group brought them into contact with the CJS due to alcohol-related offences.

Courts

- Compared with people without ABI, people with ABI had more instances of court appearances and more convictions
- The presence of an ABI along with other diagnoses increased the frequency of conviction across most other study groups (e.g., ID).

Custody

- Compared with the non-ABI disability groups, the ABI group had more instances of incarceration and spent more days incarcerated per episode
- The presence of an ABI increased the number of instances of requiring protection while in custody, the number of offences committed while in custody, and rates of self harm whilst in prison.

Community

- 35% of the ABI group had at some point been homeless (considered an underestimate).
- 87% of the ABI group had applied for Legal Aid, and 94% of those had a legal case funded by Legal Aid. This service identification and response was in stark contrast with the limited contact with other community services. Only about one quarter of those eligible for NSW Ageing, Disability, and Home Care (ADHC) services were in receipt of them.

Summary

In all, the study painted a picture of a group of people with ABI who were predominantly male, had high rates of contact with police for relatively minor offences and where alcohol was often a contributory factor, and who spent more time incarcerated than other complex clients without brain injury. They were often indigenous or homeless. They had heavy involvement from legal aid, but relatively little contact with community support services.

The authors noted that “once an individual with MHDCD (Mental Health Disorder and Cognitive Disability) comes into contact with the CJS, there is a significant likelihood that they will continue to cycle in and out of the CJS for some time” (p. 33). Furthermore

"while those in the MHDCD group in general experience very high average rates of incarceration, the presence of ABI appears to intensify this pattern" (p.37)

3.2.2 ABI: Identification and Prevalence in the Victorian Correctional System

Between 2007 and 2009, extensive data were collected on both male and female entrants to the Victorian corrections system as part of a study (Jackson & Hardy, 2010) with two main aims:

(1) to evaluate a procedure for identifying those with ABI among prisoners entering Victorian correctional system, and (2) to provide data on the prevalence of ABI within the Victorian correctional system.

This study added valuable information to what is known about brain injury in prison populations because it included ABI, not only TBI (which is more commonly reported).

The researchers initially screened male prisoners (n=110) in the Melbourne Assessment Prison (MAP) and female prisoners (n=86) in the Dame Phyllis Frost Centre (DPFC) for indicators of ABI using a pen and paper questionnaire. Approximately two-thirds of males and three-quarters of females endorsed at least one risk factor for ABI.

In a second stage, 90 of the males and 53 of the females completed extensive clinical interviews, and in a third and final stage 74 males and 42 females completed neuropsychological assessments. This final stage sets this research beyond many other efforts to assess the prevalence of ABI in prisons because objective psychometric measures can increase the reliability of the findings above less precise measures such as episodes of loss of consciousness.

With regard to identification and prevalence of ABI, the study reported that:

1. "the prevalence of ABI in the Victorian Correctional System is high, with 42% of males and 33% of females found to have evidence of an ABI on formal neuropsychological assessment" (p.83).

2. With respect to severity of brain injury, the breakdown by severity and gender was as follows: Severe (M 6%, F 7%), Moderate (M 39%, F 21%), Mild (M 55%, F 72%).

3. "the screening tool (one page of questions, and one page of guidelines) was an effective and efficient way of screening for a possible ABI as prisoners entered the prison system" (p.84).

The key characteristics of these prisoners were as follows[1]:

- More than three quarters of the male and female samples endorsed 1-3 risk factors for ABI;

1 These characteristics apply to the group in Stage 2 whose screening results indicated Clinical assessment was warranted. Not all were diagnosed with ABI in Stage 3.

- The use of substances (alcohol and other drugs) was the main cause of brain injury;
- More than 50% of the sample reported that they were affected by alcohol or other drugs at the time of the offence;
- The levels of prescribed and illicit drug use was considerably above that in the general population;
- A psychiatric diagnosis was endorsed by approximately two-thirds of male prisoners and three-quarters of female prisoners;
- More than half of both males and females endorsed two or more psychiatric diagnoses. Depression and anxiety were the most common disorders;
- They were less educated than the general population, were more likely to be unemployed, and had less stable accommodation;
- Approximately 25% of the prisoners had served time in a Youth Training Centre;
- Approximately 20% of the prisoners had been found guilty for the first time, but the average number of previous terms was three, and more than 20% were serving their fifth or later term;
- They tended to be born in Australia, single or defacto, and with a history of difficulty in school (suspension, expulsion, history of learning difficulty). Income tended to be from employment or Centrelink Newstart allowance. They were often unemployed or in casual or contract positions; and
- The most common three offences in males were (i) acts intended to cause injury, (ii) offences against justice procedures, government security and government operations, and (iii) sexual assault and related**.** For females, most common were (i) theft and related offences, (ii) illicit drug offences, and (iii) robbery, extortion and related offences.

Summary

The study highlighted the prevalence of ABI in Victorian prisons: more than 40% of males and more than 30% of females have verified ABI. It further highlighted the role of alcohol and other drugs in offending behaviour, and the presence of co-morbid mental illness in the majority of prisoners.

3.2.3 MACNI

The Multiple and Complex Needs Initiative (MACNI) became operational in Victoria in 2004. It operates outside of the CJS. Its role is to provide a coordinated service approach to individuals so as to promote stable health, housing, social connection, and comprehensive ongoing support. MACNI clients are aged over 16 years, have 'multiple and complex needs' – often including combinations of MI, substance abuse issues, ID, ABI and forensic issues.

A recent service report from MACNI (Department of Human Services - Multiple and Complex Needs Initiative, 2009) shows some of the overlap between ABI, comorbidities, broader social context, and prison.

Since inception, MACNI have engaged in almost 700 consultations with regional service providers. The clients of interest had the following diagnoses: MI (68%), Substance Abuse (57%), ID (34%), and ABI (28%). Of the consultations that became accepted cases by MACNI, many had comorbidities. When there were three comorbidities, the most common combination was mental disorder plus ABI plus substance abuse (39%).

It is important to note that the MACNI data does not indicate prevalence of these issues in the community. Rather, it shows how common these issues are among the activities undertaken by MACNI, and this will be influenced by referral pathways (i.e., those sectors where MACNI is well known or has had success with outcomes are more likely to refer to MACNI).

The report highlights that referrals to MACNI from criminal justice services were low in the early years, but increased noticeably in more recent years. By 2009, 15% of MACNI accepted referrals came from criminal justice services. The report notes that this could be attributable to the commencement of a position within Corrections Victoria that facilitates needs assessments and service access. Assuming this to be the case, it demonstrates the value of not only having a service response, but having a role dedicated to linking clients and services efficiently.

One of the key aspects of supportive environments for people with ABI (particularly those with problematic behaviour) is appropriate and stable accommodation. The MACNI report highlights that “there is a high percentage in unstable and inappropriate forms of accommodation...The percentage of individuals in prison / custody ranges from 20-25%...” (p.14; Department of Human Services - Multiple and Complex Needs Initiative, 2009).

3.3 Summary

The profile of people with ABI in the criminal justice system can be characterised as follows:

- There is a high proportion of people with ABI in prison
- Over 30% of females in prisons are estimated to have ABI
- Rates are higher for males, with over 40% of male prisoners estimated to have ABI
- High rates of indigenous persons are incarcerated
- Most offences are minor
- Recidivism rates are high

- Offenders have a low socioeconomic status, with limited education, high rates of unemployment, and unstable accommodation
- Co-morbidity rates are high, with individuals presenting with more complex conditions than the average person with disability
- Homelessness and lack of community services are a chronic problem
- Alcohol and drug dependence feature highly, and many offences are committed under the influence
- People with ABI are more frequently convicted and incarcerated for longer
- They require more protection in prison
- They engage in more self harm
- They commit more offences in prison.

4. Initial contact with the CJS

4.1 Police

4.1.1 First port of call

The police are typically the first point of contact with the criminal justice system. Police play a primary role in law enforcement, the investigation of crime, and bringing cases before the courts for prosecution. Because their duty is to serve and protect all members of the community, it is important that police have the capacity to communicate effectively and respond appropriately to people with disabilities – including people with ABI.

There have been numerous case examples where poor understanding of ABI has resulted in ineffective policing practices. Examples include assuming a person with ABI is drunk because they are unsteady on their feet (ataxic) and their speech is slurred (dysarthric), or using aggressive interview tactics with a misguided view that a person with impaired recall will remember or communicate information better if they are pressured to disclose information.

4.1.2 Initiatives to improve policing responses

Victoria Police have identified that there had been difficulties in policing persons with disabilities due to inconsistencies in police practice, a lack of resources, and not having a dedicated functional area and systematic approach to people with mental impairment (a term often used in the CJS relating to MI, ID and ABI). Furthermore, these difficulties had resulted in poor integration of information, limited data, reactivity to external events, and limited partnerships with relevant community services. In recent years, Victoria Police have been actively working to improve the understanding of disability among police officers, and to develop appropriate systemic interventions.

The Strategic Directions paper, *Peace of Mind* (Victoria Police, 2007), outlined a number of key initiatives designed to improve policing responses to persons with mental impairment (including persons with ABI). The strategy aimed to equip police to:

- Detect the symptoms and behaviours of a range of mental disorders that impact on a person's thoughts, perceptions and feelings
- Communicate effectively with people with mental impairment
- Display empathy when interacting with people with mental impairment

- Ultilise legislation, policy, procedures and partnerships to respond appropriately and effectively to people with a mental impairment.

In 2007, Victoria Police, the Office of the Public Advocate Independent Third Person (ITP) Program, and community agencies developed the *Ready Reckoner – a* two-page document that police members carried with them in their reference folder that outlined indicators of cognitive impairment, tips to assist communication, police procedures and useful contact numbers for agencies who could assist.

In 2007 and 2008, the VCASP Criminal Justice Subcommittee (VCASP-CJSC) ran a series of workshops in partnership with Victoria Police, the ITP Program, and local Community Legal Services. The workshops were well attended by service providers from the ABI, disability and mental health sectors and received highly positive evaluations (unpublished data, VCASP-CJSC). A senior police officer presented at the workshops, and this was valuable in breaking down barriers, promoting understanding of roles and finding ways to more effectively address matters when clients come into contact with police. No such workshops have been conducted since that time, although there remains a demand for this type of training.

In addition, Victoria Police appointed mental health liaison officers to promote communication about mental impairment among its members, to monitor and report on specific issues that relate to police interventions with affected persons, and to provide targeted training to members about these issues. Liaison officers were expected to update knowledge, systems and processes between operational and corporate support areas within the police force. This function has now been incorporated as a portfolio area in the Community Engagement Unit of Victoria Police.

The Law Enforcement Assistance Program (LEAP), implemented in 1993, is a records-management system in Victoria that stores particulars of all crimes brought to the attention of the Police. It also includes data on family incidents, traffic violations, cleared offences and alleged offenders. Data from the LEAP system is used to collate and analyse crime statistics. The Victoria Police Crime Statistics report 2010/2011 (Victoria Police, 2011) summarises information about offence type, geographical location, age, sex, marital status and racial appearance of offenders. The Crime Statistics report does not, however, contain information regarding offenders or victims with mental impairment. The LEAP system does appear to have the capacity to hold this information. Such data could provide valuable information about police responses to people with disability, and specifically those with ABI.

People with disabilities can be flagged on the LEAP database. On some occasions, community agencies, with the consent of the client, have provided a person's details to the Police and requested that it be listed on LEAP. For example, in cases where an individual was prone to wander and become lost, or was mentally unstable and posed a nuisance in the community, information on LEAP helped police officers to identify that the person had a disability, the police were informed with useful strategies to use when

communicating with the person, and they were more able to safely and effectively navigate the incidents.

4.1.3 Policing and the special needs of people with ABI

Cognitive-behavioural problems commonly associated with ABI can have a significant impact on police interventions. Difficulties with memory are very common after a brain injury. During police interview, a person with ABI may not be able to recall certain events, and may feel pressure to answer questions, despite having no effective recollection of the events. Some individuals will succumb under interrogation and offer information that is not based in fact, or admit to a crime they did not commit.

***Case example 4.1**: Rebecca was interviewed by the police regarding the death of a man that she had known. Due to memory impairment caused by brain injury, she could not remember the events of the previous week. She was susceptible to suggestion, and because she could not recall otherwise, she started to think that there was a possibility that she may have been responsible for the man's death. She was very stressed about this and was telling many of her support workers that she may have murdered someone. Rebecca could not read, did not understand her rights, and it took some time to finally determine that she was not linked to the man's death.*

Many people with ABI have difficulties with language and communication, and they may not be able to effectively express themselves, comprehend what is said to them or read written material. As a result, they need skilled communication support when being interviewed by Police (see section 4.2 below).

In background research for this report, some service providers in the ABI sector had described highly positive experiences in working collaboratively with police to achieve a better outcome for the client and community. Other service providers reported that they had not had a positive experience with police. They stated that the officers were abusive and treated them as if they were trying to protect the client from consequences, or obstruct the course of justice. They argued that they were attempting to provide information that they thought would be relevant and would facilitate the legal process.

Police have complained that when they have contact with a person with ABI who needs supports, they are often unsure of who to call, and long waiting lists for public services mean that assistance is not available when it is needed.

With regard to ABI, there remains scope for improvement among the police force in recognising indicators of disability and responding appropriately. Interviews for this project revealed anecdotal instances of police not following protocols in the management of persons with ABI. Examples included officers not providing their name to a person with ABI they were questioning, not providing an Independent Third Person during a formal police interview despite the alleged offender being established as brain injured, and police refusing to liaise with an individual's case manager or support

worker. These actions can impinge on client rights, jeopardise legal cases, contribute to recidivism, and undermine effective working relationships between service providers and police.

In 2003, the Disability Discrimination Legal Service released *Beyond Belief* – a report examining the difficulties faced by victims with disabilities when reporting sexual assault and seeking justice (Goodfellow & Camilleri, 2003). It revealed an assumption amongst some police that people with cognitive impairment are unable to present as credible witnesses or provide evidence to the courts. Police raised concerns about the affected person's presentation in court, communication issues, memory ability and behavioural control. As a result, an individual with ABI may not be called as a witness or have their case or complaint heard. Serious crimes, such as alleged rape, may not be followed up by police. Persons with cognitive impairment from marginalised groups, such as having low literacy or being from an Aboriginal or non-English speaking background, have been found to be less likely to receive the support needed to report complaints (Goodfellow & Camilleri, 2003). The implication is that the more marginalised a person is from mainstream society, the less likely they are to see justice.

4.1.4 Training

In 2008, the VCASP Criminal Justice Subcommittee hosted two training sessions in which experienced persons from agencies with an interest in justice matters presented to an audience of service providers. The presenters at the workshops represented Victoria Police, legal services, Independent Third Person (ITP) Program, psychology services, ABI specialist case management services and persons with ABI.

More than 40 service providers attended the workshops. Evaluations were highly positive, with overall ratings of 8/10 to the question "how relevant to your work practice did you find the information presented?" The qualitative feedback indicated that providers were aided by learning about the "inner workings" of the justice system (e.g., police approaches, ITP role), what services were available to help clients, and in being prepared for court if that ever eventuated in their own work.

Responses indicated that similar training sessions in the future should include a "go to whoa" explanation of the Victorian Corrections system, have a half-day duration, include lunch, and be priced under $50.

4.1.5 Recommendations

4.1.5a **Training for police**: Continued education and training for police highlighting several core areas: recognition of cognitive impairment and appropriate responses, dispelling myths and misconceptions, and providing information about which community services are available to assist. It would be strategic for VCASP to have input into the police training program, to review current

content delivered to officers, and offer suggestions regarding information and resources.

4.1.5b **Training by police:** Provision for the police to deliver training to workers in the field of ABI and broader disability sectors. Training could be scheduled on an annual basis and completed in conjunction with training from other stake-holders.

4.1.5c **Information resources:** There are publications available (e.g., Police Powers: Your rights in Victoria, Victoria Legal Aid, 2011) that provide useful information about dealing with the police. It would be advantageous for service providers to be aware of these resources so they can pass the information onto clients.

4.1.5d **Partnerships:** Building partnerships with community services in order to promote understanding and best practice. This could be achieved in a number of ways, including conferences, forums, and joint training sessions.

4.1.5e **Data collection:** Streamlining data collection practices should be a priority area. Reporting on the number of persons with ABI, or at least with mental impairment, who have contact with the police could be included in the annual crime statistics. Reliable statistics would be advantageous for future planning and resource allocation.

4.1.5f **Annual training:** Training in criminal justice issues relevant to ABI should be made available on an annual calendar. This could be part of the ABI Information Training and Secondary Consultation (ABI ITASC) training calendar in regional Victoria, clearly identified as the "ABI-Criminal Justice Training Series", and hosted by a peak body (e.g., VCASP) in metropolitan areas. The training needs to be advertised to a broad range of providers (e.g., DHS Disability Services, Corrections Victoria, mental health services, alcohol and drug treatment services, ABI specialist and generic services). Sufficient funding needs to be available to ensure that well informed, skilled and experienced presenters are involved. Registration fees could subsidise the training sessions.

4.2 Independent Third Person Program

4.2.1 About the program

The Independent Third Person (ITP) Program is managed by the Office of the Public Advocate (OPA) in Victoria. The Program trains volunteers to assist people with mental impairment (defined as people with mental illness, intellectual disability, dementia and acquired brain injury) to communicate during interviews with police. The police have a standing order to access an ITP to assist with communication whenever they interview a

person with cognitive impairment or mental illness, whether that person is a victim, witness, suspect or alleged offender.

4.2.2 Why is it useful?

Recent research indicated that the ITPs are viewed positively by the people they support, and the program is highly valuable for persons with disability entering or re-entering the criminal justice system (McGuire, 2012). ITPs are independent and objective, familiar with police processes, and can help the person understand their rights. Because they are trained regarding disability issues, ITPs can facilitate communication between the person and the police by explaining words, presenting information in a way the person can comprehend, and helping them articulate clearly. ITPs can support the person through the police interview process, help calm an anxious or agitated individual, encourage considered responses, request a break to avert a crisis, reduce intimidation, and foster confidence because the presence of an ITP can indicate to a person that appropriate procedures will be followed.

4.2.3 ITP under-used by people with ABI

Despite its usefulness, there is substantial evidence that as a group, people with ABI are grossly under-represented among users of the ITP Program.

In 2003-2004, the VCASP Criminal Justice Subcommittee surveyed a range of ABI service providers about their clients' contact with police. It was found that of those clients with an ABI interviewed by police, an estimated 12% had used an ITP (VCASP Criminal Justice Subcommittee, 2004). According to the specialist providers, however, 85% *required* an ITP to assist with communication. This discrepancy highlights a significant lack of access for persons who need this type of assistance.

The ITP Program performance data for the year July 2010 through June 2011 provided detail of 2068 interviews conducted by 210 active ITPs across 129 police stations in Victoria. Figure 4.1 shows the breakdown of ITP-assisted interviews across three primary disability types. Compared with ID and MI, people with ABI were involved in substantially fewer ITP-assisted interviews. Of the 1511 interviews where only a single disability type was recorded by ITP volunteers, ABI constituted only 13%. Given that people with ABI constitute approximately 30 - 40% of prisoners (Jackson & Hardy, 2010), they appear greatly disadvantaged at the point of police interview.

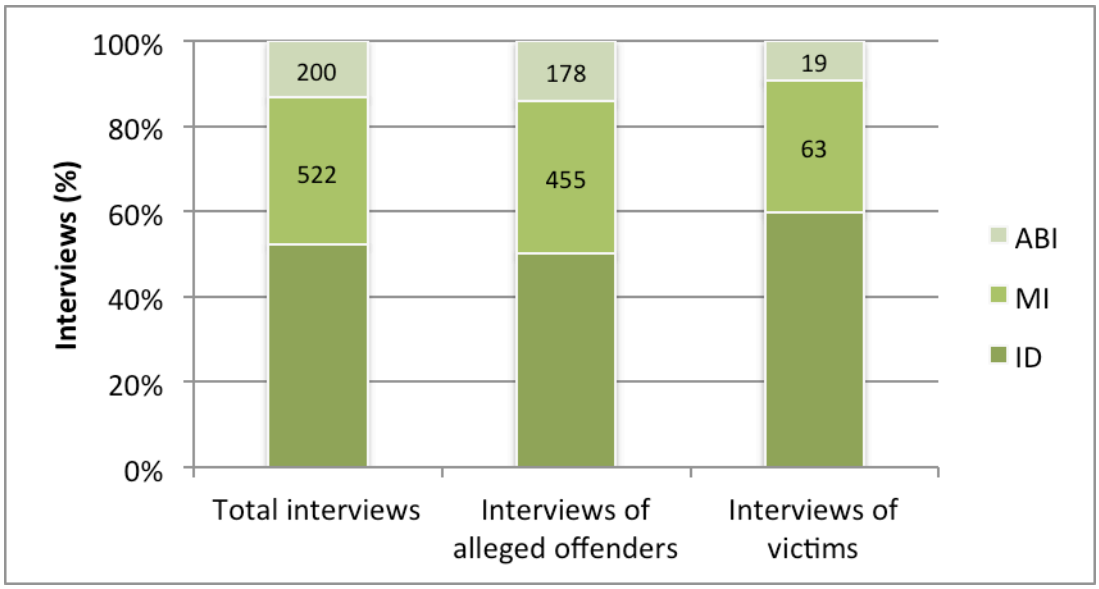

Figure 4.1. ITP-assisted police interviews according to disability type

Notes. Interviews involving dementia or unknown or unclear diagnoses have been omitted. This data does not account for all reported interviews. It includes only those identified by a primary disability diagnosis (i.e., excluding those with multiple diagnoses or complicated by alcohol) in the expectation this will increase the reliability of the data.

4.2.4 Why are ITPs under-used?

There are many reasons why ITPs may not be accessed. Police may fail to identify that the person has cognitive impairment, police may not contact the ITP Program, ITP volunteers may not be available in the required time frame, or the person with ABI may decline the assistance of an ITP. People with ABI are often unaware of their rights and that assistance is available to them. The service providers who support them, such as case managers and welfare workers, may not have knowledge of the legal system and be unaware of services such as the ITP Program, and therefore cannot effectively educate or direct their clients.

Inconsistencies have been noted in how ITP use has been reported by Victoria Police and the ITP Program. In 2007, police reported 2225 interviews using ITPs, while in contrast, the ITP Program recorded 1293 interviews (Frawley, 2008). That the police report was inflated by almost 1000 cases is cause for concern and warrants further investigation. One possible explanation is that police data does not distinguish between OPA-trained ITP volunteers and untrained independent persons (e.g., family, friends), such that the police data can imply a level of trained support for people with ABI that is not actually present.

These data inconsistencies occur in the context of broader definition and data collation problems. Police and ITPs may mistakenly identify someone as having an ID or MI instead of an ABI, or ABI is not seen as the primary disability and so is not recorded. These inconsistencies make it challenging to achieve a concise picture of how people with ABI are being dealt with at this point in the justice process.

4.2.5 Repeat presenters

A significant proportion of the ITP Program's resources are directed toward repeat presenters to police. A research project recently completed by the Office of the Public Advocate (McGuire, 2012) found that approximately 30% of ITP clients were repeat presenters and accounted for 60% of interviews attended by ITPs.

4.2.6 Recommendations

4.2.6a **Extend the scope of the ITP Program**: Many ITP volunteers and clients have suggested that the ITP Program would benefit from having capacity to refer people on for additional support; something that is not currently within the scope of the program. To reiterate the proposal by McGuire (2012), an ITP Advocacy and Referral scheme could be piloted where an ITP Advocate could respond to ITP clients who are repeat presenters, assess the circumstances of the case, intervene early, make referrals and facilitate the person's effective engagement with services and support networks. The scope of ITP support could also potentially extend from police interview to other areas of the criminal justice system such as Bail Hearings, Governors Hearings and Parole Hearings, thereby providing a service continuity that is often lacking in the ABI service sector.

4.2.6b **Training for ABI and Justice workers**: During the 2007-2008 training program organised by the VCASP Criminal Justice Subcommittee, it was found that most participants from community agencies did not have knowledge of the ITP Program. This lack of awareness will require regular redressing as new staff enter the sector. It could be incorporated into the "ABI-Criminal Justice Training Series" identified earlier.

4.2.6c **Specialist workers**: There are a range of specialist ABI workers who need to know about the ITP Program. These include Victoria's ABI/AOD clinicians, specialist case managers, and regional ITASC workers. Health organisations that employ these workers do not necessarily have the expertise or resource bank regarding justice matters in-house, so regular upskilling of new staff is required from external sources. Holding training on criminal justice issues on an annual basis would help to promote awareness, update knowledge and resources, build skills, network and share ideas regarding new directions and better outcomes.

4.2.6d **Liaison:** Liaison between OPA (ITPs) and Victoria Police could probably result in matching the fields used (and data recorded) and thereby overcome record keeping anomalies. For example, distinguishing between assistance provided by an ITP or family member.

5 Courts and sentencing

5.1 Legal representation

5.1.1 Access to legal information

Many people have difficulty obtaining information about their legal rights. Often they do not know how to navigate the system and may 'give up' as a result. They can become frustrated, stressed and angry with their predicament and lack of service response. This can substantially affect the legal outcomes for them. These 'generic' difficulties are exacerbated by cognitive difficulties: people with ABI may fail to record relevant contact details, or fail to follow up tasks even though that failure has adverse consequences for them. They may not understand what they are to do with information provided to them. Filling in lengthy forms or reading through complex material may be well beyond their abilities. Lawyers often do not have the time required to spend with their clients with ABI to cater for their needs. There is no obvious 'go to' place to access information. The Mental Health Legal Centre reported that they don't service people with ABI, and Villamanta Disability Rights Legal Service work mostly with people with ID. In Villamanta's 2010-2011 annual report, it was noted that only 6% of phone enquiries were regarding persons with ABI (Villamanta Disability Rights Legal Service, 2011).

In 2008, the VCASP Criminal Justice Subcommittee approached the Victorian Law Foundation regarding a funding submission for the development of an information booklet for people with ABI and their support networks. The booklet was intended to provide valuable information about the criminal justice system and an individual's rights under the law. There was general support for the project and acknowledgement of the need for such a resource. The submission, however, was unsuccessful and there remains a need for an information booklet for people with ABI, or at least for a booklet that broadly covers disability and justice issues.

5.1.2 Access to legal representation

Research has indicated that many people with disabilities do not have access to needed legal services (Diesfeld et al., 2006). People with ABI in contact with the criminal justice system are likely to be unemployed or in receipt of pension benefits, with limited access to financial resources and therefore cannot typically afford the costs of private legal fees. Hence they are reliant on publicly funded legal representation, such as Legal Aid.

People with ABI, like so many others with disability, face pervasive barriers, negative public attitudes and discriminatory behaviour that prevent them from accessing services available to others in the community. Legal Aid has funding restrictions and often people

are not able to access needed psychological assessment reports, particularly if the individual has not previously been assessed as having cognitive impairment (Law Reform Committee, 2012). There is a chance of missing out on Legal Aid if the legal issue is not considered serious enough to be granted support or repeat presenters may be seen to have overused a finite resource. Adequate legal representation is critical to ensure that justice is served and valid legal decisions are made.

5.1.3 Disability awareness

In the practice of Law the onus for identifying a client's needs and ability to participate in the legal process lies with the legal representative. In the preparation of a case, it is the lawyer who should present information to the court relating to the level of disability. A judge or magistrate would not necessarily have the opportunity to detect impairment and would generally rely on that information being presented to the court.

Nevertheless, there is evidence to suggest that many legal representatives lack the requisite understanding of disability issues to do their jobs effectively (Diesfeld et al., 2006).

Case example 5.1: *Wendy believed that her lawyer did not understand the nature of her ABI. She claimed that he had not explained things to her in a way that she could understand. The lawyer had given her a 15-page legal form to take home to complete, and despite her stating she could not manage that by herself, no support was forthcoming. She was also concerned the lawyer had been "yelling" at her and she felt "abused". Wendy "sacked" her lawyer and now has no one to represent her. This was the second time she had terminated legal services.*

Many duty solicitors in the courts lack adequate training and experience in working with disabled clients and therefore are ill equipped to detect or assess impairment in their clients and work with it (Diesfeld et al., 2006). Duty lawyers in Magistrates Courts deal with large volumes of cases and may not identify that someone has impaired capacity, or if the lawyer does suspect it, may not investigate it further or refer on for assessment (Howard & O'Brien, 2009).

The upshot of limited awareness of ABI among many legal professionals is that fair legal process is not achieved. This is a notable problem when one considers that those professionals who are representing persons with ABI in the justice system may inadvertently be disadvantaging them.

5.1.4 False confessions

People with impaired decision-making capacity have been shown to be susceptible to false confessions and pleading guilty inappropriately (Howard & O'Brien, 2009), and legal representatives may unintentionally contribute to their client's disadvantage and

the miscarriage of justice unless they are skillful in assessing and understanding the implications of cognitive impairment. It has been noted that in the absence of qualified legal assistance, persons with mental impairment may be coerced into confessing to an offence and may incriminate themselves even if they are innocent (United Nations Office on Drugs and Crime, 2009).

5.1.5 Recommendations

5.1.5a **Booklet.** Develop an information booklet for people with ABI and their support workers that outlines legal processes and their rights in the criminal justice system.

5.1.5b **Funding.** An application for funding could be submitted to the Victoria Law Foundation for the development of the information booklet.

5.1.5c **Needs assessment.** VCASP should liaise with community legal centers regarding the needs of people with ABI and their support workers.

5.1.5d **Priorities.** It would be prudent to prioritise the types of legal needs of people with ABI and then develop specific legal information and case work service responses.

5.1.5e **Access.** People with ABI lack readily available information and advice with respect to CJ issues. This situation could be improved in a number of ways including:

- Enabling community legal centers to provide legal education and accessible information on key topics to interested groups of people with ABI and service-provider networks
- Increasing disability awareness for all persons involved in the administration of justice who are likely to have contact with people with ABI
- Providing free legal advice in a flexible manner such as after hours to enable carers/family members of the person with ABI to attend, or via a mobile/outreach legal service component – this would be valuable to persons who are not able to travel into an office-based legal centre due to severe physical disability or inability to leave their place of residence
- Having information about accessing legal representation (for example, where to access telephone legal-advisory services, like that offered by Villamanta Disability Rights Legal Service) available at police stations and courts.

5.2 Court Integrated Services Program (CISP)

The Court Integrated Services Program (CISP) was established in 2006, commenced operation in 2007, and was designed to assist people coming into the courts with offending associated with homelessness, poverty, substance abuse, or disability. It facilitates diversion rather than sentencing. Its stated role is to "offer a coordinated, team-based approach to the assessment and treatment of defendants at the pre-trial or bail stage. It provides case management support and links defendants to support services such as drug and alcohol treatment, crisis accommodation, disability services and mental health services." (p.2; Department of Justice, 2010)

By way of process, people can be referred to CISP anytime up until they plead. A CISP case manager then assesses contributing factors to the person's offending behaviour. They can then make recommendations to the Magistrate, who will consider the CISP assessment, and will likely order the person to participate in CISP for ongoing treatment (case management, onward referral).

Outcome data to date (Department of Justice, 2010) suggests that CISP is a valuable program. Compared with a non-CISP matched sample, CISP clients have a reduced re-offending rate, and data indicates that, as time goes on, the re-offending rate gap widens between the two groups. CISP clients spend less time in prison than matched controls. CISP clients cost the community less in such things as the cost of crime (e.g., property damage) and imprisonment.

In 2007 – 2008, more than 2500 referrals were accepted by CISP. The characteristics of CISP clients are: male (81%), reporting illicit drug use (70%), mentally ill (21% with diagnosed condition), and brain injured (10% according to screening assessment).

The evaluation report (Department of Justice, 2010) noted two limitations particularly relevant to ABI. First, resources are often insufficient to enable neuropsychological assessment. Second, stable housing is critical in the CISP service approach. It further notes, however, that resolving housing issues with its clients typically takes longer than the duration of CISP intervention. Summary figures show that client accommodation status barely changes despite lengthy interventions, many referrals being made for housing assistance, and the presence of a specific CISP housing worker.

CISP has obvious advantages for clients with ABI over the Credit Bail system operating in other courts that has a single, generic case manager. CISP is available at the Magistrates' Courts in Melbourne, Sunshine, and Latrobe Valley.

A significant limitation of the CISP program would seem to be the termination of a professional link to an offender once they are imprisoned. Post-release services advise that they are referred clients with none of the case work developed by CISP (this is addressed in section 7 of this report on post-release issues).

5.2.1 Recommendations

5.2.1a **Data.** It is unclear whether the positive global outcomes reported by CISP apply to persons with ABI. It would be a relatively straightforward task to separate diagnostic groups statistically and compare outcomes across groups.

5.2.1b **CISP expansion**. Currently, CISP operates at three Magistrates Courts (Melbourne, Sunshine, Latrobe Valley). (There are 12 Metro and 42 Country Magistrates Courts.) Given the social and economic benefits purported by the Justice Department, it would seem obvious to extend the CISP to the related courts in all areas so that access to the service is available to all potential clients without a geographic limitation.

5.2.1c **Continuity of service**. There are significant gaps where continuity of service is lacking in the CJS. One way to bridge these gaps is to provide CISP staff with scope for continuity of service; that is, to work with a client from pre-sentencing to prison to post-release. This would assist with treatment, access to community services, and reduce the likelihood of reoffending, which are aims of the CISP program.

5.3 The Assessment and Referral Court (ARC) List

In 2010 the pilot Assessment and Referral Court (ARC) List (the List) was established by the Magistrates' Court of Victoria in partnership with the Department of Justice. In broad terms, the List aims to address the factors that contribute to offending behaviour, and it works closely with CISP.

During hearings of the ARC List a Magistrate sits with members of the ARC List team (program manager, three psychologists and a social worker) and the participant's legal representative and a police prosecutor. The focus of discussion is on finding tangible solutions to the issues affecting the participant, rather than the participant's guilt or innocence, which is the focus of traditional hearings. ARC List hearings often appear more like a case conference than a traditional court hearing, and "Solving problems in a collaborative way is a defining feature of the ARC List" (p.2; Rutter & Mortell, 2011).

Involvement in the ARC List is usually between six and twelve months, and eligibility criteria include:

- having been charged with a criminal offence (not serious violence or sexual assault), which is listed to be heard at Melbourne Magistrates' Court.
- having a mental illness, intellectual disability, acquired brain injury, autism spectrum disorder and/or a neurological impairment, including dementia.
- being able to benefit from receiving coordinated services (e.g., psychological assessment, welfare services, health services, mental health services, disability services).

The ARC List is currently a pilot program and a formal evaluation is yet to occur. Assuming such an evaluation takes place, it would be valuable to know referral and outcomes data relating to clients with ABI, and how those data compare with other diagnostic groups referred.

5.4 Diversion

The Criminal Justice Diversion Program provides offenders the opportunity to be diverted from the CJS and avoid a criminal record by undertaking conditions that benefit the offender, victim and the community. The Diversion Program is available in all Magistrates' Courts in Victoria. A request for diversion can be made by the accused, their lawyer, support person, the court or the police.

Eligibility for the Diversion Program is dependent on the following criteria being met:

- the offence is triable summarily (in the Magistrates' Court)
- the accused acknowledges responsibility for the offence
- the offence is not subject to a minimum/fixed sentence or penalty
- the prosecution consents for the matter to proceed by way of Diversion.

If the offender and the Court agrees that Diversion is appropriate, a plan will be developed where the offender has to comply with conditions such as:

- apologising to the victim by letter or in person;
- compensating the victim;
- attending a counselling service or treatment program;
- performing community work; or
- donating money to a charity.

There are clear benefits to the Diversion Program for the courts, prisons, victim and community. Benefits for the offender include avoiding a criminal record, and receiving appropriate assistance through participating in treatment and rehabilitation.

The Diversion Program can be applied in many cases where people with a disability have come into contact with the criminal justice system, and can help divert them from prison terms or severe penalties and compel them to cooperate with services that can assist them (Villamanta Disability Rights Legal Service, 2012).

There has been some concern that people with ABI may be excluded from diversionary programs and prison educational programs due to either a lack of acknowledgement of the impairment, or due to misconceptions regarding the impairment, and consequently individuals in this group are more likely to be sentenced to a term of imprisonment and less likely to be paroled (Dowse et al., 2011; Rushworth, 2011).

5.5 Equality of opportunity for offenders with disability

Offenders with ABI do not have access to the same type of supports that offenders with ID receive. Under Section 80 of the Sentencing Act there are special provisions for persons with ID. For example, persons with ID who commit serious offences would typically have a Justice Plan or Plan of Available Services prepared by the Department of Human Services (DHS), Disability Services. The Justice Plan provides a comprehensive assessment of need and recommends available services to address offending behaviour. This may include anger management training, sex offender education, employment placement and support, or alcohol and other drug treatment (Villamanta Disability Rights Legal Service, 2012). Residential Treatment Orders may be made for the person with ID and the person may be placed in a Residential Treatment Facility. Supervised Treatment Orders allow for the detention and treatment of persons with ID considered 'at risk' even if they have not been found guilty of an offence (Villamanta Disability Rights Legal Service, 2012).

Disability Services has a legislative responsibility to monitor and review Justice Plans attached to court orders, and persons with ID may receive case management from DHS Disability Client Services and additional supports. Treatment programs such as the ACSO Problematic Sexual Behaviour Service cater mostly to clients with ID and while eligibility criteria has broadened in recent years, the reality is that the program is not a good fit for persons with ABI and few ABI clients have accessed the service. This situation appears to be in conflict with the practice principle outlined in the *Protocol between Corrections Victoria, Department of Justice, and Disability Services, Department of Human Services* (State Government of Victoria, 2008) that promotes equality of opportunity for offenders with a disability.

5.6 Bail and remand

Bail occurs when a person charged with a serious offence is released from custody on the undertaking that they will appear in court at a later date to answer the charge. Depending on the circumstances of a case, bail may be refused and the person remanded in custody. If a person is mentally unwell they may be held in remand at the Melbourne Assessment Prison or Thomas Embling Hospital. Alternatively, they may be held at the Marlborough Unit at Port Phillip Prison or the Melbourne Remand Centre.

People with cognitive impairment are over represented in remand centers while they await sentencing (Victorian Law Reform Commission, 2007). Persons with ABI may not be granted bail due to factors such as unstable accommodation, poor decision making capacity and impulsive behaviour, lack of social support and few assets. A cycle of disadvantage is perpetuated because their disability contributes to impoverished circumstances that preclude eligibility for bail. A person may be in remand for extended periods, particularly if there are delays in going to court. In some cases, people awaiting trial have been held in custody for longer than they would have if an early guilty plea

had been made (Howard & O'Brien, 2009). Such measures could be viewed as overly punitive and leading unnecessarily to the imprisonment of vulnerable persons in remand facilities that were not designed to cater for health care, social integration and rehabilitation needs (United Nations Office on Drugs and Crime, 2009).

At times, bail conditions may be imposed that make it difficult for the person with ABI to comply. These may include reporting to a police station, living at a specified address, not interfering with witnesses, receiving medical or therapeutic treatment, or depositing a sum of money with the court before release. Without support, the person with ABI may not be able to travel independently to report to police, may forget they are not allowed to speak with certain people, may struggle to organise themselves or remember to report in, and may forget when or where they have to attend court. This is a serious situation because if bail conditions are breached, the person can be arrested and may be charged with a criminal offence.

5.6.1 Recommendations

5.6.1a **Upskilling**. The agencies that grant bail (i.e., the police, bail justices and courts) would benefit from education regarding cognitive impairment to ensure that bail conditions are suitably aligned to a person's abilities and capacity to comply.

5.6.1b **Evaluate**. Establish data collection processes to help identify and monitor the outcomes for people with ABI.

5.6.1c **Supports**. Information regarding bail conditions should be provided to the individual in verbal and written forms in a manner in which they can understand.

5.6.1d **More supports**. Support is provided to those who require monitoring, such as reminder calls, repeated explanations to assist comprehension and memory, structure and the means to enable compliance with bail conditions.

5.6.2 Centrepay

Case managers reported that clients often breach Court Orders and increase the likelihood of sentencing by failing to pay fines. Centrepay is a system used by Centrelink to enable their clients to pay bills by having an amount deducted from their Centrelink payments and paid directly towards a debt. During interviews for this project, it was suggested that using a Centrepay system as a matter of course within the courts with clients with ABI would immediately overcome that form of breach.

6. Prison

6.1 Prevalence of brain injury in prison

There is a growing body of research evidence from international and national sources demonstrating that prisons hold a disproportionately large number of people with ABI. The prevalence of brain injury is significantly greater in incarcerated populations compared to the general population (Farrer & Hedges, 2011). Most studies have focused on prisoners' self reports of having sustained traumatic brain injury (TBI), with findings ranging from 25% to 87% of those in prison custody reporting a history of TBI (Morrell, Merbitz, Jain, & Jain, 1998; Slaughter et al., 2003). Studies investigating rates of TBI in the general community have found lifetime prevalence of TBI ranged between 5% to 10% (Butterworth, Anstey, Jorn, & Rodgers, 2004; Perkes, Schofield, Butler, & Hollis, 2011). If statistics on other causes of brain injury (e.g., stroke, alcohol and substance related brain injury, hypoxia, etc.) were included, the discrepancy between prison and community ABI prevalence would likely be greater.

6.1.1 International perspective

In the UK, a study of 453 adult male prisoners found that over 60% reported a history of TBI (Williams et al., 2010). The results indicated that 48% of the sample had a mild TBI and 16% of the sample had a moderate to severe TBI. Multiple head injuries were noted in 60% of offenders with mild TBI. Compared with non-head injured counterparts, those with TBI were younger when they entered the justice system and were more frequently in custody due to re-offending.

In the USA, a study of inmates in a Seattle county jail found that 87% of prisoners reported a lifetime history of TBI and 36% reported sustaining a TBI in the previous year. It was noted that prisoners with more recent injuries presented with higher levels of anger, aggression, cognitive difficulties, and psychiatric disorders. It was also noted that TBI was more prevalent in a general prison setting and death row than in a forensic psychiatric hospital setting (Slaughter et al., 2003).

In New Zealand, 86% of prisoners surveyed reported that they had sustained a TBI, with 57% reporting multiple episodes of head trauma. A history of TBI and illicit substance use were higher in prison than in the general population (Barnfield & Leathem, 1998).

A meta-analysis investigating the prevalence of TBI in offender populations globally identified 20 epidemiologic studies between 1983 to 2009 that met inclusion criteria. Results indicated that 60% of offenders had a TBI (Shiroma, Ferguson, & Pickelsimer, 2010).

6.1.2 Australian perspective

In terms of the Australian story, a number of studies are now available that are consistent with the evidence base emerging globally.

In New South Wales, a consecutive sample of 200 men entering the criminal justice system were screened for TBI. It was found that 82% of the sample reported a history of at least one TBI of any severity (including concussion), and 65% endorsed a history of TBI with loss of consciousness. Of those with TBI, 35% had sustained a head injury within the past year. Multiple head traumas were common, with 43% of the sample having sustained four or more TBIs. Ongoing sequelae, such as neurological (e.g., headaches, memory impairment), psychological (e.g., anger, depression, anxiety) and social difficulties (e.g., relationship breakdown, loss of job), were reported by 52% of prisoners with TBI (Schofield et al., 2006).

A comparison of prisoners in New South Wales with a sample of community participants (non-offenders) matched on socio-demographic criteria found that 64% of prisoners reported at least one TBI associated with a loss of consciousness, whereas in the community sample the figure was half that (Perkes et al., 2011). Prisoners, compared with those in the community sample, were more likely to have sustained their most recent TBI from assault (45% vs 8%) and less likely from sporting activities (16% vs 46%). Prisoners were more likely than their community counterparts to be injured in a public place (40% vs 12%) such as in a bar or 'on the street', and in prison or police detention (10% vs 0%). Prisoners were more likely to report persisting side-effects of TBI and screen positive for harmful alcohol use, drug use, impulsivity and dissocial personality disorder.

In Victoria, recent research that employed objective neuropsychological tests to detect ABI rather relying on self report alone, indicated that 42% of male prisoners and over 33% of female prisoners had ABI (Jackson & Hardy, 2010).

Across Australia during the June quarter 2012, the average daily number of full-time prisoners was 29,557 persons (Australian Bureau of Statistics, 2012). In Victoria on 30 June 2011, there were 4,737 prisoners in the prison system (Department of Justice, 2012). Based on research findings that indicate approximately 40% of prisoners have ABI, this would suggest there were over 1,895 prisoners with ABI in Victorian prisons last year.

6.2 Costs

Prison is an expensive option in terms of a justice solution. The average daily operating expenditure per prisoner in 2010-11 was $257.35 (approximately $94,000 per annum), whereas the average daily cost per Community Corrections offender in the same year was $21.22 (Department of Justice, 2012).

The average time spent in prison on remand is five months (~ $39,000), and the median expected length of time to serve a sentence is two years (~ $188,000) (Australian Institute of Health and Australian Institute of Health and Welfare, 2011). Hence, the cost of maintaining persons with ABI in prisons is high, and a view to diversional programs plus disability-related supports may result in better outcomes for individual offenders and the community.

6.3 Vulnerability and discrimination

People with disabilities are vulnerable in prison, being at increased risk of human rights violations such as maltreatment, physical violence and sexual abuse (French, 2007). Discrimination issues can be intensified in prison in terms of victimisation, coercion, difficulty accessing services and system rigidity that does not accommodate special needs. Hence, imprisonment can represent a disproportionately harsh punishment for offenders with disabilities (United Nations Office on Drugs and Crime, 2009).

> *Due to architectural barriers, prisoners with mobility impairments may be unable to access dining areas, libraries, sanitary facilities, work, recreation and visiting rooms. Prisoners with visual disabilities cannot read their own mail unassisted or prison rules and regulations, unless they are provided in Braille. They are unable to use the library, unless taped materials or books in Braille are available. Prisoners with a hearing or speaking disability may be denied interpreters, making it impossible for them to participate in various prison activities, including counselling programmes, as well as their own parole and disciplinary hearings. Prisoners with disabilities can be routinely denied participation in work programmes outside prison, sometimes significantly lengthening their periods of imprisonment.* (United Nations Office on Drugs and Crime, 2009, page 45)

Due to cognitive impairment, individuals with ABI may struggle to understand the prison system or code of conduct, and they may fail to follow instructions and comply with rules. When confronted, they may be resistant or become agitated and aggressive. This can lead to physical restraint, disciplinary violations and Governor's hearings, or targeted punishment such as being placed in isolation or in a special management unit. These methods are resource intensive, and can compound difficulties rather than ameliorate them. Frequent disciplinary offences can have a negative impact on early release opportunities for prisoners with mental impairment, extending their time in custody when they would actually benefit from parole (United Nations Office on Drugs and Crime, 2009).

French (2007) outlined a number of vulnerabilities faced by persons with disabilities in the prison system:

- *Persons with disability are particularly vulnerable to physical violence and abuse from other offenders, including sexual assault;*
- *Persons with disability are much more likely than other prisoners to be the subject of emotional and psychological abuse in a correctional setting (for example, teasing, ridicule, bullying, humiliation, harassment, intimidation etc.) which may lead to the development or exacerbation of psychosocial impairment, alienation, social withdrawal and anti-social behaviour;*
- *Corrections-based counselling and rehabilitation programs are inadequate and are often poorly adapted or inaccessible to persons with disability;*
- *Corrections-based basic education (such as literacy and numeracy education etc) is inadequate, often not adapted to the specific learning needs of persons with particular impairment types, nor may it be available in accessible formats that may be required by persons with specific impairment types;*
- *Corrections-based employment and vocational education programs are inadequate and are also often inaccessible or poorly adapted to the needs of persons with disability;*
- *Persons with disability are much more likely to be influenced in an ongoing way by the negative role models, and role expectations, evident in the correctional environment, leading to the intensification of offending and anti-social behaviour. It may also lead to the development of relationships between offenders with disability and other offenders that will also continue a cycle of criminal and anti-social behaviour post release;*
- *Persons with disability are more likely to be subject to intensified stigma as a result of incarceration. They are far less able to protect their privacy, and a history of imprisonment will interact very negatively with existing stereotypes and prejudice towards persons with disability within the community;*
- *Persons with disability have little, if any, access to alternative and augmentative communication systems in correctional facilities. A person who is Deaf, for example, will typically have no access to an interpreter, and consequently, is likely to experience extreme social isolation and alienation;*
- *Correctional health services are inadequate and may have very limited knowledge of the specific health needs of persons with disability;*
- *Correctional mental health services, in particular, are totally inadequate and may have very limited expertise in the treatment of persons who may have multiple impairments, for example, intellectual as well as psychosocial impairment;*
- *Correctional facilities may not be physically accessible to persons with mobility and other functional restrictions*. (French, 2007, Page 101-102)

6.4 Rape in prisons

Prison rape is a significant issue. Interviews with workers in the disability sector indicated that rape in prison is a real problem that frequently goes unreported. Often the victims are reluctant to make a formal complaint for fear of retribution.

Hundreds of studies have been conducted regarding prisoner welfare in correctional institutions, however, only a small percentage have been conducted on sexual assault in prison (National Institute of Justice, 2010). The Prison Rape Elimination Act (PREA) 2003 indicated that 13% of inmates had been raped in American prisons (National Institute of Justice, 2010).

There have been few studies into sexually violent activities in the Australian prison context (Denborough, 2005). One exception was a survey of 300 male prisoners aged 18 to 25 in New South Wales prisons in 1995. It was found that 26% of young men reported that they had been sexually assaulted in prison and 50% stated that they had been physically assaulted (Heilpern, 2005). Inmates with mental illness, first time offenders and young offenders were at increased risk of sexual victimisation. Juveniles were five times more likely to be sexually assaulted in adult, rather than juvenile, facilities – often within the first 48 hours of incarceration (Heilpern, 2005).

Prison rape can result in physical and psychological harm that can persist long after the assault. Victorian prisoners have been noted to suffer higher than average levels of sexually transmitted diseases (Taylor, 2012). The issue of unprotected sex is an issue for disease control in the prison environment. The implications are also significant as prisoners are released into the community.

The Preventing Prisoner Rape Project is a national project in Australia aiming to raise awareness about the issue of rape in prisons, to support prison rape survivors and their support workers, and bring about appropriate law reform and changes to prison administration in order to prevent sexual violence in detention. Some useful information packages have been developed such as the *Prisoner Rape Support Package* for survivors of prisoner rape (Denborough, 2005), and the "*Preventing Prisoner rape and its effects: Some ideas from the Preventing Prisoner Rape Project*" that outlines systemic recommendations (Denborough, 2012). Continued work needs to be undertaken to address these issues in the Australian prison system and provide support to those who have been sexually assaulted.

The vulnerability of persons with ABI in prisons suggests that this group is likely to be subject to sexual assault, however, this issue had been largely ignored in the literature. Future studies should investigate the incidence of prison rape experienced by people with ABI and look at treatment approaches to the resultant psychological trauma.

6.5 Self harm and suicide

Self-harm and death by suicide in prison custody demonstrates the vulnerability of individual prisoners and is an indicator of prison distress (McArthur, Camilleri, & Webb, 1999). Self harm and suicide are not uncommon in Australian prisons. Between 1980–1998, 787 people died in Australian prisons; 47% of these deaths were due to suicide (Dalton, 1999). The most common cause of death during that period was hanging (Australian Institute of Health and Australian Institute of Health and Welfare, 2011). Researchers estimate that for every suicide there were 60 incidents of self-harming behaviour (McArthur et al., 1999).

The National Prisoner Health Census, conducted in 87 of the 93 public and private prisons throughout Australia during mid 2009, found a history of self harm was reported by 18% of prison entrants (Australian Institute of Health and Welfare, 2010).

There is evidence that ABI is a risk factor for suicide both in the general population and in prison. Compared with the general population, people with traumatic brain injury (TBI) show significantly higher levels of suicide attempts and are three to four times more likely to die as a result of suicide (Simpson & Tate, 2007).

A study of 200 prisoners in New South Wales indicated that a history of TBI was associated with higher rates of self harm and suicide attempts compared with prisoners without TBI. Prisoners who had multiple incidents of TBI were more likely to show higher rates of self destructive behaviour, with 25% of those with four or more TBIs reporting a history of self harm or attempted suicide (Schofield et al., 2006).

In most Australian jurisdictions, prisoners who are assessed as high risk of suicide or self harm are placed in special management units. Depending on their ability to engage in treatment, they may be offered an intervention program to address behaviour and attitudes. They may not, however, have access to specialist services that have expertise in ABI and neuropsychiatric sequelae.

Suicide and self harm are most likely to occur when an at-risk prisoner is alone. Segregation and isolation are often used by prisons as a behaviour-management response, and this can lead to a deterioration in mental health (Taylor, 2012). In minimising incidents of harm, an emphasis has been placed on the importance of increased social interaction in custody, visitor supports for prisoners, and increasing interaction between prison staff and visitors in an effort to facilitate effective communication of prisoner needs and risks, and to provide better support services (McArthur et al., 1999).

It is recognised that suicidality and self-harming behaviour may necessitate intervention beyond that provided by the prison institution. Information gathered for this report indicated that there was a lack of knowledge and inconsistent reports amongst workers in the justice and disability sectors regarding the pathways to access specialist services in prison for people with ABI.

6.6 Health issues and access to specialist services

A concern raised by a number of service providers is that prisoners are often unable to access basic equipment resources (e.g., aids related to their disability), specialist resources (e.g., neuropsychological or neuropsychiatric assessment), or compensated therapy (e.g., Transport Accident Commission (TAC) or WorkSafe funded services).

> *Prison guards may, for example, confiscate from prisoners wheelchairs, crutches, braces, hearing aids, glasses and medications. Prisoners who need special assistance with daily activities, such as eating, dressing and bathing, may be simply ignored. They may be left without meals and forced to urinate on themselves in the absence of bathroom assistance. Prisoners with disabilities may be psychologically abused, for example, by the moving around of furniture in the cell of a visually impaired prisoner or by verbal taunts.* (p. 45; United Nations Office on Drugs and Crime, 2009)

Prisoners with ABI are likely to be in need of special health care services, such as nursing, medical and psychiatric treatment, psychological intervention such as counselling and cognitive-behaviour therapy, speech therapy, occupational therapy and physiotherapy. Unfortunately, a lack of adequate healthcare resources in prison means that individuals are often unable to access specialised integrated treatment.

During the term of their incarceration, prisoners are not eligible for Medicare or other government benefits. They are unable to access compensation claims, for example via TAC or WorkSafe, or other publicly-funded services such as specialist ABI case management. Interviews with workers in the ABI sector indicated that there is uncertainty in the system about what healthcare services are accessible in prison. Some community agencies will provide services into the prisons and others will not. There appeared to be a lack of knowledge about which services would go into prisons, and inconsistencies in service responses. It was reported that calls to services often lead nowhere because the contact person was unavailable and messages were often not returned.

Due to confidentiality issues, a prisoner's history of ABI may not be communicated to corrections staff, and therefore appropriate treatment approaches are never implemented. Health records may be managed by an external health agency and are kept separate to the prison records. When prisoners are transferred between prisons, their medical files should be transferred with them, however, information may not be adequately communicated.

The health of prisoners has been noted to be poorer than people in the general community. The National Prisoner Health Census conducted in Australian prisons during 2009 collected detailed data on 549 offenders entering prison, 3,700 prisoners in custody who visited a clinic, and over 4,900 prisoners who were taking prescribed medication (Australian Institute of Health and Welfare, 2010). Results of the census

indicated that a high proportion of prisoners had mental health problems, high levels of psychological distress and a history of head injury leading to a loss of consciousness. Rates of hepatitis B and C were significantly higher among prison entrants than the wider community as well as high levels of smoking, alcohol consumption and illicit drug use.

Of the 549 prison entrants in the 2009 National Prisoner Health Census:

- *89% were male, the median age was 29 years and 26% were Indigenous*
- *75% had completed Year 10 or less schooling*
- *68% had been previously imprisoned and 24% had previously been in juvenile detention*
- *37% of prison entrants reported having a mental health disorder at some time and 18% reported that they were currently taking medication for a mental health related condition*
- *29% reported high or very high levels of distress measured by the K10*
- *52% of prison entrants reported drinking alcohol at levels placing them at risk of alcohol-related harm*
- *71% of prison entrants had used illicit drugs during the 12 months prior to their current incarceration*
- *43% of prison entrants reported having had a head injury resulting in a loss of consciousness (LOC)*
- *head injury with LOC was more common among males (44%) than females (33%).*

(Australian Institute of Health and Welfare, 2010)

6.7 Advantages and disadvantages of incarceration

It is not uncommon to hear service providers comment that their client "does better in prison" due to the routine, structure and supervision imposed in a correctional facility. For some individuals with ABI, a term in prison can assist them to stabilise some aspects of their lives. For example, some individuals benefit from having their medication reviewed and administered consistently in prison so that they are at therapeutic levels. Prison provides an opportunity to cease alcohol and substance use and in effect "detox". For some individuals, a period of incarceration can reduce social stressors and crises that

occur in the context of their normal living environment. Hence, there are some clear benefits that can emerge from a prison stay. These advantages, however, are not the purpose of prison and certainly incarceration is an extreme measure to achieve such outcomes that preferably would be available in the community.

For many individuals, prison can be associated with deterioration in mental health. According to Taylor (2012), prison conditions found to contribute to mental health problems include:

- lack of privacy, overcrowding
- bullying, harassment, victimisation, violence, fear, distrust
- isolation from family and community support networks
- poor access to services and programs, and to health and mental health services.

An investigation by the Victorian Ombudsman found that there was insufficient capacity within prisons to adequately deal with the variety of presenting mental health problems, there were too few visiting mental health staff, staff did not have sufficient duty hours to meet the need, and there was minimal access to after-hours services (Taylor, 2012).

It has been noted that persons with disability may experience much more intense negative outcomes from incarceration than others. They often don't have the skills to cope with the prison brutality and their mental status can deteriorate without access to adequate health care (United Nations Office on Drugs and Crime, 2009).

6.8 Initiatives

In recent years, a number of initiatives have been developed to address some of the issues regarding the custodial management of persons with disabilities.

6.8.1 Disability Framework

In 2007, *Addressing the Barriers - the Corrections Victoria Disability Framework* (Department of Justice, 2007) was launched by the Department of Justice that outlined a three-year plan to address the issues relating to prisoners and offenders with a disability. This framework included a specialised response to prisoners with a cognitive impairment (intellectual disability and acquired brain injury), mental illness, sensory disability and physical disability. The framework included a range of initiatives briefly described below. Following this, in 2009, the Corrections Victoria Disability Framework 2010–2012 put forward a continued commitment by the Department of Justice to manage the ongoing challenges contributing to elevated recidivism among offenders with disability (Department of Justice, 2009).

6.8.2 Corrections Victoria ABI Program

In January 2010, the Corrections Victoria ABI Program was established in response to mounting evidence regarding the high prevalence of ABI in the prison system. The program aimed to improve outcomes for offenders and develop internal capacity in the correctional system through the appointment of an ABI Clinician Consultant, funded by the Department of Justice. The key role of the Consultant was to assist prisons to assess and manage clients with ABI. The program also sought to increase access to external expertise and provide early and direct specialist interventions. The program addressed four key areas; direct treatment including assessment and case coordination, secondary and tertiary consultation, information and training, and networking and partnerships (Department of Justice, 2011).

Over an 18-month period, the ABI Clinician Consultant had:

- conducted 751 offender screenings
- identified 123 offenders with an ABI
- provided 362 primary/secondary consultations

One case example had been published that described a man with complex presentation being "paroled into the community without any formalised supports in place" (p. 137; Famularo, 2011), only to breach parole and return to custody. The ABI Clinician subsequently worked with a range of services and providers to create treatment plans for within and outside of prison with improved case outcome.

Presumably a dataset relevant to these appraisals will be developed over time, and become a valuable resource regarding client diagnoses, disability-related or therapeutic needs, responses within the prison, and release planning.

6.8.3 Disability Prison Services Coordinator

The Disability Prison Services Coordinator (funded through the DHS) provides a link between Disability Services and Corrections Victoria. The Coordinator contributes to the development of all aspects of services for male and female prisoners with an intellectual disability. There is a legislative responsibility to provide services to all those deemed eligible under the Disability Act, including people with ABI. Additionally the Disability Prison Services Coordinator assists in relation to assessments and consultations for prisoners, assists regional case managers in providing services for prisoners, and coordinates prisoner release planning.

6.8.4 Disability Prison Pathways

The Disability Prison Pathways Program (DPPP) provides a number of programs for prisoners with cognitive impairment. The DPPP is based on an integrated approach

where programs in specialist units are based on a 'treatment community approach' and a strengths-based approach. The intention is to have a 'continuum of care' where public and private providers and the disability sector work together in an integrated manner, with appropriate transfer of information, joint planning, integrated case management and offender management services, and specialist advice in prisoner management. In Victoria, clients with an ABI and ID who are sentenced to prison are likely to go to the Marlborough Unit at Port Phillip Prison.

6.8.5 Protocols

The Protocol between Corrections Victoria, Department of Justice, and Disability Services, Department of Human Services, was reviewed in 2008. The protocol recognised offenders with ABI and other disabilities. Of note, however, many of the systems in place still refer to people with intellectual disability. There does not appear to have been sufficient capacity building within the system to manage the high number of persons with other disability types. This is a system that is still characteristically ID focused.

- Targeted Behaviour Programs are approximately 90% ID
- Sex offender treatment programs are designed for ID
- The Disability Forensic Assessment and Treatment Service (DFATS) residential service is for ID, and regarded as "not really set up for ABI".

6.8.6 Transitional Housing

In 2010, the Supported Transitional Accommodation project was implemented whereby prisoners with ID or ABI could receive intensive transitional support when exiting prison. This project was intended to overcome a lack of suitable accommodation associated with disabled prisoners not receiving timely parole. The 10-bed facility focused on community integration including building routines, positive behaviours, managing responsibilities and social contribution. It would be useful to access data to ascertain what proportion of the target group using the service have ABI.

6.8.7 The Joint Treatment Program

The Joint Treatment Program is a 35-bed unit located at the maximum security Port Phillip Prison. It provides programs that address offending behaviour and social skills deficits for male prisoners with a cognitive impairment. The Program utilises a therapeutic approach, promoting the pro-social behaviour of offenders through the use of positive peer culture.

This Program is delivered in partnership by the Disability Forensic Assessment and Treatment Service (Department of Human Services), Port Phillip Prison (GSL Australia), and Corrections Victoria (Department of Justice). Available evidence points to the

effectiveness of a therapeutic environment, with positive improvements being noted in institutional conduct and recidivism rates.

The Joint Treatment Program is a structured program, based on assessment, that will seek to reduce offending behaviour via programs addressing cognitive skills, violence, sexual assault, and drug and alcohol-related offending. Support is provided regarding recreation, education, prison industries and art therapy. The program outcomes can enhance community safety through harm minimisation approaches and reducing recidivism.

Eligibility for this program includes sentenced prisoners with a cognitive impairment (ABI or ID) who have agreed to undertake treatment and have been assessed as being suitable for adapted offending behaviour programs. These prisoners are drawn from across the Victorian prison system. If a person is known to have ABI at the time of sentencing, they are likely to be referred to this program.

The program staff are mindful of the needs of people with ABI (as compared with ID), and report that approximately 10% of clients in the program are considered to have an ABI.

6.8.8 Portfolio holders

An initiative commenced in 2008 that saw Disability Portfolio Holders located in all Victorian Prisons. This was intended to improve responsiveness to prisoners with a disability, to provide a local contact point for staff seeking information or assistance, and to share skills and knowledge through meetings and training sessions and build capacity within the sector.

6.9 Establishing disability status

The previous sections describe important efforts made by the Department of Justice over recent years in consolidating existing services and addressing key service gaps. This section considers some significant existing gaps described by interviewees.

Within prison, some people with ABI will be recognised for their disability and receive targeted treatment and assistance at release, and many more will not.

Conversations held with staff working within the prison system indicated that many people with ABI face considerable challenges in being formally identified as having a disability.

If someone is deemed to have a disability, the DHS are obliged by law to provide services – for example, a case worker to assist with community reintegration at time of release. But a variety of hurdles exist in being formally recognised as disabled. To receive DHS services, a person is required to demonstrate disability by satisfying the requirements of

a Target Group Assessment (TGA). To satisfy a TGA, the person requires a recent neuropsychological assessment (NPAx) evidencing brain injury, and clear support needs. To have a NPAx, the person needs to first be identified then assessed – and this is where the luck of the draw presents.

Within the prison system there are two main ways someone will be detected as having an ABI: prison officers will suspect it and inform clinical staff, or clinical staff will meet a new prisoner to assess and determine their needs. Prison officers are not necessarily trained nor expected to identify clients with ABI. Prison staff report that the sheer number of clients with ABI in prisons is making the task of detection, assessment, and referral to disability/assessment services an unlikely outcome for many prisoners.

Access to NPAx seems to be particularly difficult. During this project, we were unable to find anyone who could identify a consistent referral pathway for prisoners to NPAx. Without that, no TGA, no disability, no services.

A theme arising out of conversations with corrections workers is that they need to know who to refer to if they suspect ABI, and to understand the way the roles of the ABI Clinician and the Prison Services Coordinator co-exist. Famularo (2011) noted that there were no formal processes or procedures for dealing with complex cases, and that intervention often occurred on an ad hoc basis.

6.10 Sex offenders

The following information was provided by the Offender Management Division, Corrections Victoria.

Sex offenders with an ABI are assessed to determine their treatment needs, as are all sexual offenders within prisons. This assessment includes evaluation of responsivity issues such as an individual's level of cognitive ability. Corrections Victoria recognises that prisoners with ABI are not a homogenous group and their level of functioning varies. The Sex Offender Programs (SOP) deliver Modular Management Intervention Programs for the majority of sex offenders or for those with lower-level cognitive functioning. The Skills Based Intervention Program provides for more repetition, over a longer duration, with more use of concrete concepts to cater for special needs.

For offenders whose cognitive disability prevents engagement with this level of intervention, treatment by Disability Pathways clinicians provides a modified intervention program. This is a joint program between Corrections Victoria and the Department of Human Services, Disability Client Services.

A Supervision Order under the Serious Sex Offender (Detention and Supervision) Act is imposed if a court, following full examination of all information, finds that an offender presents an unacceptable risk of committing a relevant offence if in the community and not subject to a Supervision Order.

Offenders subject to Supervision Orders are members of the community and reside in a variety of accommodated options. One of these is a residential facility which is outside Ararat Prison and is not a secure facility. Offenders subject to Supervision Orders who reside at the residential facility are accommodated there until suitable alternative accommodation can be located. Specialist Case Managers may become involved to work with offenders and other services, and identify appropriate alternative housing that in many cases requires additional funding provided by Corrections Victoria.

6.11 Training

Ongoing commitment to training is critical in affecting change. Pitman (2008) suggested there is a need for dedicated training of prison staff because knowledge and understanding of ABI is generally poor. Limited awareness can lead officers to misinterpret a prisoner's behaviour, set up the prisoner to fail, and unintentionally provoke incidents. The role of the ABI Clinician Consultant and the portfolio holders is critical here. The ABI Clinician Consultant has conducted dozens of training sessions with prison staff since the commencement of the ABI Program.

Others have broadened the target audience to personnel at all levels of the justice system, including police, court liaison officers and judiciary (Langdon, 2007). Training should incorporate appropriate assessment methods and tools to identify the presence of ABI. Continuous professional education and skill development is important in this area. One-off training is inadequate.

The Offender Management Division, Corrections Victoria reported that:

Extensive disability training had been delivered to over 1,500 staff, and some staff may have participated in multiple training sessions. Front-line correctional staff had been targeted for training, including:

- introductory disability-awareness training provided to 175 Community Correctional Officers in the past three years
- specialist sessions delivered by external experts on hearing impairment, vision impairment, and autism spectrum disorder
- introductory and advanced training on acquired brain injury
- ongoing training to staff in specialist units

One issue to be addressed is to assist personnel to refer on, and ensuring that there are services and supports to refer on to. The dilemma exists that there are often no resources or referral pathways to access additional supports (Langdon, 2007).

6.12 Release

6.12.1 Planning for release from prison

An estimated 50,000 people are released from prison each year in Australia (Australian Institute of Health & Welfare, 2010). People with disabilities require specialised pre-release planning to ensure successful transition back into the community (United Nations Office on Drugs and Crime, 2009).

A study of 113 prisoners with mental illness in a medium security facility in the UK showed that people with head injury were more difficult to discharge compared to their non-head injured counterparts. The authors concluded that information on head injury should be collected on admission to prison and considered when planning for release (Hawley & Maden, 2003).

At the time of release, the amount of support a person gets depends very much on whether their disability has been detected, substantiated, and then recognised by Corrections Victoria and Disability Services. For some clients, their time within the prison, or the urgency of their case, may mean that insufficient time has been available for substantiating their ABI. Even if ABI is suspected, it may be difficult to arrange a neuropsychological assessment that can be presented as part of a TGA assessment for eligibility for Disability Services.

6.12.2 Disability Services clients

When people registered with Disability Services are convicted, they trigger a 'justice service system' response. Best practice guidelines suggest that six months prior to a person's earliest release date, the Disability Prison Services Coordinator will make contact with the person's region of origin to commence pre-release planning and service support (Department of Human Services, 2007).

Upon release, individuals who are registered with Disability Services as having intellectual disability are allocated a DHS worker who can help establish such things as accommodation, employment, and other supports. Clients who have an ABI may receive no service. If the registration process with DHS has not been completed, they are not eligible for a DHS worker to assist with release planning.

6.12.3 Compensable clients

Prisoners who have an ABI due to a motor vehicle accident, may be entitled to services funded by the Transport Accident Commission (TAC). When entering the prison system, however, the TAC does not consistently track them, and a pending release from prison does not necessarily trigger TAC re-engagement (e.g., case management, service coordination). Unless these clients can identify to clinical staff within the prison, or those

staff detect the link to the insurer, these clients can be discharged without the assistance they are eligible for.

6.12.4 Challenges

Individuals who have been incarcerated for a long period of time may have lost access to their public housing property and will face homelessness. If there are not sufficient supports that can link them into housing, assist with Centrelink payments or employment options, then there is a high probability that they will re-offend. Workers from VACRO had noted that insufficient information was passed on post release. What is needed is well-integrated interagency communication for release planning.

If a prisoner has been through a specific program (e.g., Targeted Behaviour Program) they will have a Completion Report with important information about their situation and disability. If the person is paroled, this report can be used by a Community Corrections Officer (CCO). If the person is not paroled (straight release), there will be no CCO. Hence, prisoners with ABI often receive no support, and are discharged with verbal advice rather than a CCO or DHS worker.

6.12.5 Death following release from prison

Death following release from prison is a considerable issue. Prisoners are at markedly increased risk of death following release from custody, especially in the weeks immediately following release. The main causes of death among ex-prisoners, particularly in the first few weeks, are related to drug and alcohol use, suicide and injury (Australian Institute of Health & Welfare, 2011). It is therefore critical that appropriate pre-release planning is undertaken for vulnerable individuals, and that they are provided with adequate support and monitoring in the weeks post release.

6.12.6 Neuropsychology assessments

Neuropsychology assessment (NPAx) can be an important part of identifying someone as having a brain injury, determining eligibility for services, and assisting in release planning. Of concern, none of the people spoken to in interviews for this project could identify a consistent process within prison to trigger a NPAx. Many were frustrated that they were unable to access NPAxs.

There is evidence that, at times, prison staff do seek NPAx, but do not have funds to pay for it. There was a widespread belief among interviewees that when someone is in prison it is an ideal time to conduct an assessment because the person is accessible, likely to be drug free, and have a stable routine. They also believed that the prison system would be the likely funder of these assessments.

7. Post Release (community integration)

There are two main ways in which prisoners are prepared for release to the community. The Transition Assistance Program (TAP) is conducted by prison staff and provides prisoners with information about such things as Centrelink, legal and correctional services. There are also transitional release programs (e.g., Link Out) delivered by community-based agencies such as VACRO and Jesuit Social Services. These services provide a case management approach that involves meeting prisoners approximately two months prior to release to develop a release plan that addresses such things as accommodation, health treatment, legal, and employment issues. These services typically work with a client for approximately six months, and are time limited (e.g., not more than 12 months).

Community-based workers identified difficulties with release approaches that fell into two main categories: Generic issues that are relevant to prisoners with and without ABI, and specific issues that are particularly related to disability and ABI.

7.1 General support system problems

Almost all prisoners released to community-based transitional services are homeless and require transitional housing. This creates a lack of stability and presents problems to other administrative systems (e.g., Centrelink) that require a person have a fixed address. Clients often have a raft of problems including limited finances, social issues trying to fit in to a new environment, and personal issues including adjustment and depressed and anxious mood. Famularo (2011) reported a case study from Victoria in which a prisoner with multiple diagnoses was released without any formalised supports; he was consequently homeless, breached parole, and was returned to custody.

Post release services are referred prisoners, typically by the prisons, with little historical documentation to promote streamlined and efficient case management.

They are time-limited and face the unenviable task of solving homelessness, financial, and ongoing health and social issues within 12 months. Sourcing ongoing case management is difficult for them – especially when a client does not have a clear diagnosis.

7.2 Specific issues relevant to ABI

In many cases, people with ABI who are released from prison are left to their own devices, meaning that the same cognitive, disability, and social issues that led them into the criminal justice system persist. These very attributes left unaddressed make it more likely that clients reoffend and reenter the prison system.

7.2.1 Lack of diagnosis

Transitional (community-based) services typically receive referrals without a diagnosis. Workers report a need for a diagnosis (and, preferably, a neuropsychology assessment report) to link clients to appropriate services in an efficient way. For example, by knowing of an ABI due to motor vehicle accident, post release services could contact the Transport Accident Commission (TAC) to re-initiate case management or other services.

Clients with ABI are instead treated in a generic sense with the case manager left to discover any cognitive-behavioural hurdles to effective servicing (e.g., forgetting appointments, failing to complete documentation) by inefficient trial and error. There are no known referral data indicating whether these clients with disabilities ultimately get access to specialist services.

Even when transitional support staff identify behavioural indicators of ABI such as anger, impulse control, and gullibility among clients, they are often unable to establish a diagnosis because there may not be a neuropsychology service available; if there is, waitlists for assessment are often very long. Furthermore, they do not have discretionary funding for accessing private assessments. Without a diagnosis, the client remains locked out from the specialist service system.

7.2.2 Lack of records

A lack of diagnosis is related to the broader issue of lack of health records among clients with ABI. Because they are often poor historians, have few social contacts to provide such history, and there is no centralised file system, clients cannot provide reliable accounts of their injuries, diagnoses, medications, or treatments.

Many informants to this project reiterated that an opportune time to assess, clarify diagnoses, and compile health history is while the client is imprisoned.

7.2.3 Locating specialist services

Case managers not specialised in ABI report struggling to navigate the maze of ABI-related services at the same time as dealing with problems such as homelessness, legal, income and financial issues. They refer to other services based on their local knowledge. Hence, a client's fate is very much determined by one worker's knowledge of available services and their best guess at diagnosis. The consequence can be that clients fail to

receive the specialist support they need, and services that do receive referrals can operate less efficiently and effectively than is possible.

Case example 7.1: *"Despite requiring specific treatment intervention, for example, a violence intervention program, Mr X was unsuitable for group treatment, because his cognitive capacity presented a barrier to group work. Consequently, individual treatment was deemed the most appropriate option for Mr X to address his offending behaviour. Disability Pathways does not have the financial resources necessary to provide funding for specific services. Thus, there were initially no avenues for Mr X to be provided with specific intervention, and he was paroled into the community without any formalised supports in place.*

A consequence of this was that Mr X quickly became homeless with no support upon returning to the community, placing himself at risk. This was largely due to Mr X not having a plan, which was ready to be activated when he was re-entering the community, or strategies in place to reduce his future risk level. Subsequently, Mr X's parole was breached (he was initially released to a friend's residence) and he was then returned to custody." (p. 137; Famularo, 2011)

7.2.4 Stability

Many service providers who have worked with clients with ABI leaving prison note that "conditions that work for the client on the inside – structure, routine, consistency – are lost upon release to the outside". Many clients, due to their cognitive difficulties, are reliant on highly structured environments – predictable mealtimes, worktimes, exercise times, clear rules about behaviour, and so forth. Shifting from this predictable, consistent context to one that is largely unstructured and requiring cognitive skills for planning, problem solving, monitoring behaviour, recalling goals, and turning knowing what to do into actual doing, is often highly disruptive, confusing, and is poorly self-managed.

A client may shift from prison staff to transitional case manager. If the client moves from a prison in, say, Barwon, to home in, say, Mildura, the case manager will again change. With each change, a new worker needs to familiarise themselves with the client.

Community workers report needing more time to be able to assist clients through to a stable situation where the chance of reoffending or other crisis is minimised.

7.3 Recommendations

7.3.a. Transition to community: Establish a service model that focuses on bringing community-based services into the prison, rather than leaning heavily on prison staff informing prisoners about community services. Skilled community-based staff could enter prison in the months prior to release to address such things as details of Intervention Orders, client financial situation, accommodation options, rehabilitation needs (e.g., in-home cognitive supports, community behaviour support), and funding applications (e.g., Disability Support Register). That is, assist the client to make a smooth, supported, transition.

7.3.b. Diagnosis and records: Upon receiving referrals, transitional services (e.g., VACRO) should routinely contact pre-sentence services (e.g., CISP) to access and utilise valuable client history.

7.3.c. Alternatively, modify the scope of pre-sentence and transitional services so that one service can monitor a person who enters prison while they are imprisoned, then re-engage prior to release. This will capitalise on the large amount of work conducted during the presentencing period.

7.3.d. Locating services: Better partnerships are needed between existing ABI services and transitional programs. Case managers need an ABI-skilled contact in each region. In regional areas, that contact would be the ITASC project worker who could provide information and secondary consultation with regard to ABI-related services.

7.3.e. Staff of transitional services would be aided by training in the screening for, and recognition of, ABI, particularly distinguishing between ABI, ID, and MI. This is something ITASC workers would be able to arrange using expert trainers already part of their training calendars.

8. Summary of findings and suggestions

This project had the overarching aim of collating information from a variety of sources to establish an evidence base regarding the experience of people with ABI in the criminal justice system (CJS) in Victoria, Australia. The report attempts to portray the characteristics and circumstances of people with ABI who come in contact with the law, and to identify common themes among problems and solutions identified by current service providers. The project's scope has been limited by its level of resourcing; and it is expected that VCASP will use the content of this report plus similar reports to construct informed submissions to assist Government to develop effective service responses to people affected by ABI.

This report provides many recommendations for small and large changes that would assist people with ABI. This is not an exhaustive list, and increased resourcing of this or future projects would provide for more consultation, evaluation and planning. Key areas not addressed in this report include Juvenile Justice issues, indigenous issues, diverse cultural issues, and the often-cited disparity between the service system offered to people with ID, but not people with ABI.

The prevalence of people with ABI in Victorian prisons is high; over 30% of female prisoners and 40% of male prisoners were recently identified as having an ABI on the basis of neuropsychology assessment results. Substance use was identified as a common causal factor in the brain injury and offending behaviour. Mental illness was a common comorbidity, and this mirrors findings in other ABI research using samples from outside of prisons. Homelessness and marginalisation were common among the Australian samples considered and, in terms of service assistance, a key study from NSW found that prisoners were far more likely to have received Legal Aid (a consequence of their alleged criminal acts) than other community services that might address some of the causes of their offending behaviour.

There have been a number of notable pragmatic advances in Victoria's approach to managing ABI within the criminal justice system. The police have initiated the Ready Reckoner, Mental Health Liaison Officers, participated in community consultation, and delivered cross-service training. VCASP has initiated and sustained a Criminal Justice Subcommittee. The Department of Justice have introduced the CISP program and the courts have commenced the ARC list. Working within prisons now is an ABI Clinician Consultant. The VCASP Criminal Justice Subcommittee has run multiple training sessions in metropolitan Melbourne to educate service providers about the presence of, and activities of, the police, the ITP program and legal resources.

Three key themes repeatedly arose during discussions related to this project: (1) a lack of continuity of service for people engaging with the criminal justice system, (2) among

the workforce there is a lack of awareness of ABI and justice issues, and of where to go for assistance, and (3) inequity in services provided for people with ABI.

Examples of loss of continuity included ITPs not being able to follow up with service referrals, CISP-generated client histories not being available to post-release services, and compensable and noncompensable services ceasing at prison, but often not reactivating upon release. There is a sense that, despite a prison sentence signaling a need for service provision, going to prison elicits a cessation of services or service continuity.

Another common theme was the need for information and ongoing education and training. For example, service providers at pre-sentencing and post-release services regularly did not know that in each DHS rural region is an ABI Information, Training, and Secondary Consultation project that has as part of its brief the provision of information and training to service providers working with people with ABI.

With only a modest funding increase, the regional ITASC projects could neatly fit CJ training into their annual training calendars and advertise this through justice, disability, advocacy, and mental health networks. The VCASP Criminal Justice Subcommittee has run very successful cross-disciplinary training involving police, ITP, legal, and ABI experts educating a diverse array of service providers, but this has not been ongoing and the knowledge/liaison practices between service sectors have been lost over time.

With regard to inequity, there was a sense that people with ABI are disadvantaged at each stage of the criminal justice process. For example, as a victim or witness of crime, there is evidence that someone with ABI can be assumed not to be credible when presenting evidence to police, so may not have their case pursued. At presentencing, people with ABI constitute approximately 13% of ITP interventions and 10% of CISP clients, but at the point of prison they represent at least 30-40% of the population. Duty lawyers are known to often not recognise ABI (the “hidden disability”), thereby leaving a charged client with ABI to be judged without adequate consideration of their disability. Only a small proportion of people with ABI are managing to access specialist disability legal services.

Although release from prison to the community would be considered to be a positive change of circumstances, there was an ironic discordance because a prisoner with ABI and cognitive impairments is released often into homelessness, often with limited professional support, or time-limited support from professionals without the benefit of case history or knowledge of the ABI service sector. Individuals with cognitive deficits lose the routine, structure, and predictability of the prison environment that can help achieve stable behaviour and mood. The stage seems, then, to be set for recidivism and continued involvement with the criminal justice system.

9. References

Australian Bureau of Statistics. (2012). page title: "4512.0 - Corrective Services", Australia, June 2012. Retrieved September, 2012, from http://www.abs.gov.au

Australian Institute of Health and Welfare. (2007). Disability in Australia: acquired brain injury. *Bulletin no. 55. Cat no. AUS 96.* Retrieved from http://www.aihw.gov.au/

Australian Institute of Health and Welfare. (2008). Disability in Australia: intellectual disability. *AIHW bulletin no. 67. Cat.no. AUS 110.* Retrieved from http://www.aihw.gov.au/

Australian Institute of Health and Welfare. (2010). *The health of Australia's prisoners: 2009*. (Cat. no. PHE 123). Canberra, Australia: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare. (2011). *The health of Australia's prisoners: 2010*. (Cat.no. PHE 149). Canberra: Australian Institute of Health and Welfare.

Barnfield, T. V., & Leathem, J. M. (1998). Incidence and outcomes of traumatic brain injury and substance abuse in a New Zealand prison population. *Brain Injury, 12*(6), 455-466.

Butterworth, P., Anstey, K., Jorn, A. F., & Rodgers, B. (2004). Results from a community survey demonstrated cohort differences in the lifetime prevalence of self-reported head injury. *Journal of Clinical Epidemiology, 57*(7), 742-748.

Dalton, V. (1999). Suicide in prison 1980 to 1998: National overview. *Trends & issues in crime and criminal justice* (pp. 1-6). Canberra, Australia: Australian Institute of Criminology.

Denborough, D. (2005). Prisoner rape support package: Addressing sexual assualt in men's prisons. *The International Journal of Therapy and Community Work, 2,* 29-37.

Denborough, D. (2012). Preventing prisoner rape and its effects: some ideas from the Preventing Prisoner Rape Project. pp. 1-3. Retrieved from http://www.dulwichcentre.com.au/preventing-prisoner-rape-and-its-effects.pdf

Department of Human Services. (2007). Disability Services Criminal Justice Practice Manual. Melbourne, Australia.: Department of Human Services.

Department of Human Services - Multiple and Complex Needs Initiative. (2009). Regional Gateway Data Report 2008 - 09.

Department of Justice. (2007). *Addressing the barriers: Corrections Victoria Disability Framework 2007-2009.* Melbourne, Australia: Department of Justice.

Department of Justice. (2009). *Committing to the challenges: Corrections Victoria Disability Framework 2010-2012.* Melbourne, Australia: Department of Justice.

Department of Justice. (2010). *Court Integrated Services Program: Tackling the causes of crime*. Port Melbourne, Australia: Courts and Tribunals Unit.

Department of Justice. (2011). *Disability Framework Report Card No. 2 - Half Way Mark*. Melbourne, Australia: Department of Justice.

Department of Justice. (2012). Corrections Statistics FAQs Retrieved 28 September, 2012, from http://www.justice.vic.gov.au/home/prisons/research+and+statistics/correctinos+statistics+faqs

Diesfeld, K., Patston, P., McLean, M., Miller-Burgering, W., Vickery, R., & Phelan, T. (2006). Literature Review: Unmet legal needs of people with disabilities in the Auckland region, Report number 1: Legal Services Agency, Wellington, New Zealand.

Dowse, L., Clarence, M., Baldry, E., Trofimovs, J., & James, S. (2011). People with mental health disorders and cognitive disabilities in the Criminal Justice system: Impact of Acquired Brain Injury. New South Wales, Australia: The University of New South Wales.

Famularo, J. (2011). Corrections Victoria: ensuring responsive practices for offenders with complex needs. *Journal of Learning Disabilities and Offending Behaviour, 2*(3), 136-139.

Farrer, T. J., & Hedges, D. W. (2011). Prevalence of traumatic brain injury in incarcerated groups compared to the general population: A meta-analysis. *Progress in Neuro-Psychopharmacology and Biological Psychiatry, 35*(2), 390-394.

Fortune, N., & Wen, X. (1999). The definition, incidence and prevalence of acquired brain injury in Australia. *AIHW cat. no. DIS 15*. Retrieved from http://www.aihw.gov.au/

Frawley, P. (2008). Protecting the rights of people with a cognitive impairment in interviews with the Police: Experiences of the Independent Third Person program: Office of the Public Advocate.

French, P. (2007). Disabled Justice: The barriers to justice for persons with disability in Queensland. Queensland, Australia: Queensland Advocacy Incorporated.

Goodfellow, J., & Camilleri, M. (2003). Beyond belief, beyond justice: the difficulties for victims/survivors with disabilities when reporting sexual assault and seeking justice. Melbourne: Disability Discrimination Legal Service.

Hawley, C. A., & Maden, A. (2003). Mentally disordered offenders with a history of previous head injury: Are they more difficult to discharge? *Brain Injury, 17*(9), 743-758.

Heilpern, D. M. (2005). Sexual Assault of Prisoners: Reflections. *University of New South Wales Law Journal, 28*(1). Retrieved from URL: http://www.austlii.edu.au/au/journals/UNSWLawJl/2005/17.html

Howard, M., & O'Brien, J. (2009). *Criminal injustice for vulnerable people*. Paper presented at the Australian Guardianship and Administration Council 2009 conference: Social Inclusion: The future of ageing, disability and substituted decision-making, Brisbane, Australia.

Jackson, M., & Hardy, G. (2010). Acquired Brain Injury: Screening, identification, and validation in the Victorian Correctional system. La Trobe University, Australia.

Langdon, M. (2007). Acquired Brain Injury and the criminal justice system: Tasmanian issues. Tasmania, Australia: Brain Injury Association of Australia.

Law Reform Committee. (2012). Inquiry into access to and interaction with the justice system by people with an intellectual disability and their families and carers. Minutes of proceedings 21 May 2012. Melbourne, Australia.

McArthur, M., Camilleri, P., & Webb, H. (1999). Strategies for managing suicide & self-harm in prisons. *Trends & issues in crime and criminal justice* (pp. 1-6). Canberra, Australia: Australian Institute of Criminology.

McGuire, M. (2012). Breaking the cycle: Using advocacy-based referrals to assist people with disabilities in the criminal justice system. Melbourne: Office of the Public Advocate.

Miller, E. (1999). Head injury and offending. *Journal of Forensic Psychiatry & Psychology, 10*(1), 157-166.

Morrell, R. F., Merbitz, C. T., Jain, S., & Jain, S. (1998). Traumatic brain injury in prisoners. *Journal of Offender Rehabilitation, 27*(3-4), 1-8.

National Institute of Justice. (7 June 2010). Prison rape. Retrieved 17 August, 2012, from http://nij.gov/topics/corrections/institutional/prison-rape/welcome.htm

Perkes, I., Schofield, P. W., Butler, T., & Hollis, S. J. (2011). Traumatic brain injury rates and sequelae: A comparison of prisoners with a matched community sample in Australia. *Brain Injury, 25*(2), 131-141.

Pitman, I. (2008). *Crime and Acquired Brain Injury*. Paper presented at the The United Kingdom Acquired Brain Injury Forum and Scottish Head Injury Forum Joint Summer Conference, Edinburgh, Scotland.

Rushworth, N. (2011). Out of sight, out of mind: People with an acquired brain injury and the criminal justice system. New South Wales, Australia: Brain Injury Australia.

Rutter, G., & Mortell, V. (2011). The Assessment and Referral Court (ARC) List. *Psychiatric Disability Services of Victoria (VICSERV)*. Melbourne, Australia.

Schofield, P. W., Butler, T. G., Hollis, S. J., Smith, N. E., Lee, S. J., & Kelso, W. M. (2006). Neuropsychiatric correlates of traumatic brain injury (TBI) among Australian prison entrants. *Brain Injury, 20*(13-14), 1409-1418.

Shiroma, E. J., Ferguson, P. L., & Pickelsimer, E. E. (2010). Prevalence of traumatic brain injury in an offender population: a meta-analysis. *Journal of Correctional Health Care, 16*(2), 147-159.

Simpson, G., & Tate, R. (2007). Suicidality in people surviving a traumatic brain injury: Prevalence, risk factors and implications for clinical management. *Brain Injury, 21*(13-14), 1335-1351.

Slaughter, B., Fann, J. R., & Ehde, D. (2003). Traumatic brain injury in a county jail population: prevalence, neuropsychological functioning and psychiatric disorders. *Brain Injury, 17*(9), 731-741.

State Government of Victoria. (2008). *Protocol between Corrections Victoria, Department of Justice, and Disability Services, Department of Human Services.* Melbourne, Australia: Department of Human Services. Retrieved from http://www.dhs.vic.gov.au.

Synapse. (2012). Prison - Our best treatment for acquired brain injury? Retrieved July, 2012, from http://synapse.org.au/Issues-Statistics/prison-our-best-treatment-for-acquired-brain-injury-fact-sheet

Taylor, J. (2012). *Mental health in prisons: Monitoring and oversight.* Paper presented at the Monash University Faculty of Law International Conference: Implementing human rights in closed environments, Melbourne, Australia.

United Nations Office on Drugs and Crime. (2009). *Handbook on prisoners with special needs*. New York: United Nations.

VCASP Criminal Justice Subcommittee. (2004). *ITP use among persons with ABI: A survey of service providers*.

Victoria Legal Aid. (2011). Police Powers: Your Rights in Victoria. Melbourne, Australia: Victoria Legal Aid.

Victoria Police. (2007). Peace of mind: Providing policing services to people with, or affected by, mental disorders. Victoria, Australia: Victoria Police.

Victoria Police. (2011). *Crime Statistics 2010/11*. Melbourne: Victoria Police.

Victorian Law Reform Commission. (2007). *Review of the Bail Act: Final report*. Melbourne, Australia: Victorian Law Reform Commission.

Villamanta Disability Rights Legal Service. (2011). Annual Report 2010-2011. Geelong, Australia: Villamanta Disability Rights Legal Service.

Villamanta Disability Rights Legal Service. (2012). People who have an intellectual disability and the criminal justice system. Geelong, Australia: Villamanta Disability Rights Legal Service.

Williams, W. H., Mewse, A. J., Tonks, J., Mills, S., Burgess, C. N., & Cordan, G. (2010). Traumatic brain injury in a prison population: prevalence and risk for re-offending. *Brain Injury, 24*(10), 1184-1188.