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**Brain Injury Australia:  
Submission to The Australian  
Government's Green Paper  
"Which Way Home? A New Approach to  
Homelessness"**

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## **PREAMBLE:**

Acquired brain injury (ABI) refers to the **multiple disabilities arising from any damage to the brain that occurs after birth**. Common causes of ABI include **accidents, stroke, infection, alcohol and other drug abuse and degenerative neurological disease**. Traumatic Brain Injury (TBI) is an ABI caused by a traumatic event, from an external force to the brain such as a motor vehicle accident, a fall or a blow to the head.

ABI is common in Australia. In 2003, **432,700 people (2.2% of the population) had an ABI** with “activity limitations” or “participation restrictions” (see Glossary, below) due to their disability:

- **Almost 3 out of every 4 were aged under 65 years.**
- **160,000 had “severe or profound core activity limitations”.** (see Glossary)
- **3 out of every 4 were men<sup>1</sup>.**
- One in four reported four or more disability groups, compared with one in eighteen of all people with a disability.
- One in three people with an ABI reported 5 or more health conditions, compared with about one in eight of all people with disability.
- **Only 12,500 of them accessed a Commonwealth State/Territory Disability Agreement (CSTDA)-funded service in 2004-05.**

National-level information about the incidence (new “cases” each year) of ABI is unreliable. Hospital admission data is compromised by the fact that not all people who suffer an ABI are hospitalized. It is estimated that 70%–85% of all TBIs fall into the mild category and while those injuries rarely require inpatient rehabilitation, between 10%–15% of people with mild TBI report physical complaints including headache, difficulty with attention and memory; and irritability, insomnia and sleeping difficulties<sup>2</sup>. Furthermore, even given new statistical linkages between different hospital datasets, ABIs requiring multiple hospital admissions are susceptible to double-counting. Given these limitations in the incidence data, **in 2004–05, there were 21,800 admissions to Australian hospitals for which a diagnosis associated with TBI was recorded** as either the principal or an additional diagnosis. Approximately 6,000 were for young people aged 12-24. Males accounted for more than two-thirds (69%) of admissions. The heritage of research on the outcomes of TBI shows that roughly **1 in every 5 hospital admissions for TBI will result in some permanent and/or profound disability**.

The consequences of an ABI can be profound, complex and multiple. The physical problems commonly reported by people with an ABI **include headaches, fatigue, seizures, poor balance and coordination, visual and hearing disturbances, chronic pain, paralysis and epilepsy**. Many people with an ABI experience cognitive problems, including **poor memory and concentration, reduced ability to learn, plan and solve problems**. Roughly two-thirds of people with an ABI exhibit shifts in behaviour post-injury, including **poor impulse control and disinhibition, aggressive verbal and physical tendencies**. **The international literature shows that ABI is 10 times more common and produces, on average, 3 times the level of disability as spinal cord injury.**

“Which Way Home? A New Approach to Homelessness” cites studies indicating that: up to 75 per cent of Australians aged 18 years and over experiencing homelessness were found to have a mental health concern; the prevalence rates of mental disorder are four times higher among the homeless than in the general population and almost 30 per cent of Supported Accommodation Assistance Program (SAAP) service users experienced an intensive mental health problem. **A**

**person who has experienced an ABI has a four-in-five likelihood of developing a diagnosable mental illness.** (Conversely, people with psychiatric conditions are at risk of incurring a subsequent ABI.) The types of psychiatric disorders present after (or before) an ABI may include major depression, anxiety disorders, borderline and avoidant personality disorders, and bi-polar affective disorder. **There are several types, or combinations, of disabilities that come under the heading of “Dual Diagnosis”, one of which is ABI and mental illness. ABI is often referred to as the “invisible disability” because its consequences (above), even if observable, are often not associated with disability generally nor ABI specifically.** (This is especially the case with people with a mild or moderate ABI). The cognitive-psychological and psychiatric problems, while often the consequence of ABI, can also mask it. The presentation of ABI and mental illness can be very similar. Indeed, in some clients it is impossible to separate whether a presentation is due to ABI, or mental illness, or both. **The local and international study evidence demonstrates that roughly one third of clients of a mental health service have an underlying ABI.**

The overarching point of Brain Injury Australia’s submission to the Australian Government’s Green Paper “Which Way Home? A New Approach to Homelessness” is to demonstrate that **most of the population subgroups that comprise the homeless – people with a mental illness, people with alcohol and other substance abuse problems, people leaving (or at risk of re-entering) prisons or juvenile justice institutions, people fleeing domestic violence etc. - are absolutely commensurate with the constituent populations of Australians with an ABI. And unless, in whatever strategies derive from this consultation, the Australian Government builds the capacity within all services to the homeless to firstly recognise, and then address an underlying - perhaps undisclosed, perhaps undiagnosed - ABI then every interaction with a homeless Australian simply fiddles at the edge of chronic conditions, and places a person with an ABI at risk of permanent homelessness.**

#### **ABOUT BRAIN INJURY AUSTRALIA:**

Brain Injury Australia (BIA) is the national peak ABI advocacy organization representing, through its State and Territory member organizations and network relationships, the needs and interests of people with an ABI, their families and carers. A major component of BIA’s role is: advocacy for Australian Government program allocations and policies that reflect the needs and priorities of people with an ABI and their families and the provision of effective and timely input into policy, legislation and program development through active contact with Australian Government ministers, parliamentary representatives, Australian Government departments and agencies, and national disability organizations.

Numerous local surveys have attempted to estimate the number of people with an ABI either at risk of, or who are, homeless. A 1998 “Down and Out in Sydney” project suggested that **10 per cent of people using inner-city Sydney hostels and refuges have cognitive impairment as a result of alcohol-related brain injury or TBI**<sup>3</sup>. Two Victorian studies of pension-only Supported Residential Services (SRSs) pointed to the high proportion of residents with ABI; **13 per cent and 17 per cent**<sup>4</sup>. A study conducted by Ozanam Community Support Services Outreach Program revealed that over the three year period, 1997-2000, **33% of clients had a diagnosed alcohol-related brain injury**<sup>5</sup>. Brain Injury Australia has confidence in these estimates since they are consistent across studies and time, and across populations and jurisdictions.

Ever since 1994, when the Commonwealth and State governments agreed on a “National Policy on Services for People with Acquired Brain Injury”, ABI has been recognized – by name - in most legislative and administrative contexts as a distinct disability. Most notably, 1998’s first (and all

subsequent) Commonwealth/States/Territories Disability Agreements cite ABI as a distinct disability group. Since as many as one-third of the overall estimated homeless population of 100,000 comprises people with an ABI, given their levels of social exclusion (indicated in the numbers above) and the complex, multiple and unmet needs of their ABI *when they do present* to a service, **Brain Injury Australia is disappointed that there is no specific mention of ABI in the Green Paper, especially when there was clear opportunity to do so with reference to other at risk groups; the mentally ill, those with “alcohol and other drug issues” and “people leaving prisons or juvenile justice institutions”.**

Furthermore, given the difficulties in detection, detailed above, and the reluctance of many people with an ABI to disclose their disability, Brain Injury Australia is also frustrated that, throughout the twenty-three years in which the Australian Government’s Supported Accommodation Assistance Program (SAAP) has been in operation, its **National Data Collection Agency (NDCA) – managed by the Australian Institute of Health and Welfare (which, peculiarly, recognises and records ABI specifically in every other avenue of its research) – still does not invite self-report of ABI in its “Client Form”**, though it does for intellectual and physical disability and while offering “psychological”, “specialist counselling” and “psychiatric services” as well as “drug/alcohol support or intervention” as “specialist services” in its “support to client”.

The beginning and end of Brain Injury Australia’s work is building awareness of ABI. Any attempts at “top down” awareness raising via the evidence-based arguments contained in submissions like this is hamstrung while “bottom up” data collection resists simply including, say, another field in *the form* that gathers client information. The Australian Government is rightly interested in *prevention* measures for homelessness. Taking into account the relatively high level and multiplicity and complexity of their needs with their relatively low rates of service use, any opportunity that can be offered to homeless people with an ABI to identify themselves for appropriate supports and referrals should be seized. Because the costs of not doing should be viewed by governments as prohibitive.

#### **“WHAT GOAL(S) SHOULD WE SET TO REDUCE HOMELESSNESS?”**

Brain Injury Australia believes that the *prevention* of homelessness should be a primary goal. A range of “upstream” measures are detailed below. As far as its constituency is concerned, Brain Injury Australia can make no specific recommendation in regards to goals – in either prevention or reduction - unless the relevant data, against which achievement can be measured, is there to begin with. For instance, since it began operation in 1985, the Australian Government’s Supported Accommodation Assistance Program (SAAP) does not collect client information about ABI.

**Recommendation One:**

Brain Injury Australia recommends that the Department of Families, Housing, Community Services and Indigenous Affairs directs both the Information Sub Committee (ISC) and Coordination and Development Committee (CAD) of the Supported Accommodation Assistance Program (SAAP) to amend client data collection to include information about Acquired Brain Injury.

Brain Injury Australia also recommends that the Department of Families, Housing, Community Services and Indigenous Affairs encourages non-SAAP providers of services to the homeless to include information about Acquired Brain Injury in their client information collection.

**Recommendation Two:**

In the absence of self-reporting, Brain Injury Australia recommends that the Department of Families, Housing, Community Services and Indigenous Affairs require staff of Supported Accommodation Assistance Program (SAAP) and non-SAAP funded-services to the homeless to undertake training to enable them to screen clients for Acquired Brain Injury.

**“WHAT TARGETS WILL BEST HELP US REACH OUR GOAL?”**

Brain Injury Australia believes that people who experience both ABI and mental illness (Dual Diagnosis), or alcohol and other substance abuse problems and those leaving prisons or juvenile justice institutions with an ABI are at the greatest risk of homelessness. On the basis of those studies cited by “Which Way Home? A New Approach to Homelessness” people with an ABI could make up one-third of the 75 per cent of homeless adults with a mental health concern.

Both Brain Injury Australia’s submission to the Australian Government’s 2001 National Homelessness Strategy Discussion Paper and its participation in the consultations that resulted in Third National Mental Health Plan (2003-2008) led to a commitment from the Commonwealth to a continuity of care and greater inter-agency cooperation for people with a mental illness and/ or dual disability and/or alcohol and other drug problems. But it has been the long experience of Brain Injury Australia - and that of its State and Territory member organisations – **that people with Dual Diagnosis are still regularly refused assistance by mental health services. Conversely, if they are accepted by a mental health service, they may receive treatment for their mental illness, but have their ABI ignored. And the presence of either will radically diminish, or outright deny, access to drug and alcohol services.** Despite attempts by some jurisdictions to break down the ‘silo’ approach to service delivery – by, for instance, enacting inter-departmental and intra-departmental/ inter-agency agreements - Brain Injury Australia is **unaware of any government agency that takes active responsibility for this large group of people at primary risk of chronic homelessness.** But Brain Injury Australia is regularly made aware of people with Dual Diagnosis either being bounced back and forth between the disability, health and (then) homelessness services, or falling into the gaps between each.

The New South Ombudsman's 2004 report into SAAP directly coincides with Brain Injury Australia's experience across jurisdictions. In spite of Memoranda of Understanding and bilateral agreements between the Commonwealth and States/ Territories and the latter's service frameworks, **SAAP continues to fail to deliver promised services that are: free of discrimination within a framework of human and consumer rights; accessible and inclusive of people with a wide range of needs and circumstances, including people with complex needs or requiring a high level of service response; flexible and responsive to individual needs; and coordinated and collaborative in its approach to meeting clients' needs and working with other service systems**<sup>6</sup>. The NSW Ombudsman reported "significant groups affected by exclusions" from SAAP services, included "people with disabilities, including people with physical disabilities, intellectual disabilities and *acquired brain injury*"; people who exhibit or who have previously exhibited violence or other challenging behaviour (many of whom would be people with an ABI); people with a mental illness and people who use, are affected by, or dependent on alcohol and/or other drugs.

The New South Ombudsman found most SAAP services "did not have the capacity or expertise to provide comprehensive disability and mental health services. Not surprisingly, in 2004–05 a substantial number of adult users of SAAP services who had a mental health issue reported that **their mental health needs were not being addressed by homeless services**. Other services not commonly provided were for **specialist services such as drug and alcohol support or intervention and services for people with physical or intellectual disabilities**."<sup>7</sup> Brain Injury Australia's has no knowledge of a SAAP-funded service capable of delivering either the specialist nature or level of service appropriate for a person with an ABI. Brain Injury Australia acknowledges that the expectations placed on SAAP-funded services are extensive. Given their capacity and funding restraints, Brain Injury Australia does not believe that SAAP services should necessarily be funded to conduct this kind of work. Nonetheless, Brain Injury Australia agrees with the New South Wales Ombudsman that SAAP, as a "safety net for those most vulnerable in our society, must move away from presumption of risk to considered assessment and risk management, and from a culture of 'gate-keeping' to a culture of inclusion."<sup>8</sup> Instead, Brain Injury Australia believes that **every SAAP-funded and other service to the homeless should have the capacity to make a referral to a specialist assessment (for example, to a neuropsychologist) and/ or a specialist advocacy service for people with an ABI**.

***Recommendation Three:***

Brain Injury Australia recommends that, as part of a whole-of-government approach to the prevention of homelessness, the Departments of Families, Housing, Community Services and Indigenous Affairs and Health and Ageing mandate that all Supported Accommodation Assistance Program (SAAP) and other-funded services to the homeless have the capacity and access to assessment and referral for people with an Acquired Brain Injury.

***Recommendation Four:***

Brain Injury Australia recommends that the Department of Families, Housing, Community Services and Indigenous Affairs, as part of its ongoing review of the National Disability Advocacy Program (NDAP), fund Brain Injury Australia – through its State and Territory member organisations – to provide specialist advocacy services to people with an Acquired Brain Injury.

**Recommendation Five:**

Brain Injury Australia recommends that, as part of a whole-of-government approach to the prevention of homelessness, the Departments of Families, Housing, Community Services and Indigenous Affairs and Health Ageing work with its counterpart departments in the States and Territories to enforce genuine inter-agency and inter-disciplinary co-operation in both the recognition and treatment of the Dual Diagnosis of Acquired Brain Injury and mental illness.

**Recommendation Six:**

Brain Injury Australia recommends that the Department of Families, Housing, Community Services and Indigenous Affairs include the specific category of Dual Diagnosis within all future iterations of the Commonwealth State Territory Disability Agreement (CSTDA).

**“WHAT ARE THE BEST WAYS TO MEASURE THE TARGETS WE SET?”**

The Australian Institute of Health and Welfare’s 2003 report into homeless people in SAAP found that:

- **“The ‘disability’ client group received specialist services less often than the ‘nondisability’ client group** [specialist services were able to be provided in only 69% of requests by the ‘disability’ client group compared with 81% of requests for the ‘non-disability’ client group], suggesting that SAAP may not always be able to cater for the specialised needs of homeless people with a disability.”

and

- **“Clients in the ‘disability’ group were more likely to seek assistance due to drug, alcohol or substance abuse** issues than clients in the ‘non-disability’ group. They were also **more likely to seek assistance due to being a recent arrival in the area and due to recently leaving an institution—such as a prison, detention centre or hospital.**”

As per above, Brain Injury Australia believes that “measures” are only meaningful if the relevant information is being collected to begin with. Once SAAP and non-SAAP-funded services both amend their client information collection (for self-reports) and the Australian Government, through the Department of Families, Housing, Community Services and Indigenous Affairs, require service staff to undertake training to enable them to screen clients for Acquired Brain Injury, then Brain Injury Australia will be able to see, via the reporting of the Australian Institute of Health and Welfare and other agencies, whether progress has been on measures, such as; improved capacity for services to the homeless to be able to refer people with an ABI to specialist services, including – but not limited to – genuine interdisciplinary/ inter-agency specialists with qualifications and training in Dual Diagnosis and/ or alcohol and other drugs.

## **“WHAT ARE THE THREE RESEARCH PRIORITIES FOR A NATIONAL HOMELESSNESS RESEARCH AGENDA?”**

Again, as above, Brain Injury Australia believes that **the first step to meaningful and useful research into homelessness is in the reform of service agencies’ data collection** – so as to include the significant subgroup in the population with an ABI. The second step – in circumstances of an undisclosed or undiagnosed ABI – is training in screening for ABI for all service staff to the homeless.

With those reforms in place, Brain Injury Australia has identified the following as its “three research priorities”:

1. The **first longitudinal survey of homeless people with an ABI**, to determine service use, rates of specialist referral, the incidence of mental illness (Dual Diagnosis) and alcohol and other drug problems, their experience of public (and private) housing etc.
2. To underpin the kind of longitudinal work, above, a study exploring the **potential for data linkages across agencies like health, housing, criminal justice, and SAAP** – such as those undertaken in Western Australia.
3. A cost-benefit analysis study that identifies, for example: barriers for people with an ABI entering public (and private) housing, savings in early intervention, behaviour management etc., and unit costs of ABI-appropriate accommodation.

## **“WHAT ARE THE BARRIERS TO RADICAL CHANGE IN HOMELESSNESS SERVICES AND HOW COULD THEY BE OVERCOME?”**

Again, Brain Injury Australia believes that the “barriers to radical change in homelessness services” begin with awareness-raising – thus, including **the capacity for people with an ABI to self-identify (in client information collection) and the training necessary for services to screen for ABI at intake**, and identify an ABI that might be masked by mental illness (Dual Diagnosis) or alcohol or other drug abuse.

Dual Diagnosis is common in the population of the homeless with an ABI. As per “Recommendation Five”, above, Brain Injury Australia recommends that the Australian Government, through its Departments of Families, Housing, Community Services and Indigenous Affairs and Health and Ageing, work with State and Territory counterpart agencies to **develop genuine inter-agency and inter-disciplinary co-operation in both the recognition and treatment of the Dual Diagnosis of Acquired Brain Injury and mental illness**.

## **“TAXPAYER FUNDS ARE LIMITED—WHERE, ACROSS THE RANGE OF POSSIBILITIES UNDER OPTION ONE, SHOULD WE DIRECT OUR EFFORT TO GIVE US THE BIGGEST IMPACT?”**

This submission presents to the Australian Government one absolutely revenue-neutral means of identifying one of the most significant subgroups of the population at primary risk of chronic homelessness – people with an ABI – simply by means of **the inclusion of extra fields in the client information collection of Supported Accommodation Assistance Program and non-SAAP funded services**.

*Brain Injury Australia: Submission to “Which Way Home? A New Approach to Homelessness” (June, 2008)*

For homeless people who are unprepared to disclose their ABI – or whose ABI may be undiagnosed – Brain Injury Australia urges the Australian Government, through its Department of Families, Housing, Community Services and Indigenous Affairs, to provide **training in ABI and its identification/ screening to services to the homeless**. Brain Injury Australia, through its State and Territory member organizations and networks, is in a position to either provide or procure such training.

#### **“YOUR SUGGESTIONS/ OTHER ‘BOLD IDEAS’ OR NEW PROPOSALS...”**

People with an ABI are radically over-represented in Australia’s prisons. A 2003-04 survey of 200 New South Wales inmates found that 82% had experience of Traumatic Brain Injury (TBI), with 65% reporting a loss of consciousness and, of those, 52% said they had ongoing effects (headaches, memory loss, personality or behavioural change, anxiety or depression etc.) and 22% had sustained four or more TBIs. These kinds of prevalence rates have been broadly replicated by similar studies conducted by the NSW’s Department of Juvenile Justice, its Corrections Health Service, the Centre for Health Research in Criminal Justice and Victoria’s Department of Justice. Overall, somewhere between 40 and 60 per cent of people in custody in NSW and Victoria report ABI. And these local survey results conform to results from overseas. Two US studies of death row inmates found that 75% had a history of “brain damage” and 100% had a history of TBI. Another study of prisoners in US county jails found that 87% of inmates had a TBI.

The 2003 Young People in Custody Health Survey, conducted by the New South Wales Department of Juvenile Justice, found that 40% of young men had sustained an ABI resulting in significant loss of consciousness. Most ABIs were the result of being struck by an object or person during fights (63%). Memory loss (19%) and poor concentration (18%) were the most common unresolved side-effects from reported ABI by young men.<sup>9</sup> (It should be noted that the highest age-standardised prevalence of ABI in the general population is in the 12-24 age group.)

A recent study of 340 prisoners who agreed to be interviewed pre-release (195 in NSW, 145 in Victoria) found that, prior to their imprisonment approximately 20% (in NSW) and 12% (in Victoria) of them were homeless, and post-release 16% expected to be homeless or did not know where they would live post-release. In 2005–06, 5 per cent of people leaving prison or juvenile justice institutions sought accommodation from SAAP services and 12 per cent of SAAP clients reported that they had spent time in the criminal justice system, 11 per cent reporting that they had repeated stays in correctional facilities.

From the data above, there is not only clear cross-over between prisoners with an ABI and the homeless population, but from its contact with State and Territory member organisations and their constituents, Brain Injury Australia remains convinced that an ABI simply serves to enhance the primary risk of homelessness experienced by many prisoners post-release. In this, Brain Injury Australia would join with many other submissions to “Which Way Home?” in making the ambit claim for more and better public housing, more and better services and support for people with an ABI generally, prisoners post-release particularly. But, as with Brain Injury Australia’s frustrations with the limitations in SAAP’s data collection (detailed above) it can only seek to hold to account government agencies – like the nation’s departments of correction and juvenile justice – for their responsibilities to detainees under the *Disability Discrimination Act (1992)* or the *UN Convention*

on the *Rights of Persons with Disabilities* (ratified March 30, 2007 by the Australian Government) if those agencies choose to collect the relevant detainee information about disability to begin with.

But Brain Injury Australia is aware of only two jurisdictions - South Australia and the Australian Capital Territory – that screen prisoners for a history of ABI at reception. Brain Injury Australia is also unaware of any jurisdiction that screens detainees in juvenile justice prisoners for a history of ABI at reception.

**Recommendation Seven:**

**Brain Injury Australia recommends that the Department of Families, Housing, Community Services and Indigenous Affairs urges, via the Corrective Services Ministers' Conference (as well as equivalent meetings of State and Territory ministers for juvenile justice), States' and Territories' departments of corrections and juvenile justice to include the screening and identification of Acquired Brain Injury in detainees at reception.**

The Australian Institute of Health and Welfare's 2007 report into prisoner health noted that **“there is no routine injury surveillance within Australian correctional systems.** Jurisdictions report rates of ‘prisoner on prisoner’ and ‘prisoner on staff’ assaults as part of the annual Report on Government Services published by the Productivity Commission. However, this is simply a tally of the number of ‘Governor’s Reports’, is administrative in nature, lacks detail, is likely to underreport injury, and does not aim to serve any public health purpose.”<sup>10</sup>

This is in spite of the fact that in New South Wales prisons, for example, **assaults are the second most common injury treated in the prison clinics.**<sup>11</sup> Whether a prisoner brings their ABI with them into prison or acquires one while there, the potential consequences – in cognitive function, in changed behaviour etc. (detailed in the “Preamble”, above) while detained or post-release - should be well known, as should be the increased risk both of further ABIs and, thus, the potential for re-offending.

**Recommendation Eight:**

**Brain Injury Australia recommends that, as part of a whole-of-government approach to the prevention of homelessness, the Department of Families, Housing, Community Services and Indigenous Affairs urges, via the Corrective Services Ministers' Conference (as well as equivalent meetings of State and Territory ministers for juvenile justice), States' and Territories' departments of corrections and juvenile justice to improve surveillance, recording and reporting of Acquired Brain Injury among detainees.**

As with homelessness, there is a complex inter-relationship between ABI and offending behaviour. While studies have consistently found high levels of ABI among prisoner populations, they are equivocal on a causal link between ABI, the personality and behavioural results of ABI and subsequent offending behaviour; whether the ABI itself is the cause of offending behaviour or whether the life circumstances of offenders who subsequently report ABI are perhaps criminogenic. What is clear is that prisoners and the kinds of people at risk of *any* injury have a lot in common – they tend to be poorer, they tend to have lower levels of education, they tend to

have histories of mental illness, alcohol or substance abuse. And they tend to be indigenous: the imprisonment rate for Aboriginal and Torres Strait Islander people is currently 13 times that of the rest of the population (it should be noted that the jurisdiction with the highest age-standardised prevalence of ABI also has the greatest proportion of its population identifying as Indigenous – the Northern Territory). And they tend to be men (93% of prisoners, around 75% of people with an ABI.)

Whatever the nature of the relationship between ABI and criminal activity, re-offending rates are generally high (one survey of New South Wales prisoners found that 44% had returned after two years, and the rate was even higher for those convicted of assault or robbery). While Brain Injury Australia does not believe that all roads from an undiagnosed, undeclared or unchecked ABI necessarily lead to prison there is no substitute for correct identification, early intervention and better-targetted – and better-funded – services and support for detainees with an ABI. Moreover, the appropriate care, support and management of people with an ABI in contact with the criminal justice system is not only a core responsibility of Australia's departments of attorneys-general, corrections and juvenile justice - in recognition of the equal rights of people with disabilities - but also potentially an evercise in crime prevention.

***Recommendation Nine:***

**Brain Injury Australia recommends that, as part of a whole-of-government approach to the prevention of homelessness, the Department of Families, Housing, Community Services and Indigenous Affairs, via the Corrective Services Ministers' Conference (as well as equivalent meetings of State and Territory ministers for juvenile justice), directs States' and Territories' departments of corrections, juvenile justice, health and disability to provide appropriate levels of service and support to detainees with an Acquired Brain Injury.**

## **GLOSSARY:**

### ***activity limitations***

Activity limitations are “difficulties an individual may have in executing activities” such as learning to read (Australian Bureau of Statistics’ 2003 *Survey of Disability, Ageing and Carers* [SDAC])

### ***disabling condition***

A disabling condition is a “disease, disorder or event that leads to an impairment or restriction that has lasted or is likely to last for at least 6 months”. [SDAC]

### ***incidence***

The number of new cases [of ABI] within a given period.

### ***main disabling condition***

A “main disabling condition” is, in circumstances where multiple conditions are, the one reported as causing the most problems.[SDAC]

### ***participation restrictions***

Participation restrictions are “problems an individual may experience in involvement in life situations” such as attending school or participating in recreation. [SDAC]

### ***young people***

This submission uses the Australian Institute of Health and Welfare’s (AIHW) “young people” as those aged 12–24 years. (Defining young people as those aged between 15 and 24 years is also a widely accepted statistical convention and is used by many studies on youth.)

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## ENDNOTES:

<sup>1</sup> “Quantifying the extent to which people with disabilities appear in the homeless population and in the SAAP population can be difficult. As can be seen from the above, there is no single data item that allows easy identification of clients who have a disability. The ‘disability’ client group is therefore assembled from a variety of data items and there are several combinations that could be used. In addition, some of the data items used to estimate the SAAP ‘disability’ client group were not collected on forms used by agencies with a high turnover of clients (the high-volume form), resulting in a possible underestimate. However, data from both the general and high-volume forms are used in the analysis where possible. In Australia in 2002–03 there were 32,648 high-volume forms returned, accounting for 20% of all forms returned. *Of the 20% of high-volume forms returned, 77% were for male clients.*” Homeless People in SAAP: SAAP National Data Collection Annual Report, 2002–03, Australian Institute of Health and Welfare 2003.

<sup>2</sup> Interpersonal relationships and work may also be affected. This large group of people with TBI can face many years of impairment, possibly affecting health, education, occupation, and social and emotional functioning.” (“Medical Journal of Australia Practice Essentials – Rehabilitation 4: Rehabilitation after traumatic brain injury”, Fary Khan, Ian J Baguley and Ian D Cameron Medical Journal of Australia, 2003, 178 (6): 290-295)

<sup>3</sup> Hatzitaskos., P. (1995) “Crime Times”, Vol. 1, No.1-2, p.5.

<sup>4</sup> Byrne, B. (1997) SRS Socialization Facilitation Project (Caulfield General Medical Centre, Melbourne) and Community (Residential Services) Visitors’ Board, Annual Report of Community Visitors, 1996, Health Services Act 1988 (Office of the Public Advocate, Melbourne) cited in HACC Program Development & Access SRS/Rooming House Project, Final Report December 1998.

<sup>5</sup> McGregor, Robb (2000) “Comparative data between clients with alcohol related brain injuries and other clients, Ozanam Community Support Services Outreach Program.

<sup>6</sup> “Final Report arising from an Inquiry into Access to, and exiting from, the Supported Accommodation Assistance Program Assisting Homeless People – The Need to Improve their Access to Accommodation and Support Services”

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> “2003 Young People in Custody Health Survey Key Findings Report”, Psychological and Specialist Services Unit, NSW Department of Juvenile Justice, Haymarket, 2003.

<sup>10</sup> Belcher J and Al-Yaman F, “Prisoner health in Australia: contemporary information collection and a way forward”, Canberra, AIHW, 2007.

<sup>11</sup> Butler T, Kariminia A, Bond J, Trevathan L. Injury surveillance in the New South Wales prison system. Australian Journal of Health Promotion 2004;15:146–149.