C O R R E C T E D V E R S I O N

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 — 16 April 2012

Members

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Ms J. Shuard, Deputy Commissioner, Offender Management Division, and

Mr P. Persson, Manager, Disability, Youth and Ageing Portfolio, Corrections Victoria.

The CHAIR — Thank you very much for attending the committee hearing today. As you are probably aware, the Law Reform Committee is a cross-party committee that was set up by Parliament. We are given terms of reference by Parliament to write reports on and present, and the recommendations may or may not be picked up as new legislation in the future. Everything you say here is covered by parliamentary privilege. There will be a transcript which you will get a copy of within the next week or two to check for any errors.

Could you start with your name, professional address and who you represent and then talk us through your submission?

Ms SHUARD — I am Jan Shuard. I am a Deputy Commissioner with Corrections Victoria, and I have a portfolio called the Offender Management Division. We are on level 22, 121 Exhibition Street, Melbourne.

Mr PERSSON — Peter Persson. I am the Manager of Disability, Youth and Ageing for Corrections Victoria, located at level 22, 121 Exhibition Street.

The CHAIR — Do you have separate submissions that you want to talk us through?

Ms SHUARD — No. We have a presentation that is based around the questions that we thought the inquiry is looking into, so we are going to go through that presentation and then we will take some questions, if that is all right.

The CHAIR — Yes.

Ms SHUARD — If you like, I will just give you a bit of an overview of the corrections system, and then Peter will give you a presentation of the detail around how we deal with people with disabilities in our system in Corrections. We have tried to structure the presentation around the questions that were in the inquiry, so: who is this group of people, how do we know who they are, how do we identify them within our system, what are the particular services that we provide for them and why do we do it in the way we do.

As you would appreciate, I am sure, this is a particularly complex group of people in our population. Of 4928 prisoners we have as of today in the system, 4602 are men and 326 are women. In Community Corrections, which is often forgotten — the prison population is one that people know about — we have nearly 8700 people under supervision in the community on any one day as well.

The CHAIR — Do those figures refer to people with a mental disability?

Ms SHUARD — No, that is the total population of the prison system and community corrections system. When we get into it, we will talk about the numbers of people who come into our system who have a disability.

I guess from the start of the presentation we acknowledge that this is a very complex group of people within our system, and they require a specialist response. Certainly without a specialist response they would not be able to function within a corrections system if they were treated the same as everybody else. They require something that is unique and for their particular characteristics.

The second part of our response is that it is not something we can take sole responsibility for. It is really important when we are dealing with people with disabilities that we work across the sector with other agencies to make sure that the services we provide are consistent with what is provided by other agencies and also that there is a continuity in the services that are provided across them and that there are multidisciplinary and interdepartmental interventions that we provide to people with disabilities.

I guess our aim for those people with a disability is the same as our aim for anybody else who comes into the system. We hope that if they come into our system, we are able to make a difference in their lives and that they can leave and become law-abiding citizens — and we hope not to see them again. We are not people who want return business. We are in an industry where our success is measured by people who do not return to us, not by people who return to us.

Our mission is obviously confidence in Corrections. We achieve this through our offender management practices and actively engaging with offenders and the community to promote positive behaviour change and address social disadvantage. We acknowledge that most of the people who come into our system are disadvantaged in the community. We have a specific disability response that is consistent with that vision and

purpose of Corrections. We also acknowledge that the corrections system is made up of many different sub-populations, so we cannot provide a service that is the same for everybody, otherwise their access and benefit would not be equitable. So we must provide a unique service for the different populations that we have.

Hence we have had two disability action plans in Corrections, commencing in 2007, and the action plan we have now will expire in December 2012. Those action plans are what we measure the services that we provide to people with disability by. Peter will talk to you now about those action plans, the sorts of services that we provide and the people we provide them to.

Mr PERSSON — Just to put in context our disability action plans, obviously they are connected to the state's disability plan. The Department of Justice also has a disability action plan which falls out of the state plan. The committee might be aware of the more recent National Disability Strategy, which is an initiative of COAG — of the state, territory and federal governments. Included in that National Disability Strategy is specific reference to the forensic disability population, so I guess there are layers around the country, including in Victoria, that we have hooked into in terms of our specific response.

We acknowledge up-front that really this has to be a long-term piece of work. As Jan alluded to, this is a very complex group of people. Our aim really is to try to embed within our everyday correctional practice the issue of disability so that it is not seen as a sort of add-on that we think of down the track. It is something that we should consider on a systematic basis. I guess to realise that, we have taken these two disability action plans, so there is a long-term commitment to this group of people within the correctional system. As Jan mentioned, our current plan concludes in December 2012. We have started the planning process for our next disability action plan for the next three years, commencing in January next year.

Consistent with the approach in disability services more generally, there is a view within Corrections that we should try to make mainstream services accessible. That is really our preference, but we also accept that some of the complexity and some of the nature of the disability means that we have to develop specialist services. So we have developed, I guess, a two-tiered approach to trying to provide a range of services for people with disability within our system. An example of the former accessing generic services is that we have a general complaints process within Corrections, and we have tried to make that accessible to prisoners with disabilities, and those prisoners with literacy issues, in terms of making that complaints process accessible through the use of easy English.

In terms of the specialist response, as an example we have developed a specialist program for prisoners with an intellectual disability or acquired brain injury who are convicted of violent offences, and we run a specialist program for that group of people. So as Jan mentioned, trying to be consistent about what the committee is looking for, it really does underpin the way Corrections has responded over the six years or so. We have tried to frame our work around three questions: who we have got — because I guess we need to know who is coming into the system so that in the first instance we can try to keep people safe because in many instances people with an intellectual disability in particular are very vulnerable and are not particularly street savvy. They can be the subject of standover, for example. Also, ideally we want to understand who those people are in terms of what their characteristics are so we can train and target our response. We also try to answer the question of why have a specialist response. I will talk a little later about that, and likewise we will go to the heart of what we actually provide, which is the most important question.

So in terms of who we have and what the committee is interested in and what our focus has been, we have looked at people with an intellectual disability and likewise people with acquired brain injury coming into our system. In terms of people with an intellectual disability, there is a pretty well-developed system of identification, and certainly the way that disability services in the community identify people from a very early age as having an intellectual disability stands the correctional system in good stead because those people are known to disability services, they get case managers and more often than not they go to special schools et cetera. So they are known to the system more generally.

In terms of when they turn up for court, the system will have an idea that they are coming into the criminal justice system. That does not always happen, but more often than not we know the person has an intellectual disability before they come into the correctional system. There are obviously instances where people slip through the net, and I guess within the correctional system we have tried to build up the capacity so that people have a skill base to be able to identify those people who have slipped through the net, so to speak, so there are a

number of points in the system where we can identify any areas of concern. In terms of formally identifying them, we can advise disability services to undertake a formal assessment.

The issue of acquired brain injury is a much more challenging issue for Corrections, and I will talk a little more about that in terms of the scale of the issue. Certainly the diagnosis of an acquired brain injury is very resource intensive. It requires a full neuropsychological assessment, which is a very time consuming and expensive process. But given that that is the case, we have done some research around that, which I will talk a little bit about, but we have started to undertake our own screening and identification process. We accept that there are significant numbers of people with ABI in our system, and we have started to try to identify who those people are and then do something about it.

The CHAIR — What sort of tool do you have to identify people with ABI?

Mr PERSSON — We use a screening tool called the Heidelberg tool. We have adopted that tool because it is able to be applied by non-clinicians. So in terms of its accessibility to a broad number of staff across the correctional system, it means that obviously we do not have to rely on a neuropsychologist or a psychologist to undertake the screening. The question then is: what do we do with that information once we have screened for ABI? That, as you would understand, is the more challenging issue for us. But certainly we have gone for that Heidelberg screen because it is accurate but also because it is accessible and less costly for the system.

The CHAIR — Vaughn, is that something that one of the other presenters told us about in Geelong — a simple sort of question-and-answer type of thing?

Mr KOOPS — Yes, they did talk about a tool.

Mr NORTHE — It was not that term though; it was a different term.

The CHAIR — Would you be able to provide us with a copy of — —

Mr PERSSON — The Heidelberg tool? Of course. There are a number of other screening tools. There is a screening tool that has been developed by arbias, which was the industry partner that helped us do the research into ABI, so there are a number of ways that you can identify ABI. The more serious question is: what do we then do about it? Moreover, what do we then do about it particularly when people with ABI exit the prison system? It is getting a bit off the topic, but in many ways people with ABI manage in a structured environment, and prison provides that. It is when people are released into the community that many of the issues associated with ABI become more apparent. There are issues about short-term memory loss, impulsivity and so on and so forth. I am not advocating that the prison system is where they should be, but in many ways that structure means that they operate not too badly.

The CHAIR — What do you do with the information if you conclude that someone is likely to have an ABI? How do you then deal with the person?

Mr PERSSON — As a result of the research, we have developed an ABI program. We have employed a specialist ABI clinician. We have targeted our effort so that where we believe a person has a serious acquired brain injury, our ABI clinician gets much more intimately involved. As I have alluded to, where people have a mild brain injury within the prison system, they operate at not too bad a level, so we try to target our resources in terms of those people who tax the system most. We have some capacity to fund neuropsychological assessments, but we do not necessarily do that as a matter of course. We certainly do it where there is a reason in terms of the person's presenting behaviour or where there is a reason such as the person might be eligible for a disability support pension on release and they need that sort of diagnostic assessment to go with the Centrelink application.

Ms SHUARD — In some areas we have trained staff particularly working with people who have an acquired brain injury so that the way they are working with them does not make it worse but in fact makes the management easier if they understand what they are dealing with because it can often be interpreted as aggressive or difficult behaviour. If staff have an understanding that it is actually an acquired brain injury, then they operate differently and the outcomes are much better for everybody.

Mrs PETROVICH — Just while we are on that particular page talking about intellectual disability, do we talk then about Asperger's or — —

Mr PERSSON — Yes, autism spectrum disorder. I guess as we have gone along we have started to unpack a whole range of people who might be in the correctional system. There are also people who potentially have Huntington's disease in the correctional system. More recently we have been supporting a piece of work done by Deakin University looking at the prevalence — it is a very early study — of autism spectrum disorder in the correctional system. I guess we would follow that same kind of framework — trying to understand who we have in the system first off, and the number of people, so we certainly recognise that potentially there are people with autism in the correctional system. We would hopefully use that piece of research to think that there is an issue here. It gives us some sense of scale of the problem, so what is our next move, essentially?

Mrs PETROVICH — You talked about acquired brain injury and the structure actually suiting them. I imagine that for those with autism disorders, that sort of environment may actually not suit them.

Mr PERSSON — Yes, that is right. I guess the point that Jan makes is essentially right — that if we can identify that a person has a particular disability, then in terms of their presenting behaviour, if you understand where it is coming from, then obviously you can start to manage that better. I guess we have put in a large amount of effort in terms of the training that goes into specialist units but more generally a large amount of training across the board around the fact that a person might have a disability or short-term memory loss and so on and so forth. You are trying to skill up all your staff in terms of working better with those people.

Ms SHUARD — That is absolutely critical. I guess people working in the corrections environment are used to dealing with people who might have challenging behaviours or difficult responses, and to be able to separate what is somebody with bad behaviour from somebody who has some form of disability is really important.

Mr PERSSON — Just going back to who we have in terms of intellectual disability, as of last Thursday we had 120 people in the system who are registered as having an intellectual disability — that is, men and women who are sentenced and on remand. That equates to roughly 2.5 per cent of the total prison population, which is in line with the more generally accepted prevalence rate of intellectual disability in the community of 1 per cent to 3 per cent. At least in Victoria we believe there is not an overrepresentation of people with an intellectual disability in the prison system. However, we would obviously add the rider that these people who do come into the prison system are very complex people.

To that end we did a piece of research three or four years ago which we published. We wanted to understand who our population is. Is the population in Victoria the same as what has been researched nationally and internationally? I guess some of these findings will not surprise the committee given the work it has been doing. We wanted to use that information perhaps to drive some of the responses we have developed to date. For example, it would not surprise the committee that more often than not our group of people have had contact with the youth justice system at a greater rate than the non-disabled population. In terms of this piece of research we had a comparison group. We had a group of intellectually disabled prisoners and then we had a cohort of non-disabled prisoners, and we compared the two groups.

In terms of youth justice detention, 33 per cent of our prisoners with an intellectual disability had contact with the youth justice system in terms of being detained as compared to 10 per cent. They were more likely to have had community-based orders, so they came into contact with the corrections system more often and, for whatever reason, they have been sentenced to prison subsequently. They are more likely to be younger, 28 years compared to 33 years; they are more likely to have had psychiatric treatment, 27 per cent versus 13 per cent; they are more likely to have been involved in incidents or fights in prison; they are more likely to have attempted suicide or some form of self-harm; and they are much more likely to be indigenous compared to the mainstream group. You can see from the very short summary of that piece of work that this is a very complex group of people, and I guess these are some of the challenges we have tried to address in the programs, which I will talk about subsequently.

In terms of acquired brain injury, we started this investigation about six or seven years ago. The reason we wanted to look at it was really because the reasons that can lead to a significant acquired brain injury are exactly the same reasons why a person might come into contact with the criminal justice system. In terms of alcohol

abuse, drug abuse, ending up in fights, being in a car accident, these are exactly the same reasons that you might end up with an ABI and you might end up in the criminal justice system.

As we have already touched upon, an ABI can result in a series of things. It can result in aggression, it can result in short-term memory loss, it can result in uninhibited behaviour and it can result in poor planning. There are a whole range of factors that in fact might lead them to do something that might bring them to the attention of the police and the courts and to coming into the corrections system.

The CHAIR — Is there any assessment being done in terms of the proportion of people in the prison system with an ABI as opposed to those outside the prison system? Presumably they are overrepresented in the prison system.

Mr PERSSON — Significantly. The next slide — —

Ms SHUARD — Slide 10.

The CHAIR — I am glad it isn't slide 8 and I was not listening!

Mr PERSSON — No, you are spot on. Again, we ran a study where we had a sample and we compared it to a non-disabled sample. Essentially we found extremely high rates of ABIs. In the male sample there was a prevalence rate of 42 per cent; in the female population there was a prevalence rate of 33 per cent. We confirmed that diagnosis through full neuropsychological assessment, which is the gold benchmark in terms of diagnosis. As we have already touched upon, the vast majority of the ABI that we found was mild in nature, but there are a significant number of people who we believe are in the prison system, many of whom come to our attention, who have a moderate to severe acquired brain injury.

Mr NORTHE — Peter, just for clarity, on top of ABIs for males of 42 per cent — —

Mr PERSSON — Yes.

Mr NORTHE — On top of that, you have intellectual disability, which is about another 2.5 per cent.

Mr PERSSON — Yes. I guess to an extent we have found out who we have. We just want to talk a little bit about why we have developed a response. There are four main reasons why we thought we needed to do something specific around the population, including obviously community safety. To date we have investigated the issue particularly around people with an intellectual disability, and they have much higher recidivism rates. In terms of that very basic kind of responsibility of Corrections Victoria, we felt we needed to do something much more targeted. Internationally and nationally there is a developing evidence base about what is effective in working with this population, so we have tried to piggyback off that.

As we have already said, we have touched upon the fact that if we know a person has a disability and we can inform our prison staff, then obviously the way we can manage those people day to day is much more effective. Also, in terms of the sorts of specific programs about reoffending, we can have a much more specific and targeted response. The third one is just an equality of opportunity. We believe we have to provide all prisoners with access to the programs and services that all prisoners should have access to. We do not believe that an impairment should be a barrier to those people getting access to that range of services, so we adapt those programs if they are required.

As Jan rightly pointed out, we think we have a significant part to play in a whole-of-systems response. Given the complexity and given that we have high reoffending rates, it means that people come in and out of the correctional system, so we need to be working hand in glove with other parts of the service system to try to respond to and manage these people effectively when they are released into the community.

Ms SHUARD — I also think that sometimes it is that period of stability in people's lives that are sometimes out of control, so when they come in things such as an assessment and the like can take place because they are there and they have to turn up and are able to take advantage of that time. I guess we can make the period or episode of imprisonment at least as productive as we can, given that they are in our care for that time.

Mrs PETROVICH — Just on that, it strikes me that a lot of these people are, as you said, people with complex needs — high needs. When they are released is there a mentoring or support system available for them?

Mr PERSSON — Certainly there is a case management system in terms of disability services. From our point of view, I think one of the gaps in our system is that for many of these people the only significant people in their lives are paid workers. I would go back to our earlier research where people end up in the youth justice system at an earlier age. What that said to us is that in many cases these people are disconnected from their families and their communities at an earlier point in their lives, then the most significant people in their lives tend to be paid workers. I think that the role of unpaid people — mentors or volunteers — could play a very significant part in our response, you know, trying to keep them on the straight and narrow. You have hit the nail on the head; I think that is a real need. The paid worker is terrific — committed and all that kind of stuff — but it would be good if we could have something that lasted longer than the paid worker. Likewise, obviously Corrections has a fixed point where their parole finishes and then we move off the scene, so to speak. Again, that is where that whole of system needs to come in.

Just going back to the next slide, this is just an example of a concept we use in Corrections. It is also used in the forensic disability sector in the community. This is trying to give you an example of the fact that in terms of collaboration, it would be good if we can all be using the same kind of approach. This is a pictorial representation. It shows in a way that we have tried to adapt quite a tricky concept so that people hopefully think about the 'old me' and the 'new me'. Hopefully it is an example of where this is consistently used across the service system.

Probably the most important question is: what have we tried to do in terms of our response? What I wanted to talk about briefly was, firstly, what is it that is different about those programs and then just a little bit about some examples of some of the programs that have been delivered. You can see some of those key features there, such as length of programs. Guys with intellectual disability take much longer to get the idea, so we have to run programs for a much longer period of time. An example is: a violent offenders program might run for 4 months for non-disabled prisoners, but for our guys we have to run it for 9 or 10 months. That is a very concrete example of the difference between the type of programs we have to run.

On the style of delivery, this is a very pictorial representation of concepts. It is not very helpful sitting around a table with guys with intellectual disability spouting off like I am and being didactic; it really needs to be activity based and very pictorial and those sorts of things. Their learning style is much different. That goes to communication — skill acquisition. Again I go back to that research. For many of our guys it is not a matter of rehabilitation; it is a matter of habilitation. In many instances they have whole gaps in their repertoire of skills, particularly around independent living and the day-to-day stuff of making a life. Often they have not got those sorts of skills, so it is incumbent upon us to try to deliver that kind of stuff.

There is the issue of ongoing contact — again this idea that the system needs to be involved with these people for a longer period of time because often they fall off the rails.

With the delivery of programs in the community, one of the features of someone having an intellectual disability is they have difficulty with abstract thinking. We talk at a table in a prison unit about pro-social behaviour, but it is very hard to think and conceptualise about how they might act that out in the community. That is certainly one of the challenges for us, and we want to try to put more emphasis on delivering those sorts of programs in the community.

Now I will talk about much more concrete things in relation to some of the things that Corrections has done as part of its current disability action plan. Those are the five kinds of areas that we have tried to cover in our plan. With the things that we have already talked about, the key things are around programs, services and partnerships, and certainly we have tried to address some of the issues around people with acquired brain injury.

The first example is the disability units that we run within the prison system. The unit we have spent most time on is at Port Phillip Prison. That is a 33-bed unit for male prisoners with intellectual disability or acquired brain injury. Historically — when I started at Corrections — that was the place where people were sent to and kept safe. We have tried to build on that in terms of developing a therapeutic approach, delivering a range of

rehabilitation programs. I should say that Port Phillip is a maximum security prison, and this unit is within that prison.

We have extended that service to Loddon Prison, which is a medium security prison in Castlemaine. We are trying to move people through the system from a maximum security prison to a medium security prison.

Mrs PETROVICH — How many beds does Loddon have?

Mr PERSSON — They have six specialist beds, but currently we have 20 guys with intellectual disability at Loddon, and thankfully we have 1.5 specialist disability staff at Loddon managing those people. We have a group of specialist staff. It is a very specialist area in terms of working with disability and working within that forensic domain.

As I have already touched upon, we run a range of specialist programs for violent offenders, and then we run a range of other things around anger and so on and so forth. We try to run a whole range of different programs.

Importantly the oversight of this system does involve our partners. Certainly disability services is part of the governance of the way that we are operating in the prison pathway. Indeed there are disability services staff who work in the prisons with us as part of that collaboration.

We have already touched upon the Corrections Victoria ABI program. Our ABI clinician spends a significant amount of time around identification of ABI and training up staff around the ABI screening tool. Then it is really a matter of trying to prioritise — target — her work subsequently in terms of the particular people with acquired brain injury. Also a significant amount of her time is spent on building staff capacity, so training around how you work with someone who has an acquired brain injury.

I have already touched a little bit upon training. Obviously we do that with respect to ABI. We also do that with respect to intellectual disability. We run a whole lot of different training depending on the staff who we are dealing with. For example, we run introductory disability training for all new community correctional officers. We run very specialist training for those prison staff who work in the dedicated prison units, such as at Port Phillip or at Loddon Prison. We have done a heap of training, and that is incredibly important in developing that awareness and skill base amongst our operational staff.

Almost finally, in terms of our partnership with disability services, we have a protocol with disability services. The key feature of this is that at a very concrete level as part of the protocol there is an agreement between ourselves and disability services that a disability client services case manager will be activated six months prior to the release of a prisoner with an intellectual disability being released into the community. Really that goes to the heart of that collaboration — that continuity of care that really is critical in hopefully maintaining people in the community.

As I touched upon, we have some disability services staff actually working in the prison system. One of those significant staff is called a Prison Services Coordinator. He is basically the conduit between the disability services system and the correctional system. In terms of that advice about a client coming into the system, the disability services case manager will contact the Prison Services Coordinator and advise us. Likewise, it is his role to be responsible for the activation of that case management six months prior to a prisoner's release.

I guess there are a range of other partnerships that we have tried to foster as well. There are some examples there that go to different parts of, I guess, what we have tried to do around disability in Corrections. One example is that within the prison system there is a range of rules, as you would expect, and if those rules are broken, prisoners are subject to internal disciplinary proceedings. For our guys with intellectual disability we have instituted a program, in collaboration with the Office of the Public Advocate, where either a staff member from OPA or one of their volunteers sits in on that governor's disciplinary hearing with the prisoner with an intellectual disability. Their role is really to make sure that the prisoner understands the system. They are not there to advocate for them; they are just there to ensure that they understand what is happening and that they get a chance to put their point of view.

On a completely different tangent, another program is the street soccer program. That is a program run by The Big Issue. The committee may have heard of it. It is more broadly run in the community for homeless people. We run the program at Port Phillip Prison and Loddon Prison. It is a terrific program in terms of engaging

people, physical exercise, hopefully developing some discipline and confronting difficult situations in terms of a soccer match, but also, because it is run in the community, we are hopeful that — and there have been examples — prisoners who have been involved in the street soccer program in prison follow it out into the community. So it is trying to build that into something more meaningful upon release.

More recently we have set up some seeding money with the Salvation Army in terms of helping people with acquired brain injury coming out of the prison system. Many of these guys end up in the care of the Salvation Army or other generic welfare agencies, and I guess we are trying to add some value to the work that the Salvation Army already does in terms of supporting people with a disability who come out of the correctional system.

Finally, as we have touched upon, we are starting the planning for our next disability action plan. Some of the things we are hoping to do includes obviously consolidating the work that we have done. Obviously there are things there that we want to improve and expand, if you like. One of those is the extension of our Disability Pathways Program into a minimum security location. It looks as though we are able to do that at Dhurringile Prison, which goes back to my point earlier about the inability or the difficulty in people with an intellectual disability being able to generalise their behaviour. In an open camp situation you obviously get a much better chance to practise your skills rather than being behind a large fence.

The CHAIR — Just on that point, do you think there is any value in having prisons specifically for people with acquired brain injury, or are they better off mixed in with the general prison population?

Mr PERSSON — I certainly think you need to take into account their vulnerabilities in terms of being in the prison population. I guess you are hoping to place people with an ABI with people who have pro-social attitudes. Obviously there are people in prison who do not have pro-social attitudes, but there are some people who have started to turn their lives around. I would highlight that we run a very significant mentoring program in prisons so that we have non-disabled prisoners working with the disabled prisoners in terms of that kind of modelling, if you like. We have developed a very extensive training program for those mentors so that they can work very closely with the fellows. I think it goes to your point that obviously those prisoners have a different relationship with the guys with disabilities than, say, a prison officer or a clinician. I guess it is just hopefully another way of supporting their adopting a more pro-social view of the world.

The CHAIR — So far as the safety of people with ABI goes, is the main danger to them the non-ABI prison population, or is it other ABI people who pose the greatest risk? Or is there not really any generalisation?

Mr PERSSON — I do not know whether there would be anything we could say about that directly. I do not know whether you would have a view, Jan.

Ms SHUARD — No.

Mr CARBINES — Do you have any observations in relation to carers, family members, people who come to visit or people who support those who are obviously imprisoned in the system? Is there any difference in the sort of support that is provided to them that you have observed as compared to, I suppose, other people who are incarcerated in the population generally?

Mr PERSSON — We do have a specialist group of people who work with this population. Obviously anyone can visit, including a family member. I guess we might have a view on how appropriate or how supportive that relationship might be. I guess what you try to do subsequent to the visit is to try to work through the issues that might have arisen through the visit. Hopefully it is a very supportive relationship and the family is involved in a positive way. If that is the case, terrific. If it is not the case, then I guess you are trying to potentially work through issues like, 'If you did this, would you be putting yourself at significant risk? If you returned to that living situation, might you be in a risky situation?'. So I guess through the kinds of programs that we run you try to identify the risky situations for people.

Mr CARBINES — Just to follow up on that, is that about trying to help people sort out who will be potentially supporting them or helping them to adjust when they go back out of the system?

Mr PERSSON — Yes. It is also about identifying if their families — you know, unfortunately, there are some — are collusive in the offending behaviour. That will not be a good place for the person to go back to if it

is not a protective arrangement but in fact a collusive arrangement in whatever their offending behaviour might be. That can be hard if that is all you have, if that is the only family you have. The other choices are very limited. As we said before, often there are not many supports out there, other than professional support. Then that can be difficult to deal with. In some of our programs we will work with the families. Certainly in the sex offending area we will work with the families to try to build their skills to be protective rather than not protective or, even worse, collusive in the offending behaviour.

Mr CARBINES — I would like to look at just two other aspects on that. It sounds like that would be common across the general population — the sorts of issues and the sort of environment you are in generally are probably just as reflected in that sort of environment for people with ABI or other intellectual issues.

Mr PERSSON — Sure.

Mr CARBINES — That seems to be what you are saying. The other question, then, is whether you find that carers, family members or people who are perhaps advocating for or supporting people with those sorts of issues who are incarcerated raise any particular concerns consistently that come to your organisation about their welfare, wellbeing or those sorts of things? Not particularly?

Mr PERSSON — Nothing that would not be more general across any family with a family member who is in the prison system.

Mr CARBINES — Sure.

Mr PERSSON — It is a difficult situation for the community, it is a difficult situation for the family, and it is a difficult situation for the victim. If there is a victim involved, there are obviously a whole lot of different parts to the issue. I do not think there is anything specific to people with a disability. Generally speaking, I would say that people with an intellectual disability would not have their family involved at the same level. The number of people with an intellectual disability as compared to the non-disabled population means it is less likely that their family would be involved.

Mr CARBINES — Involved in — —

Mr PERSSON — Involved in their lives. They are more likely to rely on support mechanisms that are provided by government and other agencies.

Mr NORTHE — Just in terms of the assessment of a person who might have an intellectual disability or an ABI, I may be reading this wrong, but in terms of Corrections assessing one for those particular afflictions — —

Mr PERSSON — Yes.

Mr NORTHE — I would have thought it should be picked up far earlier when one comes before the police or the judicial system rather than relying upon Corrections maybe to pick up some of the impediments that people have. Are you able to talk a little bit more about what you see we could do to enhance that aspect of it, or what works well and what does not?

Mr PERSSON — Certainly, I think that in terms of intellectual disability, as I said, the system is pretty robust in identifying people at the front end. The issue of ABI is much more problematic. Potentially it reflects a larger population. There is a range of reasons. Historically, intellectual disability has had a higher profile, not just in Victoria but across Australia. We are talking about generic disability services. I do not know the reasons why ABI has not been on the radar to the same extent as intellectual disability.

Ms SHUARD — I think also, often many of the symptoms, if you like, or what people see in the community or when other parts of the justice system — perhaps the police — need to deal with people, is that it can be masked or misinterpreted — —

Mr PERSSON — That is right.

Ms SHUARD — Because people are under the influence of drugs or alcohol and the like whereas when they get into our system those things are not available and, again, it is a period of stability and therefore it can be

identified if there is something happening for this person that is not related to too much alcohol or too many drugs or too much partying or whatever. People can see that. The other thing is that people are observed an awful lot within the prison system — that is what we do — and so it will perhaps be picked up or noticed that people are not coping as well as somebody else or not understanding.

I think the training that Peter talked about with our staff is absolutely critical. Years ago it might perhaps have been interpreted as a person not listening when you speak to them whereas today it would be interpreted as there being something wrong because you have to tell them each day what they have to do — it is not about them being difficult — and they will bring it to the attention of a professional staff member to say, 'There is something different happening here'. In some ways that is probably why it is picked up in the corrections system for what it is because there are not the other things that are happening.

Mr PERSSON — I think Jan has hit the nail on the head, because ABI has been referred to as the hidden disability. Until you know a person it is very hard, particularly where it is very mild, to know they have some sort of ABI. It is tricky.

Mrs PETROVICH — I was really interested in this slide about acquired brain injury and CJS risk factors, which obviously have a lot of commonality. From the perspective of your dealing with the end result — and obviously there is a lot of masking going on until they perhaps have that opportunity — is there an opportunity from a community perspective for going right back to school circumstances to perhaps be prosecuting a case now around the number of standard drinks even more strongly? I think the cause-and-effect factor is important, particularly if people have social disadvantage and a whole range of other things. I do not think we are linking into those people. From your perspective, are there other agencies out there who work with you now that are perhaps further down the track in identifying some of these people at risk?

Mr PERSSON — I certainly think the alcohol and drug sector is a common population for us. In terms of child protection, childhood trauma and those sorts of things in terms of brain injury, that is certainly an issue, and also youth justice in terms of those sorts of habits, particularly drug and alcohol habits and traumatic brain injury as a result of fights and those sorts of things with young fellows. The earlier that the community can be involved with people and try to divert them away from the risk factors and support them through those issues, the better.

Mrs PETROVICH — Should we be talking to our schools?

Mr PERSSON — Absolutely.

Ms SHUARD — I think this ABI research probably would be quite staggering.

Mrs PETROVICH — I think that is right.

Ms SHUARD — For people in the community to then relate the representation of people with acquired brain injury in the corrections system and then go back and see that is how it can be caused, would be quite staggering — young people, if you like.

The CHAIR — Thank you very much for that. That was very helpful. It was good to get your perspective.

Committee adjourned.