CORRECTED VERSION

LAW REFORM COMMITTEE

Inquiry into access to and interaction with the justice system by people with an intellectual disability and their families and carers

Melbourne — 21 February 2012

Members

Mr A. Carbines	Mr R. Northe
Ms J. Garrett	Mrs D. Petrovich
Mr C. Newton-Brown	

Chair: Mr C. Newton-Brown
Deputy Chair: Ms J. Garrett

Staff

Executive Officer: Dr V. Koops
Research Officer: Ms V. Shivanandan

Witnesses

Ms K. Stringer, Chair, and

Mr M. Paradin, Policy Officer, Victorian Coalition of ABI Service Providers.

The CHAIR — Welcome, Marc and Kerry. We are a cross-party committee, which has been set up by the Parliament to investigate various things. It gives us terms of reference, and this is one of three inquiries that we are doing at the moment. At the conclusion of our hearings we write a report, which makes recommendations for potential legislative change which Parliament then considers, and it may or may not act on our recommendations. Everything you say here is protected by parliamentary privilege, but you are not protected outside this room. Everything is being recorded.

Perhaps you could start by giving us your name and professional address and who you represent. Then if you could talk us through your submissions, we have until 11.20 a.m. We will ask some questions along the way as well.

Mr PARADIN — My name is Marc Paradin. I am the Policy Officer with the Victorian Coalition of ABI Service Providers, which is located at 27 Hope Street, Brunswick.

The CHAIR — ABI stands for ‘acquired brain injury’?

Mr PARADIN — Yes.

Ms STRINGER — I am Kerry Stringer. At the time of undertaking this research and providing the report I was the Chair of the Victorian Coalition of ABI Service Providers at the same address.

The CHAIR — You are an umbrella organisation?

Ms STRINGER — Yes.

The CHAIR — Who is in the coalition?

Ms STRINGER — The coalition was established in 1998, and it has a range of service providers represented from the Summer Foundation, an organisation which advocates for young people with disabilities in nursing homes, arbias, which is an alcohol and drug agency, Melbourne Citymission and a number of rural agencies. We have representatives in each of the rural regions undertaking a range of services for people with acquired brain injuries.

The CHAIR — Do your submissions today represent the coalition or do they also represent the individual organisations as well? Have you gone out to your members and asked them?

Ms STRINGER — Absolutely. VCASP has a subcommittee which focuses on justice issues. Part of the consultation that was undertaken was with those agencies that provide specialist responses to people with acquired brain injury in the criminal justice system as well as the broader views of the subcommittee. The subcommittee also has membership, for example, from the Office of the Public Advocate, so it has quite a wide representation.

Mr PARADIN — It is a longstanding subcommittee; it has been in existence for approximately a decade.

The CHAIR — What do you want to tell us?

Ms STRINGER — Essentially acquired brain injury, as you may be aware, affects cognitive, physical, emotional, social and independent functioning and can result from a range of traumatic injuries, including falls, motor vehicle accidents and sporting injuries, or non-traumatic injuries, including strokes, tumours and alcohol and/or other drug misuse. ABI is not to be confused with intellectual disability, for example. The people we provide services to retain their intellectual abilities. People with acquired brain injury, generally with severe to profound disabilities, are covered under the Disability Act 2006. You mentioned that this committee would look at legislation, and in fact if you look at the Disability Act in terms of services provided to people with intellectual disability versus people with an acquired brain injury around justice and mitigating against the impact of disability with justice-targeted interventions, people with ABI are generally excluded.

The CHAIR — Can I just clarify that? Are you saying that people with ABI are different from people with an intellectual disability in that they still maintain all the functions of their brain but their communications are not there?

Ms STRINGER — Yes, so essentially under the act you measure intellectual disability based on an IQ under 70 percentage points. Someone with an acquired brain injury may have a normal IQ, for example, but will have disabling impacts of their disability like short-term memory loss. Nick Rushworth from Brain Injury Australia is going to be here today. I guess the latest example of that is Molly Meldrum, who has suffered a severe brain injury as a consequence of a fall. The impact of the disability is arguably the same as someone with an intellectual disability, but the focus is really around cognitive impairment rather than impact on intellectual abilities.

The other kind of factor is that it crosses socioeconomic groups. We work with people who have worked in corporations and people who have worked in coalmines. It has a broad scope, given the nature of the many ways that you can actually acquire your brain injury.

The CHAIR — There are some people with ABI, though, who do have impaired intellectual ability?

Ms STRINGER — Yes. And what you find, for example, particularly in children, is that after a period of time post injury, because of impacts on the developmental capacity, they can have a reduced IQ.

The CHAIR — Okay.

Ms STRINGER — I guess the other thing that is kind of a point of difference is that people who we work with have had experiences of marriage, working, successful relationships and owning their own homes, and so again part of the impact of disability is the trauma that is associated with what is often a loss of that status within the community.

Ms GARRETT — Is it your submission that people with ABI who are excluded from the cohort of intellectual disability in these processes that should be — —

Ms STRINGER — I think there should be some equity in services — —

Ms GARRETT — There should be an umbrella approach to both?

Ms STRINGER — Yes.

Ms GARRETT — Because the impacts, even if there is not a cognitive impairment, whilst there is a debilitating behavioural change or memory loss that has similar — —

Ms STRINGER — Absolutely. How you would pitch some of those interventions might be different. So people with acquired disabilities in a program for people with intellectual disabilities often feel that sometimes they are talked down to and, again, based on their previous life experience, would have a different perception of how they should be treated. People often talk about programs that they are dumbing them down. So there should be equity of access, but the programs need to — —

Ms GARRETT — Be tailored.

Ms STRINGER — That is exactly right, for people with acquired brain injuries. I guess the other thing we are saying is that there is significant evidence, and it is in the report that was commissioned by the Department of Corrections and undertaken by La Trobe University and arbias. What is kind of frightening about that report is the numbers of people with moderate to severe disabilities: 39 per cent of prisoners have a moderate disability, and 6 per cent have a severe disability. My employment has been in the Summer Foundation with people with acquired brain injuries in nursing homes, and that is the same level of disability that a person in a nursing home would have. I can only imagine, and these people are not known to the disability system, the level of confusion and distress that they must experience as a part of having that degree of disability within an institutional setting with no access to interventions to support that disability. We would certainly argue, and it has been raised in the Productivity Commission report around the NDIS, that those people need to have some form of targeted intervention. They would be eligible under the current eligibility criteria for the NDIS, and they are currently receiving very little, if any, support.

The other thing we would be saying is that there are multiple examples across both the intellectual disability services system and the acquired brain injury system of good programs, beneficial programs and interventions that work. We would argue that you need to build on the strengths of those existing programs.

The CHAIR — Okay.

Ms STRINGER — That is pretty much it.

The CHAIR — Okay. That is great.

Ms GARRETT — Is there anything you want to add?

Mr PARADIN — No.

Mr NORTHE — I have a question, Mr Chair, if that is all right. Kerry and Marc, just in terms of reading through the submission, which is a very good one, by the way — thank you very much for your 10 recommendations, which are very helpful. Recommendation 6, where, I guess you are talking about the information and awareness training being provided to Victoria Police or targeted at Victoria Police to support the identification of ABI as part of that, and further to that noting some of the transcripts on page 5 of your submission, where a particular person says:

> I forget to say I have an ABI. I get so confused, I don't think to call (the case manager). Maybe we could carry a card or something like a medical alert.

That is something that has probably been discussed in other public hearings. I just wonder what your thoughts are on that — identification of somebody who may have an ABI?

Ms STRINGER — The criminal justice subcommittee has actually developed what we call a ready reckoner for police. It is a one-page fact sheet around acquired brain injury and the sorts of indicators that you might look for. Often people with acquired brain injury complain that people think they are drunk when they are not — those kinds of things. There was a point probably five or six years ago when we were working quite closely with the police around use of the ready reckoner, but given the priorities of the police service, those sorts of initiatives need to be repeated and renewed fairly regularly.

We had quite a colourful conversation in our consultations with people with acquired brain injuries about carrying some form of identification. People essentially want to be included in the community and do not want to be singled out. There were discussions about, 'What, do you want us to tattoo it across our heads?'. For other people, it was about having some form of identification that they might be able to use to alert the police around their acquired brain injuries, and everybody thought that having an independent third person involved through the Office of the Public Advocate was a fantastic idea. Again, you would want it to be discreet; I mean, people want it to be discreet.

Mr NORTHE — Without putting words in your mouth, would you maybe advocate for an optional identification card?

Ms STRINGER — Yes, I would. I think that would be a great idea.

The CHAIR — Presumably if it is something they can carry which they may never pull out ever, but if they are apprehended by the police and they are having trouble making themselves heard, they can pull their card out?

Ms STRINGER — Absolutely, yes.

The CHAIR — Are you saying that some people did not want to have even that as an option?

Ms STRINGER — I think people are very conscious of not being singled out. They want their lives to be as normal as possible. The rest of us do not carry a card saying, 'I laugh loudly' or whatever, or 'I use my phone incessantly, and it might drive you crazy'. If it was discreet and it was a choice, I think people would take that up again. We met people, particularly in rural regions, who knew the police and the police knew them. I think in that situation it would be really advantageous, because people are saying they are being singled out anyway. It is certainly the view that in rural regions the people involved are known well by their case managers and by the service systems. There were certainly some instances described to us where you imagine that if the police knew there was a worker involved, that worker would be involved more quickly and some of the issues that arose would potentially not arise.

Mrs PETROVICH — Thank you for your presentation. You talked about the number of people who are finding their way into the correctional system, which is pretty high. Once they have been in the correctional system, is there an acknowledgement that they do have some issues and is assistance perhaps given to them, or is it business as usual?

Ms STRINGER — I think that is highly variable. Again, one of my previous roles was with the Department of Human Services in the north and west region. I was responsible for a justice team which primarily provided services to people with intellectual disability. Occasionally we would get someone with an acquired brain injury who we would provide case management to. That was essentially because someone had been advocating for them. Certainly within the correctional system the ABI clinician who is covering the north and west region is able to identify people and support some planning around service delivery once people go back into the community, but it is pretty ad hoc, I would say, and certainly not in any significant way to reduce recidivism, for example.

The CHAIR — Thank you very much. It has been very helpful.

Ms STRINGER — Congratulations on this piece of work. I am looking forward to reading about it.

Witnesses withdrew.