THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON ASHLEY, YOUTH JUSTICE AND DETENTION IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON TUESDAY 13 FEBRUARY 2007.

Ms DEBORAH BYRNE, BRAIN INJURY ASSOCIATION OF TASMANIA WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Hall) - Thank you, Deborah, for coming along. If you would like to tell us where you come from in regard to this inquiry I will then give the opportunity to members to ask you some questions.

Ms BYRNE - I do apologise; my intention was to prepare a full submission for you and some of the information that I will cover puts into context why you have not received the submission; all you got was a covering letter. The Brain Injury Association is the peak body organisation in Tasmania for people with brain injury and their families. The duties we undertake include systemic advocacy, professional support, community education, information and referral. We do that on a statewide basis and we get $59 500 from the department to undertake that, so in terms of resources our capacity to put together a really good comprehensive submission for you is a bit limited. We are not like Anglicare that have all those resources at their disposal, so what I have done is bring along quite a lot of information that I am happy to make available to you around some of the topics.

CHAIR - If you think it is pertinent you can table that.

Ms BYRNE - All right. As you may have noticed in the letter, I wanted to come along and talk to you today because of the concern that some research has indicated that potentially up to 60 per cent of detainees in our youth detention centre could have either an undiagnosed brain injury or a diagnosed brain injury and not have it treated. I think that is something that is particularly important in terms of having a look at the detention centre because it is no good having all these young people in the centre and putting in rehabilitation programs for them if you don't have the understanding that they could have cognitive disabilities.

So today I wanted to have a look at it in terms of the context of brain injury in Tasmania and to provide you with some information to touch on that, because I think it is important to understand that there is that direct link between the fact that because we are not resourcing brain injury services in Tasmania, because we are not resourcing organisations such as ours to provide professional development to teachers, because we are not resourcing organisations such as ours to prevent brain injury from happening, the impact is that you have significant numbers of young people and also older people in our criminal justice system. I do not know whether some of you may have seen a letter that I wrote to the editor - I actually have the full copy of that which I am happy to make available to you if you would like.

In terms of the numbers of people with brain injury in Tasmania, you are looking at about 2 500 people sustaining a brain injury in Tasmania each year, and a significant number of those are children. They are only the ones that we know about. In terms of the resources that are available to brain injury, some of you may be aware that the

disability budget is $117 million - I know that you made some inquiries about it. Out of that $117 million, brain injury gets just over $2.3 million of that, but $1.5 million of that $2.3 million provides accommodation for 12 clients only. So out of what is left, you are then looking at individual support packages and day support, and out of the day support bucket, which is about $700 000, $185 000 of that supports only four clients. So what you then have is just over $500 000 for the organisations across the State to support people with brain injury.

The problem with that is if we cannot get in and provide people with support and information then there are people out there that do not know, and as I said before, organisations like ours cannot then get in and provide the education packages that are needed for teachers. One of the biggest problems, particularly in Tasmania, is the lack of understanding and awareness around children and brain injury.

I think it is important to understand the whole context of brain injury in Tasmania so there are some documents that I am happy to table and to leave for you if you would like to get an understanding of brain injury. One of those is an issues paper that was developed from some consultations we did in October 2005 which does touch on the issue of children and brain injury and also the criminal justice system as well.

There was also a verbal presentation I put together for the senate committee around the CSTDA which once again talks about brain injury in the context of the disability sector in Tasmania. I am happy to leave those for you to have a look at to give you a bit of understanding around that because there is that domino effect with that.

I guess the next thing is to actually understand the implications of not assisting children who may have brain injuries because they are likely to be at a higher risk of undertaking high-risk behaviour and we know, particularly in Tasmania, that there have been reports around child abuse. Anecdotally, we have had families come to us about this, and in one particular case a grandmother whose grandson had run away to her because his step-dad had violently abused him. She gets $28 a fortnight to support her grandson, and he is undertaking all these high-risk behaviours and is at risk of entering the criminal justice system.

In some of the information that I gave to you, there is emerging evidence to link criminal offending and brain injury.

Mr WILKINSON - Are those brain injuries the result of assault or were they born with some type of brain injury?

Ms BYRNE - This is where it is really important to understand the link. People who are born with brain injury are more likely to be classed as intellectually disabled. Brain injury is more where you might have, say, a young child of five or six who comes off their bike, or there is abuse in the family, or they fall out of a tree, and you then have interruption to the normal development of the brain.

Mr WILKINSON - Right.

Ms BYRNE - It used to be thought that the younger the child had brain injury the better the outcome, but they now know that is not the case. The problem is that you may not see

that happening until the child is older and unfortunately the link is not then made to perhaps that early brain injury. I have brought you some general information that links all that in around children and brain injury.

Mr WILKINSON - So therefore the 60 per cent of the people with brain injuries are those who have done something since birth?

Ms BYRNE - Yes, something acquired.

It was interesting that in our prevention program we did at Mission Australia called the U-Turn program there were probably half a dozen young boys and every single one of them had a story like, 'I jumped out of a tree and fell on my head and had to go to hospital and now I have problems with my memory'.

The biggest problem is in terms of the frontal lobe development because that is the part of the brain that controls your impulsiveness and is more likely to put you at risk of high-risk behaviour. We know now that that is still developing in teenagers up until the very early 20s, which really supports the argument why they should not be driving at such a young age because a lot of them they just do not have the capacity.

There was an article in the paper about a young P-plater whose excuse for road rage was, 'The guy pulled out in front of me'. That is that frontal lobe reaction - 'I'm angry at this and I'm going to react. I won't think of the consequences now, I'll think of the consequences later', and this is what we are seeing in a lot of the young kids. I have been into Ashley three times with our prevention program and a lot of the young kids there are identifying and saying, 'I had a brain injury when I was younger'.

CHAIR - Do I understand you to say that you think quite a high percentage of those current residents at Ashley may have some acquired brain injury?

Ms BYRNE - Yes.

CHAIR - Can you really prove that the percentage is higher per head of population than it is out in the general community? Is there any way you can do that or is it just a gut feeling?

Ms BYRNE - No, it is not just a gut feeling; there is evidence to suggest a link. I have a paper from Queensland - the *Public Advocate* - that has looked at that and said that up to probably 65 per cent of people in our criminal justice system have an acquired brain injury, both in New South Wales and Victoria. In fact, the criminal justice system is the biggest accommodation provider for people with acquired brain injury in Victoria. So if you are looking at the adult population we know that much. The quote I included in the letter was one of Professor Sandra Chapman's from Texas and she is saying the same thing: that up to 60 per cent of detainees in our juvenile detention centres mostly likely have an undiagnosed brain injury.

Mr DEAN - What is the correlation there with low IQ levels of detainees in Ashley and brain injury - what is the mix there?

Ms BYRNE - This is where it is difficult; I could have a perfectly normal IQ but have quite significant brain injury. A good example is a chap who goes to Headway, and he does not mind me mentioning him because we use him as an example in a lot of our training sessions. He could come in here and tell you all about his life before his brain injury, play you at backgammon and beat you every time, have a perfectly normal conversation with you, then walk out the door and around the block, come back five minutes later and have no recollection of ever having met you - and he could do that 10 times.

So a person's IQ may not necessarily be affected but the cognitive processes are. It is the ability to be able to process information, the ability to plan, to organise. With frontal lobe injury you can be very disinhibited, impulsiveness is also very common and all those things are going to get young kids into trouble. They are more likely to happen in families where there is child abuse perhaps in the lower socioeconomic area, so maybe there is a correlation there in terms of IQ, but it is really important to understand that a person with brain injury may not necessarily have a reduced IQ and that is where a lot of people make the mistake.

Mrs JAMIESON - You see it with dementia too, don't you, in older people?

Ms BYRNE - Yes.

Mrs JAMIESON - You see that with dementia too, in older people. It's quite interesting.

Mr WILKINSON - The thing is that they commit crime and they can't really say why they commit crime - they just do it. They appear normal, they appear like you and I, but there is a couple who come from very good families and they commit crime. It is that impulsivity. They do it because it is there.

Ms BYRNE - Yes, and brain injury can affect a person's sexual behaviour. They can become very sexually uninhibited. We know there are people going out into the public and they have no understanding that what they are doing is actually socially inappropriate. It's a really difficult disability because a lot of the time there isn't that obvious physical impairment. The impairments are cognitive and there are quite a range. The back of the issues papers talks about some of the areas that can be affected: a person's academic ability, comprehension, concentration, language skills, the ability to follow instruction. They can become very inflexible, very rigid in their thinking. They can perseverate; they go on and on about the same ideas. This is one of the things we really wanted to emphasise in our submission. Staff at Ashley need to have an understanding and need the professional development to understand that if they have children in their system who have an acquired brain injury, then treating them like a child that doesn't have an acquired brain injury is a waste of time.

Mr DEAN - I though it was almost mandatory that for every child or youth who goes into Ashley there was a full report on them. There would be a full report done on their backgrounds and so on but it might not necessarily cover their medical. Is that what you are saying?

Ms BYRNE - Even in the adult prison population in Tasmania there is no assessment tool that picks up cognitive impairment. There is a study in Victoria at the moment that is looking at an assessment tool that will become mandatory for adults entering the criminal

justice system. With the adult population you are talking about 65 per cent, so if you could reduce it down to 30 or 40 per cent, that is a significant number. They're not being treated any differently.

I rang the prison the other day. They give their staff a week's training on psychiatric impairment/mental health issues. They get nothing about braining injury. Nothing at all. With acquired braining injury, you don't know what you can't identify. We have a really good braining injury training package that we would dearly love to get into the prison system and particularly the education system. If you look at brain injury in a child, maybe they are six, seven or eight but in the primary school environment everything is fine. They get back to school and a very structured environment of one classroom, one teacher. They then move onto high school. You have those teenage years with hormonal development. Their frontal lobe is developing. They then have to move into a classroom or school situation and have to be able to plan and organise for themselves. They have to be able to interact differently and on different levels socially. That is all frontal lobe development. If that has been impaired then this is when our children are starting to get into problems. The Education department aren't picking up on that because there is no education category for acquired brain injury. A whole report was done that details a lot of the implications of that.

These are kids who are starting to get into trouble. They are falling through the cracks. They are labelled with bad behaviour and these are the ones that we are then likely see in your detention centres.

Mrs JAMIESON - So this could be some of the ADH kids too?

Ms BYRNE - No, they're not labelled ADH. With kids going into the education system we ask if they have been immunised. We should also ask whether your child ever had a fall and has been unconscious.

It could be just something as simple as, 'I want you to come into the classroom, put your bag in here, get your homework out from the night before, and put your lunch in here'; by the time I've mentioned lunch you have forgotten all the other instructions I have given you. Kids with brain injury get information overload if you put them in a noisy classroom. There are a lot of really good, simple strategies that teachers or teacher aides could put in place to assist these children, and there is certainly a lot of literature. We particularly want to develop an issues paper around children with brain injury that I can then use as a tool to lobby the Education department to get some education for professional development for teachers around brain injury.

Mr WILKINSON - That is a fair recommendation, isn't it, being able to go into prisons with an education program so that people can assess whether any of the inmates had a brain injury?

Ms BYRNE - This gets back to our prevention program. The prevention program that we have talks about brain injury. We did a survey of the prevention program and 100 per cent of the kids said they had a better understanding of the impact of brain injury on their family and friends, which is really great for us. Fifty per cent of them said they had modified their behaviour since they had done our program. We said, 'What do you mean 'modified your behaviour'?'. 'We don't drink-drive any more. We don't drive unlicensed.

We don't speed. We don't resort to violence. We don't cliff dive.' So they are identifying really high risk behaviours that they had chosen not to do. I would say that out of every one of our sessions we get at least one young person saying, 'That explains a lot. I had this happen to me and that explains why I have problems at school and with socialising'. If we can prevent a lot of it happening in the first place, and it is going to happen or it has already happened, then you need to resource the Education department and skill them up to recognise and deal with these children. Then if you are still missing them and they are getting into Ashley you need to skill up your staff at Ashley to deal with these children. The way that you would perhaps treat other children who don't have injury is not going to have any effect on some of the kids who have brain injury. There are simple strategies.

Mrs JAMIESON - Do you have any figures at all on the effect of drugs during pregnancy, maybe a child born with a drug withdrawal problem or having drug-related acquired brain damage?

Ms BYRNE - There are probably figures around. Once again, when you only get $59 500 from the Government to work on a statewide basis to provide professional support and everything we are expected to do, it is very difficult. We would love to do that research. Our prevention program is at risk because of the limited funding we get. It is really frustrating spending half your time battling government. I have a set of Cuisenaire rods and I keep threatening to give them to the Treasurer and saying, 'Spend some of the little green ones so that we can save the big orange ones'.

Some research that came out of the UK said that 80 per cent of problem gamblers probably have undiagnosed brain injury. It is no good putting all your money into gambling problems once the addiction is already there. You have to look at some of the causes. It is the same with Ashley. You can put in all your programs once they are in the detention centre but let us have a look at why they are there and how we can prevent them getting there or, if they are there, how we can best assist them and support them once they are in there.

CHAIR - As I understand it, each new admission to Ashley goes through a medical assessment process, therefore if the GP and the staff who are conducting that process were apprised of your information then it would certainly be helpful. Would they be able to diagnose it?

Ms BYRNE - Probably not. There are a lot of GPs around who don't have an understanding of brain injury. Someone with a brain injury can go to a GP but then doesn't get appropriately referred. What you probably would be looking at is something like a neuropsych test, some of the recognised tests that would pick up whether there is cognitive impairment. Once again, we are not talking about an IQ test.

CHAIR - So who would conduct that?

Mr BYRNE - You would have to get a neuropsychologist to do that. Victoria might come up with an assessment tool or maybe we need to have a look at developing an assessment tool. Certainly some research into that it would be really useful.

CHAIR - It is obviously pretty important. If there are intervention methods or ways of establishing whether there are residents who have these problems then it may well help.

Mr DEAN - It would be a small price to pay, when you look at that person continuing a life of crime, just to find out why they are doing it and then be able to treat it.

Mr WILKINSON - I know a kid who was badly injured in a car accident and was unconscious for a number of days. He does not think he has any problem and in that initial assessment the GP would say he can speak lucidly. However, if you talk to his grandparents, who care for him, they say, 'On the face of it he seems okay but at home when you are with him more than five or ten minutes you can notice real differences'. Am I right in saying therefore that the GP and other staff would not know he has this brain damage because he would appear to everybody to be okay.

Ms BYRNE - One of the biggest issues for brain injury is lack of insight; 'I don't have the problem; it's everyone else. My behaviour hasn't changed, my memory is fine and I can still concentrate'. It is difficult. I read a story about a guy who had quite serious brain injury. He knew how to drive but he had no concept of speed limits, so he just got in a car and drove. You can have no insight into the fact that your behaviour may be sexually inappropriate. One of the examples we use in our prevention program is that quite often you hear that brain injury stops your life. If you have a young kid who has a brain injury at 18, they might still view themselves as 18. It is appropriate for 18 year old males to be interested in, say, 16 year old girls but if you are 40, though believe yourself to be 18, it is not appropriate. That is something that can happen because of that lack of insight. So if you have a young person or anyone with a brain injury who does not have that insight then, as you said, a GP may not be able to pick it up. This is where you need the specialist psych tests.

There is a service in Victoria which is for alcohol and substance-related brain injury. The Government funds that. They have 50 staff, and four neuropsychs to do those assessments. I went to a world congress and they had a whole section just on children and brain injury. In Western Australia, if they have a child in hospital with brain injury, the Education department sends in their liaison teacher to work with the hospital and the child to getting them back to school. It was a bit like the old Monty Python movie, 'You lucky bastards'. We do not even recognise it. You contact the Education department here and we do not have any kids with brain injury.

We have a neurotrauma register and are doing some studies around traumatic brain injury since 2003. We know that up to 250 children each year in Tasmania are sustaining brain injuries of all severities, so if they are not in the education system, where are they? What happened to them? They may have a brain tumour and if you remove a tumour you remove part of the brain, or they might have come off their bike. Imagine if it happened to you. You could get rear-ended. Your head hits the windscreen, you are unconscious for about five or 10 minutes, and by the time the ambulance gets there you are conscious. They might fix your broken leg or your cut arm but we know of people being sent home with quite serious head injuries. In two or three months your whole life is turned upside down.

The report from the Queensland Public Advocate is quite a good one and there was also a paper that I copied for you concerning the relationship between head injury and violent

offending in juvenile offenders. There is some information here around our prevention program. I think it is well worth having a look at the prevention program because prevention is the only cure for brain injury. It is really frustrating for us when we are getting good outcomes that we cannot get anyone interested in resourcing or funding the program.

Mrs JAMIESON - Because of the high rate of Aboriginal descent in Ashley, have you any facts, either anecdotal or actual, on acquired brain damage in children of Aboriginal descent?

Ms BYRNE - It is something we haven't looked at. The service in Victoria has a really good resource book. It was written for the Koori community about alcohol-related brain injury. One of the things I would like to do this year is some work with the Aboriginal community about the incidence of braining injury.

Mrs JAMIESON - I was thinking along the lines of antenatal care and things like that.

Ms BYRNE - Yes, most definitely. There are so many areas we would like to look at but this year our focus is on children and brain injury. We haven't even looked at the issues for the Aboriginal community in Tasmania.

Mrs JAMIESON - It clearly is a major problem.

Ms BYRNE - Most definitely. In our prevention program we would like to liaise with them and have a look at alcohol and drug issues specifically for the Aboriginal community.

CHAIR - Deborah, thank you very much for your evidence and tabled documents.

THE WITNESS WITHDREW.