THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON VIOLENCE IN THE COMMUNITY MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON THURSDAY 1 DECEMBER 2011.

Mr MARK LAMONT, CLINICAL NEUROPSYCHOLOGIST AND **Ms DEBORAH BYRNE**, EXECUTIVE OFFICER, BRAIN INJURY ASSOCIATION OF TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Wilkinson) - Welcome. These hearings are covered by parliamentary privilege so no defamation or court proceedings can flow from anything you say here. However, if it is said outside the room and if it is defamatory, or any other matter that can be looked at legally, then you are not covered by the same privilege that you are covered with as we speak. If there is any evidence that you want to give in camera then you can do that, which means that it does not become public because otherwise the evidence that you give will be on *Hansard* and will be public, but if there is anything that you do not want to be public please let us know, we can discuss that and decide whether it should or should not be in camera. That is sometimes the case if it is going to be embarrassing or you think it might be detrimental to employment or whatever might be the case.

The way we have been dealing with it is letting you take the floor then after you finish any comments we can ask you questions. So I hand it over to whoever wishes to start.

Ms BYRNE - I suppose I will go first. You asked for Mark to appear before you so that you could have a look at the linkages between brain injury and violence in the community.

For me initially it is just about querying the political will to make the changes. As you know, I have been with the Brain Injury Association for a number of years and we have produced quite a lot of evidence and documents, some of which I have brought along today to highlight the relationship between head injury and violent offending, and an exploratory study of crime and brain injury. So certainly there is evidence that links brain injury and criminal issues.

CHAIR - Do you mind if we have a copy of that, please, Deb?

Ms BYRNE - I can produce copies for you of this. The other thing is, over the time that I have been with the association we have produced quite a lot of research and evidence around the social and emotional impacts of brain injury on the people, families, and on the community. In the report that we did around acquired brain injury and these issues, we had a series of recommendations. We costed those recommendations around an action plan, submitted that to government but did not get any additional funding around addressing that.

We then tried to look at an approach that looked at the economic cost of brain injury and things such as it makes more sense to provide early intervention and preventive services for young people rather than the $200 000 that it costs per year to house a young person at Ashley. This formed part of our submission to Treasury but we still have not had any response in relation to that. You may be aware there has been quite a number of documents that we have produced around acquired brain injury in the criminal justice

system. The research indicates that up to 80 per cent of people in the criminal justice system have acquired brain injury. Certainly there are linkages between acquired brain injury and youth detention; that research is indicating that up to 65 per cent of detainees in youth detention have undiagnosed brain injury - which gets back to that argument about supporting those early intervention programs in the community rather than housing young people at Ashley.

So there are a number of reports and recommendations that have been produced around that, but to date we have not seen any recognition of the impact of brain injury on the community and that flowing on to us as an organisation as the peak. We were given $50 000 by the State Government back in 1999 to be a statewide peak to work across quite a number of significant areas. We have had no increase in funding since 1999, other than CPI, yet we estimate that in terms of incidents and prevalence of brain injury up to 2 500 Tasmanians each year sustain brain injury across all severities. So that has quite a significant impact and it was interesting yesterday we met with the minister and even the minister's adviser was saying, 'We recognise the false economy of not investing in brain injury because we understand the impact it has on the community but there are no resources.'

I notice that one of the things you are looking at is how do we address the situation, but if there is not the political will to recognise brain injury and the huge impact that it has on the community, then I feel I am perhaps wasting your time and wasting my time. So that is my frustration.

Once again the evidence is here and I am happy to make available to you copies of anything that you feel is relevant to that. I just wanted to start by flagging that but perhaps then to hand over to Mark.

CHAIR - Thanks for that, Debbie. I agree with you. It seems to me that it is frustrating. There is the evidence. You have advised the Government of the evidence and yet nothing really happens. I hear what you are saying. You ask, 'Are we wasting our time?' to be brutally frank, coming here today because what is going to be the outcome? I can understand that. All I can say is that all we can do is hear what you are saying, read what you are very kindly going to give to us and then we can make recommendations, but we cannot promise that anything is going to happen. All we can endeavour to do is put the blowtorch on these people to say that this is the evidence, this is what we believe should be done, how about doing it. We can put pressure on them that way, but we certainly cannot say, and I know you know, that as a result of this certain things are going tohappen. All we can do is hope that things are going to happen to stop it from occurring. I had not heard the statistic before. I have heard the others, the 80 per cent and the 65 per cent, but I have not heard of 2 500 people each year.

Ms BYRNE - The Australian Institute of Health and Wellbeing did a report specifically around acquired brain injury in 2007 and they estimated that there were 9 300 Tasmanians that identified as having activity limitations or participation restrictions as a direct result of acquired brain injury. When you look at the brain injury services in the State, there are three specialist brain injury services, each of those would probably support at best 200 or 300, some direct but some just by regular phone contact. So I guess it begs the question where are the other people in the community. We know there is a high percentage of them in the criminal justice system but there are significant

numbers of people out in the community who are really struggling on a day-to-day basis as a result of brain injury. These are the ones that actually identify and know that they have a brain injury. One of the problems, particularly around mild to moderate brain injury, is that people are not aware that they may have a brain injury.

One of my roles is an information and referral role and it is interesting the number of people who come to us with brain injury looking for some support and when you start talking to them about the impacts of brain injury it is almost like a light bulb being turned on. They did not realise that certain behaviour was as a result of the brain injury, or the family member was not aware that the person was not just lazy or angry, that it was a direct result of the brain injury.

CHAIR - Are we able to say how many of those 2 500 people acquired the brain injury as a result of violence?

Ms BYRNE - I guess that is one of the difficulties and it gets back to resourcing. We would really appreciate some additional resources to have the capacity to look at research and the data. We do not have that capacity. We can say roughly between about 500 and 1 000 of those are as a result of stroke. We can have a look at the catastrophic injury and get some stats from MAIB around motor vehicle accidents, but it is very difficult getting into the hospital and looking at their coding there and some of the causes.

One of the other challenges in the hospital is that you could present to the hospital after a car accident and maybe have a broken bone so you actually come into the system as perhaps orthopaedic or in plastic surgery but the brain injury is not then picked up. It may never be picked up or it may not be recognised in terms of that statistical evidence.

Mr LAMONT - My background is in rehabilitation. What we can probably say, anecdotally, is that for traumatic brain injuries in terms of numbers, after motor car accidents the next level would be the assaults then things like falls, sporting injuries and so on. It is a higher level than those other two groups. I have talked with my colleagues and there is certainly a growing number of TBI-associated assaults.

Ms BYRNE - Once again this relates to age groups. Falls in the elderly would be higher than with younger people, but certainly within that younger demographic assaults and violence are quite significant causes of brain injury and are secondary to motor vehicle crashes.

Mr HALL - Deborah, you talked about that 80 per cent undiagnosed acquired brain injury that you thought were in AYDC, for example. Is that just anecdotal? Is that just your gut feeling that there are 80 per cent of those people? As you said, they are undiagnosed.

Ms BYRNE - The youth detention is up to 65 per cent and that was from research -

Mr HALL - Oh, sorry.

Ms BYRNE - from other States plus other countries. We do not have the resources or the opportunity to go into Ashley. This is part of the problem with the system; there is no screening that is specific to picking up brain injuries in either the adult prison system or in Ashley. We recommend, and have been lobbying for quite some time around. having

a screening process that is going to pick up that cognitive impairment of a brain injury as a person enters the criminal justice system.

CHAIR - How would you do that?

Ms BYRNE - There are tools that can be used that are sensitive to picking up cognitive impairment so it would be incorporating those into the screening process when a person enters the system.

Mr HALL - Just forgive my lack of medical knowledge but if somebody is violent or whatever then it could be acquired brain injury, or it could be a depressive illness or anything else. How do you separate some of those issues? It might be quite difficult.

Ms BYRNE - It would be easier for Mark to talk about that.

Mr LAMONT - For a diagnosis of acquired brain injury we would be looking for a particular event, whether it be stroke, traumatic brain injury, some sort of illness, some sort of neurological illness or tumour. We would be looking for some sort of event and cognitive behaviour or emotional changes associated with that event. They are probably the key identifying factors for an ABI. It is certainly measurable in terms of particular syndromes that we see in neuropsychological assessments.

It is certainly quite measurable, as distinct from mental health illnesses. I suppose from a neuroanatomical point of view with your mental health illnesses we talk to you about where the nerve cells connect. We have the synapse, so we are talking about biochemical transmission issues there. Too much of a transmission substance or too little is amenable to intervention pharmacologically to address that so we look at medications that would increase or assist that transmission.

With acquired brain injury, though, it is actually destruction of the nerve cells. It is breakages, pathways that have been obliterated, basically. So it is not about a biochemical transmission, it is more about substance loss in the brain and that is measurable, again, through imaging and so on.

Mr HALL - As the Chair said and you talked about the matter of resources and everything else, to be able to try to nail all that down is a big issue.

Mr LAMONT - Yes, a lot of the screening aspects here are not necessary. We are talking about tools that could be applied as people are coming through their intake interviews and so on - a questionnaire sort of approach. For example, with a traumatic brain injury, have you ever had an episode of loss of consciousness? Following that was there a period of confusion and how long was that for? That gives us an indicator of sorts.

Dr GOODWIN - Deborah, you were talking about the screening issue and I know that it has been raised before in a forum looking particularly at the issue of sentencing of people with acquired brain injury. When you talk about early intervention and when they come before the courts trying to get a sentence that is perhaps tailored to the fact that they do have an acquired brain injury and then being able to have services to actually refer people to, from what you have said there are not enough services for people with an acquired brain injury.

Ms BYRNE - It is a bit like a catch-22. If you look at the mental health diversion we've missed as an example, that depends on having services in the community that you can divert people with a mental illness to, rather than putting them straight into the criminal justice system. We have actually been asked by the chief magistrate, given the high prevalence do we need a brain injury court. But, once again, you would have a similar problem. It depends on having services in the community that you can divert people to to support them. Because we do not have those services in the community, if you are then diverting people to those services and they are supporting them then they are not supporting people in the initial stages, because they do not have the resources, so then you are getting people not getting the support in the early stages, ending up in the criminal justice system and then being supported at this end. Do you look at early intervention - increasing the resources there to stop people going into the criminal justice system, while at the same time expanding resources for the services to deal with people that are coming out or being diverted? There is certainly a demand. For a diversionary system to work, you would have to increase the capacity of the community services to respond, otherwise it would fail, and fail significantly.

Dr GOODWIN - In terms of broader community awareness of ABI, one of the issues is with people who have an acquired brain injury, but do not realise they have one. How is it possible to get that message out more, particularly for young people at risk of becoming involved in crime - early intervention, in fact?

Ms BYRNE - There is a need for much broader community awareness. We have our 'Heads Up to Brain Injury Program', which is our school-based program. Unfortunately, we have had a really poor response from the Education Department in picking that up for their grade 10 students, despite the fact that it has a learning sequence developed by the Education department that fits into the Health and Wellbeing curriculum. We are trying a different response to that. Acquired brain injury, like a lot of things, if it does not impact on your life, then you do not know what you do not know.

There needs to be greater investment in the capacity of organisations such as ours to enable us to look at broader community awareness opportunities. Because there is no cure for brain injury, we should focus on prevention. There is lots of evidence that if you raise community awareness, people are aware of the impacts of brain injury and the long-term effect it can have on their lives, and they are more likely to be aware of their activities and not engage in high-risk activities.

That is what we have found with our school-based program. If kids are aware, they are less likely to engage in the high-risk activities that put them at risk of sustaining brain injury. The problem is that if you have children and young people in the community that have early mild to moderate brain injury, the impact of that injury puts them at greater risk of undertaking high-risk behaviour, which is what we are talking about today, and sustaining even further brain injury themselves, or putting other people at risk of brain injury. These are the ones who will instigate such behaviours, at a fight or something, because they have lost the regular capacity to think about the consequences of their actions.

Certainly, there is a greater need for community awareness. But, it is a bit like a Pandora's box and we find that quite regularly. When we undertake a community

awareness campaign people suddenly start to think they, or their child, may have a brain injury, and ask where they can go to get some services or support, and the services and the supports are not available in the community, so we cannot do anything about it. That is where it is really frustrating.

Mr WILKINSON - Are we able to determine a relationship between alcohol, and violent behaviour, and brain injury?

Ms BYRNE - Most definitely. Mark might like to speak about that.

Mr LAMONT - In preparing for this, I was looking at the issue of violence in the community generally, and thinking about where the ABI fits in with that. It has come up to the committee over and over again that alcohol is the big issue. Excessive alcohol use, risk taking, and thrill seeking are associated with that level of violence.

There are two groups that I think of in terms of the effect of ABI. One is those who have identified ABI - traumatic brain injury - and the associated issues with self-regulation of behaviour. They are more impulsive, with provocation - they will react rather than think, and manage confronting situations appropriately. That just does not happen. It is like there is provocation and response. So, we will potentially see an aggressive response to provocation.

Working in rehab, we are aware that when people are provoked, they respond with familiar behaviours. They can be impulsive. If have been brought up with quite adaptive skills, I have the gift of the gab or whatever, if I can talk my way out of a situation then when I am provoked I will start to do that because it is a well-learnt, well-consolidated behaviour. But if my way of responding in the past has been with the fists, then that is what I will be doing. So, I suppose we're seeing the effect of alcohol there. It's obviously lowering the threshold for violence to occur. It's going to take less provocation for the person to snap and react.

Another area that's now being researched a lot more - and it's still probably controversial - is the effect of witnessing violence on the developing brain. Young children growing up in environments where they're witnessing frequent violence, in the home, or other sort of traumas - we potentially see it in children coming from war zones - where they're frequently witnessing Post Traumatic Stress Disorder scenarios, are showing fight/flight brain reactions. Their brains are going into alarm mode.

If that persists while the child's brain is developing, it interferes with the development of normal brain function. We all know about homeostasis - when our body goes out of whack it tends to call in resources to bring it back into homeostasis. There is an argument that says that when the brain is constantly being stimulated, it seeks to bring the effects of that excess stimulation back down to a normal level. The alarm centres of the brain become habituated to that trauma, and so it takes a lot more provocation to the brain to get that response.

The reality is that most of us like a bit of thrill from time to time. You know, someone comes and gives you a fright and your adrenalin surges. It's frightening at the time but it makes you feel alive. The argument is that for these kids, whose brains have become

habituated to trauma, their lives are pretty dull and boring, because nothing gives them that thrill. They tend to have a very blunt effect, and things like that.

So, the argument is that for them to feel as though they're alive, they engage in thrill-seeking behaviour. So, they say 'Right, here it is Friday night, what are we going to do? Let's go down and start a fight'. They start to feel alive again - it gets the adrenalin surging. That's the thrill most of us like, to feel as though we're alive.

So that's one of the arguments - we have the brain that has been interfered with at the developmental stage. It now takes a lot more to stimulate that brain, so it sets up this thrill-seeking behaviour. So that, to me, is a real challenge for the future - identifying these kids at the developmental stage, and addressing the issue, where the brain hasn't learnt, or the person hasn't developed skills to manage what is going on with their brains. Or they haven't developed skills to find other, more adaptive, ways of thrill-seeking.

For your benefit, it gives an understanding of why kids are perhaps out there perpetrating violence. These kids are a different group from those with a clearly-identified traumatic brain injury. They may have got their TPI in the first place from being assaulted, or in a motor vehicle accident. They are not predisposed to seeking violence, however, if they come up against one of these other people who are seeking violence, their thresholds for adaptive thinking are down and they react so what we will often find is that the person with a TBI reacts and the perpetrator disappears because of this person's reaction. They are not sharp about talking their way through the system and the next thing is they have been incarcerated.

Dr GOODWIN - Mark, I was just going to ask you a question, you mentioned that issue about the trauma when the children are young, is it still a bit controversial? Is there much evidence of it?

Mr LAMONT - I suppose violence is not my expertise but rehabilitation from a brain injury is, but I can give you some contacts for that - Warrick Brewer, in particular through the Orygen Youth Health Research Centre in Melbourne and I certainly encourage you to find out from Orygen. They are looking at those issues between development of mental health issues and maladaptive behaviours associated with the developing brain and I think what we are going to see over the next 20 years is that we have spent so much time trying to distinguish mental health and acquired brain injury, and what we are likely to see over the next 20 years is a bit of re-emerging of understanding how closely these things actually are related.

Dr GOODWIN - You would think that those kids would end up coming into contact with the child protection system at some point and there will need to be obviously structures within the child protection system to try to deal with that to address those longer-term issues that you are talking about.

Mr LAMONT - Yes, and it is a big issue because where we are talking about any of us who acquire a traumatic brain injury, we have well-learnt skills to draw on so it is about rehabilitation that is helping the person to create a space, I suppose, to recognise, to stop, to think through and to recruit those adaptive skills. What we are talking about with the kids who have had, if you like, the developing brain interfered with, basically what we are looking at there is the adaptive skills have not been well-developed in the first place

so we are actually trying to teach skills that have not been there in the first place and established well and so their automatic responses are towards violence or towards thrill-seeking. It is almost like, what interventions do you put to dampen people's desire to focus their thrill-seeking on socially appropriate areas?

I am not aware at the moment that there are programs that are addressing that but I think these are things that will be emerging because I think that as we get research around us to confirm that these are the sort of patterns that are emerging, we are going to see programs that are then saying how do we intervene at that level, and places like Orygen will be the people to talk to about that.

Dr GOODWIN - At the very least having some insight into the impact of those early experiences can help perhaps the foster parents.

Ms BYRNE - I can give you anecdotal evidence; we have had an incident where we have a caring grandmother and she has two grandsons and when you hear what these grandchildren have been through it is absolutely horrific. The younger one was involved in an incident at the school where he was provoked and he reacted, and he ended up with a five-day suspension and the person that provoked him only ended up with a two-day suspension and the reason why they gave the other one a five-day suspension was that he was not able basically to come back down from the experience from what had happened and to regulate his behaviour. Of course you cannot regulate his behaviour because of the impact that the trauma has had on his brain but the school were not aware of that. So here is this boy that, through no fault of his own, received a five-day suspension and the perpetrator only got two days because, like you said, he stepped away and the other young boy's behaviour was quite escalating and he just did not have the resources to be able to come back down so he was penalised quite significantly.

Mr LAMONT - I can probably provide you with an example of what I think is a positive intervention and that would be the situation where I have been asked to consult with a school and this is a child who is in the secondary school system. The teachers have become concerned about where this chap is going to end up down the track because of the family background - dad is in jail and he is under the care of his grandmother and they can see that it is a matter of time before this guy is going to end up in the criminal system. They have sent out 'help us'. There has been speech involvement for quite some time, clinical psych involvement for some time in terms of teaching this kid and helping him to self-regulate behaviour, working with the family in terms of setting up good structure, good routines and a structured environment around him so that he can self-regulate. Also, they have asked me to come in to help the teachers to understand this, that everybody is understanding the ABI issue in here and what it means.

I suppose where we are going with the child, because he is of adolescent age, is moving towards an intervention that is saying to him, 'Look, you have a choice at this stage and it is a hard choice,' but, if you like, he has an awareness that he could end up where his dad is. But it is almost saying to him, 'You have a choice of taking some control of this and self-regulating, but part of that is understanding what this brain injury is about. People out there are not going to regulate this as you grow up. If you do not, you will be in jail.' So it is working with him about trying to improve his awareness of the issue and an acceptance of responsibility for self-management in relation to that - a huge ask for a kid of that age, a huge ask of any kid of that age, but I guess we are looking at that being the

nature of the intervention, that he does understand if he is given resources to cope. That is something where this may be a child who does not end up being one of these thrill-seeking offenders. So that is the thing, I suppose, we could be looking at.

Ms BYRNE - On that point that Mark made, we have been successful in getting some funding through MAIB to do some brain injury training in the community and we will certainly be targeting child protection. We have done some training already with the drug and alcohol sector and the mental health sector. So that is an opportunity we will have but one of the areas where I think there is a significant need for some training at a more formal level is in the graduate programs for teachers et cetera, so that they are aware, because one of the things that we find with brain injury is that people do really well with routine and structure. So in terms of gaps in the community, you might have a child who has early brain injury, they are in primary school, one classroom, one teacher, they are literally told what to do and when to do it, so do very well. It is when they then move onto high school with different teachers, different routines, you get your maths homework Monday and you have to be organised to have it in on Thursday. You really struggle with that executive functioning. Then, what happens when the young person does start to struggle? Quite often they cannot cope and you start getting behaviours and that is where the kid starts slipping through the gaps and where you might start seeing them entering Ashley with their behaviour, certainly the ones we see in our Custody for Life program.

If teachers were aware and had a better understanding of brain injury, then it might stop some of these kids either falling through the gaps or being incorrectly labelled as ADHD or just difficult children. It is similar situation, I guess, for people within the criminal justice system. For some people, they do really well in the prison system because, once again, it is very orderly and they are told what to do and when to do it. It is when they come back out again that they have no routine, they have no structure, they cannot cope and they then look at re-offending to go back into the system where they are comfortable and familiar and, quite often, that violent reoffending might be the way that they are entered back into the system. So if we had programs within the prison system that would support people to be able to better manage and that were sensitive to cognitive impairment and better management when they get out in the community, it might lessen the recidivism rate and the people who are committing violent crimes getting back into the criminal justice system.

Mr HALL - When you think about it, ABI has been around for centuries and it is just the fact now, with modern diagnostic tools and medical science, we are able to recognise it. But is there any evidence, anecdotal or otherwise, that perhaps in the last two or three decades there has been an increase in the percentage of people and that is causing more issues of violence? Are there any indicators, because of our modern society and what we do, that things have become worse?

Mr LAMONT - I suppose it is the issue of record keeping, that we can't compare to what was going on 100 years ago. Having said that, motor vehicle accidents has been the big one. The amount of traffic on the road and people driving cars has gradually risen as the number one cause of brain injury in the traumatic areas. The other thing is that in the broader picture of acquired brain injury, as we are addressing issues such as heart disease and so on, we are seeing people living longer. When you go into the degenerative Alzheimer's and so on, a lot of those things are then growing in prevalence now because

people are living longer. There are shifts in the balance of what the key causes of ABI are, but in terms of the prevalence of ABI full-stop, I don't know that there is a lot of data around that.

Ms BYRNE - It is interesting, in our Custody for Life program, one of the things we do is ask the young kids whether they have ever been drunk before. If they have their parents there, they might say the know someone who has been drunk. These are kids who are 13 through to 17 and every single one of them identifies with having been drunk. It seems to be so much more socially acceptable for younger people - I am not quite sure what the evidence was 20 or 30 years ago; was it socially acceptable?

Mr HALL - It would seem that that is a fundamental change to what happened a couple of decades ago.

Mr LAMONT - It's probably the frequency of binge drinking that has been the prominent change. You guys growing up no doubt had nights out from time to time -

Laughter.

Mr LAMONT - I suppose it is about the frequency and I guess it now almost the norm for a lot of kids 15 and upwards.

Ms BYRNE - And younger. The impact of alcohol on the developing brain is hugely significant.

Mr LAMONT - We are finding that within a three-year period we are seeing measurable changes in the brain associated with binge drinking. For 15 to 18 year olds, we are seeing in that period of time changes in the hippocampus, which is the key memory area of the brain; it is the part of the brain that lays down and stores memories. We also find that there are changes in the frontal lobes associated with binge drinking within that period of time. That has become an alarming issue about addressing teenage binge drinking because the brain is still developing at that stage. We are not talking about a well-established brain that is now getting some damage and will try to recover; we are talking about a brain that is not fully developed and therefore will stall that development.

CHAIR - We are talking about the registration, retention and recall aspects of your memory, how alcohol and other things can affect that. Are you able to drill down in relation to alcohol and assaults and whether it just affects the memory as a whole or, alternatively, any particular part of that memory?

Mr LAMONT - In terms of the effect of alcohol with assaults, it is more to do with the frontal lobe regulation. For example, I am self-regulating while I am talking to you, I am using very correct language, I am not using everyday speech; I am in front of very eminent people so I self-regulate. When I'm amongst friends I might drop my guard just slightly. So that is my frontal lobe kicking in. Basically, what happens with frontal lobe damage is what we see when people are drinking. We see that they become disinhibited. We see that they start saying things that - hang on, this is not the appropriate place to say that - and the frontal lobes help with that self-regulation. Basically, alcohol at a temporary level, at that transient level when you are drinking, drops the guard, but chronic alcohol use causes permanent damage to those structures so that is the everyday

behaviour then. I may not be under the influence of alcohol with my frontal lobe injury at that stage and with provocation then, rather than thinking through, which is what the frontal lobes do, rather than stopping and thinking what is the best way to respond here I react impulsively. I might do things that I regret after. Typically we will see in those situations there is remorse from the person with TBI. They did not want to respond that way. They are not out seeking the thrill. That is not what they are there for but they have been provoked and they will snap.

Ms BYRNE - A classic example is a group of young people that went through our Custody for Life program; they were on the north-west coast, 16-, 17-year-old males, they all identified as having brain injury. We were talking about that impulsivity and the consequences thereafter, and this young bloke said, 'Oh, that makes sense now. Now I know why we go and break into people's houses and steal stuff, get home and think, "Shit, what did we do that for? Now the police are going to come after us".' That is exactly a classic example of that frontal lobe regulation.

CHAIR - We have about 10 minutes. I am sorry, I do not want to rush you. We can frustrate you even more.

Ms BYRNE - That is all right, we can stay here all day.

CHAIR - I was wondering if Ivan has a question and then if I can at least have five minutes to say is there anything that you believe we have not asked you that you want to tell us and then also what I will be saying is, if you were in our position what would your recommendations be?

Mr DEAN - Just quickly, it seems to me that we are selling the message out there that acquired brain injury is related predominantly to crashes and accidents and those sorts of things. We do not seem to be getting the message out there that alcohol consumption, violence in particular, is a significant cause of acquired brain injury as well. We do not seem to be getting the message out because you speak to the young people who say, 'Every Thursday night I go out and I get plastered'. I mentioned that before we convened with you this morning. You have them doing that constantly - 'I do it every Thursday night. I do it every Saturday night. I go out and get plastered, I'm having a good time.' But they never realise the damage or what is happening to their brain as a result of it. What do we need to do? Where do we need to go to try to get this message through to these young people that that is a bad position to adopt?

Ms BYRNE - With the Heads Up 2 Brain Injury program which we are trying to get now, we have recognised that perhaps grade 10 was not the best target group for that given their curriculum. What we are now doing is moving towards the grade 9 level and that program looks at all causes of brain injury, probably more so at alcohol and their high-risk behaviour than the car accidents because, as you said, we have quite a lot of media focus on brain injury as a result of motor vehicle crashes so people do tend to be aware of that. But people's perception of brain injury is interesting too, and why you don't hear about it as much in the community is because of the stigma. People think you deserve your brain injury, you got in the car and drove drunk, or you went out fighting, so that stigma around brain injury is something that we certainly, as a community, need to work to address.

In terms of recommendations, greater resources need to go into that community awareness. There is certainly research evidence that talks about if we have a community that is more aware of the impacts, they are less likely to engage in that behaviour. I do not know how you tackle the fact that kids think they are 10 feet tall, they are bullet proof, and 'That's fine, you can tell me all this stuff but it's not going to happen to me' until it then does happen. That is an area that we spend a lot of time looking at. Certainly we need to do more work on that community awareness around brain injury given its prevalence.

Mr DEAN - We do not seem to be getting that message out there to the parents either. It is all very well for the younger generation to behave and to do that, but it just seems that we are not getting through to the parents either in them getting that message through to their children.

Mr LAMONT - It is hypocritical - that is the problem. Parents might tell you not to smoke, but they are smoking; don't drink hard, but they are drinking hard. We are in a society where the way we talk about alcohol is 'I had a great night last night, I cannot remember it'. It is adults talking that way. Until there is some sort of change, as a society, in our attitudes to alcohol – it may be a social lubricant, but it is also a huge social cost to us all. Until we have a mature attitude to drinking. The bottom line is that it is the most severe drug we use. It is the most costly drug we use in terms of what it is doing to society. And yet it is the one that we least want to address because, and again I am appealing to you guys, it is politically an extremely unpopular thing to do. Prohibition did not work, did it?

Ms BYRNE - Look at your role models in terms of the AFL teams, and so on. I think it will take something like a party where parents are allowing alcohol, where a young kid dies from binge drinking, or aspirates his vomit, and goes into a coma. Then there will be a public outcry. Like a lot of things, it will take something drastic to happen, and it will be like shutting the door after the horse has bolted.

Mr LAMONT - It could be campaigns. If you think about the smoking campaigns - Dad is dying, and you should have been there Dad - that is a very potent message. They have had to get very potent with those messages. The TAC ads in Victoria about car accidents became extremely graphic. There was a lot of criticism about them, but they got through. And they had to keep changing them because people became habituated to them. We are looking at similar campaigns - Dad seeing the kid in hospital dying because he crashed a car under the influence of alcohol, and Dad standing there saying he should have controlled his own drinking, so that his child did not learn from him. It needs to be those very graphic, poignant messages that say, 'Adults, you start taking control'. How can we start with these wonderful education campaigns for kids, when we are not regulating ourselves?

Ms BYRNE - Not so much that they are not regulating themselves, they are actually condoning, because of the peer pressure, going out and buying their 13- to 14-year-old kids alcohol and sending them off to parties with it. It should be no alcohol, underage, at parties. That should be the socially accepted norm, as opposed to what we have now where it is socially acceptable for kids at quite a young age to start drinking.

CHAIR - If you were in our position, what would your recommendations be?

Mr LAMONT - One thing we have not touched on, which I think is quite relevant here, is the less sensational aspect of violence in the community - violence at the domestic level. One of the things to keep in mind with brain injury is that we are talking about very significant losses for the person - a change in their identity, and their sense of self. The tools they need to manage their lives have gone missing. When a person suffers a spinal injury, they can use their brain to work out the strategies they need to get on with life.

When the brain is damaged, that ability to make adjustments and move forward is interfered with. We find that people get stuck with ABI in terms of the grieving and getting on with their lives. We have people who are extremely frustrated on a day-to-day basis. This frustration is sitting under the surface - they are not violent people, but the day-to-day struggle makes them very frustrated, and it does not take a lot. Where we will see people tip over the edge is with their nearest and dearest. Forget about down at the pub - when we are talking about violence and its relation to ABI, it's more likely to be happening in the home. It is also more likely to be emotional violence. If they have a TBI, they may not punch, but they might smash windows, or rip fly screens off the back door, or yelling at kids, and occasionally they might hurt somebody unintentionally. But getting away from that sensational part, it is an issue for families living with the person who has a traumatic brain injury, where they frequently angry, they are raging, they are yelling and the impact of that on the family is quite significant.

CHAIR – So, that causes the child not to have the tools to cope at a later stage?

Mr LAMONT - I suppose I am saying that has an impact on the kids in the house. But I am thinking in terms of anybody in the house, not necessarily in terms of developing brains. Living around this constant barrage is going to produce mental health issues for a family down the track. Maybe divorce, if that is a good outcome in a particular situation. But typically, families stay together after TBI. So we are seeing, particularly the partners, copping a heap, and they are then moving into the mental health services down the track because of their coping issues.

Ms BYRNE - My key recommendation would be to support us in our push to get brain injury taken out from under Disability, which is stopping any additional funding coming into the area, and for a whole-of-government response to brain injury, given that it impacts across education, mental health, homelessness, unemployment, criminal justice, police and road safety, et cetera. If we could get a whole-of-government response and the recognition that it has a huge, significant, social, economic and emotional cost to the community, and we need to invest in it. I know your focus is on the violence, but you get flow-on effects to a range of areas. So, if we could have investment in this particular area, you are going to get flow-on effects in terms of greater community awareness and preventative messages, and the resources for us to work effectively with those areas where brain injury intersects - like the alcohol and drugs sector, and the mental health sector, et cetera. That would be my key recommendation.

CHAIR - Would you have a key recommendation, Mark?

Mr LAMONT - The dilemma for me is, I am working very much at the individual level, so it is key recommendations for a specific person, and what we are going to do in their particular case. In terms of a systemic approach, I am working with BIAT, so I am going

to be supporting the push in terms of that. I would be looking to other people in terms of systemic approaches, and what is required there.

Mr DEAN - Very strong campaigns, obviously.

Mr LAMONT - Compound.

Ms BYRNE - I get the whole economic situation the Tasmanian Government is in, and so my question would be, 'Can you afford not to invest in brain injury?' All the research talks about looking at investment in early intervention programs, particularly in the case of mild to moderate brain injury. Vancouver, for example, has a concussion clinic. So, for people with mild to moderate brain injury, it is about getting in early, putting in the supports so they can re-integrate back into the community and find meaningful employment, and the family can be supported. They are not seeing the level of frustration building to the point of violence, and they are not turning to drugs and alcohol, which can result in violence. They are not being seen in the prison system. If we can look at investing in early intervention, you are going to see a significant reduction in the negative flow-on affects. It is more cost effective.

Mr DEAN - I was going to ask who is doing it is better than us, and it would appear everybody is.

Ms BYRNE - Everybody is, yes.

CHAIR - So, as far as lagging is concerned at the moment, Australia-wide, we are lagging behind as far as research and resources are concerned?

Ms BYRNE - I will leave you with that one, because that looks at the political statements in 1991 that said we were going to have the best. We have the worst, nothing has happened.

Mr LAMONT - I have worked in New South Wales and Victoria, and coming back to Tasmania at the beginning of last year, the thing that hit me is that there is a multitude of agencies with the potential to assist. They are lacking in knowledge of ABI, and from the systemic point of view, there is poor integration of those services so that service does not know that there is that service out there and there is no framework to do referrals between them. What is required, I think, at a statewide level is an ABI system so that people are being identified and appropriate pathways can be plotted. Some of that has come through with the Gateway services and that has been a very positive development. I guess I am looking at something akin to that but with focus on looking at pathways for acquired brain injury that are going to pick up those issues and link people - case management being there throughout and monitoring down the track and being proactive and responsive around a lot of this.

Ms BYRNE - One of our other key recommendations to Treasury was a statewide strategic plan around acquired brain injury. Other States have had strategic plans around acquired brain injury. We have a future directions plan for alcohol and drugs for mental health but we don't have one for acquired brain injury and that would address a lot of the problems that we have raised but also that Mark has raised as well.

CHAIR - Mark and Deb, sorry we have run out of time. We could keep going really for another 60 minutes.

Ms BYRNE - I notice a number of you have iPads. There is a really good ap called 3D brain. You talked about the hippocampus, well you can spin it around and you can go into any part of the brain and it will label it for you and it will tell you all that it does. It is called 3D brain and I will organise to get a copy.

CHAIR - Yes, you could contact Tom.

Mr LAMONT - You got that contact for Orygen, didn't you? Orygen mental health services in Melbourne would have a number of publications as well.

CHAIR - Thank you very much. I am sorry we have to rush.

THE WITNESSES WITHDREW.