Understanding the Complexity of Causality: The View from Here

By Nick Rushworth*, Executive Officer, Brian Injury Australia

In the (good) old days of government, all it would take was one aggrieved constituent to beat the ear of a politician at a Sunday barbeque for a gripe to become policy Monday morning. Nowadays, so it's said, governments only respond to beefs with a base in evidence. So, while I believe the White Paper when it says it "addresses the causes of homelessness" — in the same way that I believe any politics with progressive tendencies trying to differentiate itself from a "law and order" platform in its opponents, by stressing an interest in the "causes of crime" — I'm unconvinced that the Australian Government has evidenced sufficient knowledge of those causes, which are as multifarious and complex as any other social phenomenon.

This, of course, reflects Brain Injury Australia's beef, the "view from here". What's called Acquired Brain Injury (ABI) refers to any damage to the brain that occurs after birth. Common causes of ABI include accidents, stroke, infection, alcohol and other drug abuse. Traumatic Brain Injury (TBI) — ABI's largest sub-category — is an ABI caused by an external force to the brain, like a motor vehicle accident, a fall or a blow to the head. Around 500,000 Australians are living with an ABI. Roughly 160,000 of them need help daily with the activities of everyday life. ABI is a "prime of life" disability — 2 out of every 3 acquired their brain injury when they were less than 25 years of age. 3 out of every 4 are men. Overall, ABI is 10 times more common than spinal injury and produces, on average, 3 times the level of disability. Because it happens to the brain.

The consequences of an ABI include: headaches, fatigue, seizures, poor balance and coordination, visual and hearing disturbances, chronic pain, paralysis, epilepsy, cognitive problems including poor memory and concentration, reduced ability to learn, plan and solve problems, shifts in behaviour post-injury, including poor impulse control and disinhibition, verbal and physical aggression. Given the large number of people living highly, complexly and multiply disabled, it is alarming that so few people with an ABI access Commonwealth State/Territory Disability Agreement (CSTDA)-funded services — 10,219 in 2006–07, down from 11,866 in 2004–05.

Numerous local surveys have attempted estimates of the number of homeless people with an ABI. A 1998 "Down and Out in Sydney" project found 10% of people using inner-city Sydney hostels and refuges had cognitive impairment the result of alcohol-related brain injury or a TBI. Two Victorian studies of pension-only Supported Residential Services pointed to the high proportion of residents with an ABI; 13% and 17%. A study by Ozanam Community Support Services Outreach Program found that over a three year period 33% of its clients had a diagnosed alcohol-related brain injury.

There's an array of places where people with an ABI and populations at risk of homelessness converge. The White Paper states; "7% of prisoners reported that they were homeless at the time of their arrest" and 1.3% of SAAP clients "reported that they had spent time in the criminal justice system immediately before entering SAAP". People with an ABI are radically over-represented in Australia's prisons. Between 40% and 60% of prisoners in NSW and Victoria report a TBI. And if they haven't got one going into prison, they're more than likely to get one while there (22% of prisoners in a NSW survey had experienced 4 or more TBIs): assault is the most frequently reported injury in the nation's prison health clinics. The White Paper again; "escaping violence is the most common reason provided by people who seek help from specialist homelessness services" and "domestic and family violence is the principal cause of homelessness among women." While men outnumber women in the experience of TBI the result of assault by a

factor of 5 to 1, women are 5 times more likely to receive their TBI at the hands of a spouse, partner or family member than men.

And just as "the rate of homelessness for Indigenous Australians is significantly higher than for non-Indigenous Australians", their rates of ABI are around 3 times as high as those of non-Indigenous Australians. A chilling Medical Journal of Australia study of assault-related head injury showed that Indigenous women are 70 times more likely to be hospitalised than non-Indigenous women. And while reliable figures on alcohol-related brain injury in Indigenous communities are hard to come by, a recent Senate report recorded 60 Indigenous deaths in the Northern Territory and 120 people in Central Australia with permanent brain damage as a result of petrol-sniffing alone.

None of this potential cross-over in populations would matter if services — government and non-government — could agree: on what the underlying "cause" of an individual's homelessness might be, on which cause to "treat" primarily and whether they really want to count causes to begin with anyway. The White Paper again; "Rough sleepers and people who are chronically homeless are more likely to have complex needs such as mental health issues, substance abuse and disabilities. They are also more likely to experience chronic health issues and have a mortality rate three to four times higher than that of the general population." A person with an ABI has an 80% chance of developing a diagnosable mental illness during their lifetime. Based on both the local and international survey evidence, Brain Injury Australia believes that people with an ABI could make up as much as one-third of the 75 per cent of homeless adults with a mental health concern. But it's been Brain Injury Australia's — and its State and Territory member organisations' — long experience that people with a "Dual Diagnosis" of ABI and mental illness are either regularly refused assistance by mental health services or, where 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 promote a "whole-of-government" approach to service delivery, 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.

Two Boys and a Girl at the Beach, Mark H

Brain Injury Australia is under no misapprehension as to what a thoroughgoing assessment and support of clients' ABIs could add to the responsibilities of already overstretched and underfunded services to the homeless. But, if this White Paper is serious in its commitment to "address the causes of homelessness and provide a framework for preventing homelessness", let alone in "halving overall homelessness by 2020" or "offering supported accommodation to all rough sleepers who need it by 2020" either services will want to know as much as they can find out about the causes of a client's homelessness, or they won't. Neither is Brain Injury Australia under any misapprehension that services are ultimately at the mercy of what clients choose to tell them about their life circumstances, and that for many people with an ABI how they "acquired" their brain injury can be a source of embarrassment, guilt or shame and therefore difficult to disclose to a relative stranger. But it's a source of ongoing frustration for Brain Injury Australia that, for instance, throughout the twenty-three years in which SAAP's been operating its National Data Collection Agency — 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" (thought 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 a basic awareness of ABI as widely as possible. Any attempts at "top down" awareness-raising from evidence-based arguments in submissions to government discussion papers, white or green papers is hamstrung while "bottom up" data collection resists, say, simply including another field in the forms that gather client information. Brain Injury Australia welcomes the Australian Government's $800 million funding for the reduction and prevention of homelessness as it does the commitment to delivering "evidence-based services to stop people becoming homeless in the first place". But homelessness will persist. And any opportunity that can be offered to homeless people with an ABI to identify themselves, and for services to be educated about ABI, should be seized. Because the costs of not doing so should be viewed by all as prohibitive. ■

* Nick Rushworth is Executive Officer of Brain Injury Australia — the national peak Acquired Brain Injury (ABI) advocacy organisation representing, through it State and Territory member organisations, the needs of people with an ABI, their families and carers. [In 1996, armed with a bicycle, Nick attacked two cars. The cars won, but Nick's recovery from a severe ABI was exceptional. Formerly a producer with the Nine Television Network's "Sunday Program", his most recent work has been for the Northern Territory Government setting up their new "Office of Disability".] Brain Injury Australia's submission to The Australian Government's Green Paper *Which Way Home? A New Approach to Homelessness* is available from their website — www.braininjuryaustralia.org.au