**BRAIN INJURY AND THE CRIMINAL JUSTICE SYSTEM**

**RESPONSE FROM HOWARD LEAGUE SCOTLAND**

We are grateful to the Justice Committee for the opportunity to comment upon brain injury and the criminal justice system.

**Background**

Brain injury is not a single entity in terms of its causation, severity or impact. Causative factors include, amongst others: direct physical trauma; injury sustained from oxygen deprivation – for instance in the course of an overdose or epileptic seizure; and chemical trauma – for instance alcohol related brain injury. Several of these factors may be operative within one individual.

From a policy perspective, it would be artificial to attempt to develop responses to brain injury as caused by trauma and to ignore that caused by other mechanisms.

Severity varies from apparently trivial to obviously severe, and damage may be cumulative. The impact of any instance of brain injury may be exacerbated by the age of the person at the time of the injury (worse in children) and by the person's resilience/coping mechanisms.

The impact may be felt across a wide range of parameters including (re)offending, violence, impulsivity, vulnerability (e.g. vulnerable adult status), employability and may affect cognitive functioning, personality, memory and physical abilities e.g. balance, vision, hearing, smell, co-ordination.

Some existing policy is relevant to this area already, e.g. vulnerable adult legislation.

**Awareness and existing practice**

Awareness of brain injury and its potential relationship to offending and impact on rehabilitation is variable across both the criminal justice system and health services. Howard League Scotland, Scottish Drugs Forum and the British Psychological Society (Division of Neuropsychology) have all held events, in a variety of fora, to raise awareness. Publications such as *‘Repairing Shattered Lives’* by Professor Huw Williams of Exeter University have also contributed to awareness raising.

Experience working in the criminal justice system would suggest that more could be done to improve communication between agencies to share assessments, including that of brain injury. For instance, community based criminal justice disposals do not have access to prison based health assessments.

Assessment can be difficult for a variety of reasons, including: ongoing drug/alcohol use, psychiatric co-morbidity, poor physical health and the ability to assess level of functioning both in a prison environment and in the community.

Awareness amongst offenders themselves is variable. Many do not volunteer histories of even highly significant head injuries unless asked directly.

There is also relatively low level of awareness about the potential link between head injury and offending/rehabilitation issues.

Informal sampling of offenders on Drug Treatment and Testing Orders (DTTOs) suggests that they are not aware of being asked about head injury in custody. Whilst this may not mean that they were not asked, it does suggest that it did not feel like a significant issue for them whilst in custody. All can remember being asked about drugs, by contrast. Further, more formal, research would be useful in this regard.

The subject may be relatively taboo/stigmatising ("It's not something I talk about"). This differs from drug use, which often appears to be the subject of informal discussion between offenders.

Training for professionals is inadequate and should not be limited to prison staff only. This is an issue that affects everyone in the criminal justice system.

**The importance of prevention**

Howard League Scotland believes that more resources should be focused upon prevention. Traumatic brain injury forms part of a "web of causation" – its origins are woven into the fabric of deprivation, drug/alcohol misuse and trauma in general. It will not be possible to eliminate it and no single policy intervention would be sufficient in and of itself.

However, on the basis that clinical experience suggests that many people who have had significant head injuries either failed to seek appropriate help or failed to attend follow up, it is likely that awareness raising will be an important part of the response in places such as schools, youth clubs and primary care settings.

Underage drinking is a significant factor in exposure to the risk of traumatic brain injury because of the association with violence, particularly in boys. Policy initiatives aimed at restricting the availability of alcohol to underage people are likely to be important factors. Policy aimed at reducing levels of alcohol consumption generally and at improving access to treatment is likely to positively impact on the risk of brain injury not only through reduction in levels of violence; but also through reduction in alcohol related brain damage.

**Brain injury and links with abuse**

Some of the most tragic instances encountered in clinical practice involve people who were abused as children, sustaining severe head injuries at the hands of their parents who then concealed the problem thereby denying them access to treatment, affecting their education and contributing significantly to drug/alcohol use and offending.

Domestic violence is a risk factor for brain injury, particularly for women, and policy directed at this issue may also be expected to play a role in decreasing the likelihood of such injury.

**Consequences of brain injury for rehabilitation**

Clearly this depends on identification of the problem in the first place. This is best done early on so that awareness of issues likely to affect ability to engage with a service are identified before problems arise which may lead to unsuccessful completion/breach of a disposal.

Multi-disciplinary teamwork is key as the impact on an offender's life may be global. For instance, appointment scheduling, benefits applications, ability to hold down a tenancy, ability to comply with/regulate a supply of medication, impact on risk assessments as they relate to child protection/protection of other vulnerable people may all be impacted by a brain injury.

Access to specialist neuro-rehabilitation, neurology and neurosurgical services for assessment and rehabilitation for more severe cases needs to be improved. The capacity of such services to absorb an additional caseload is an issue requiring careful consideration. These services may not have experience working with an offending population, particularly with a history of violence. There may be risks in introducing such a population into services that manage a variety of often very vulnerable people.

The following points are worth bearing in mind:

* Facilitating attendance at an outpatient appointment in a clinical setting usually geographically entirely separate from the usual point of care can be challenging.
* Attempts to refer people often founder at this stage – after a long wait for an appointment, failure to attend may delay assessment for a lengthy period.
* Sustaining engagement past an initial assessment visit can also be difficult.
* An outreach model whereby neuro-rehabilitation specialist staff can carry out assessments and provide treatment not only in prisons; but also in other, community based, criminal justice disposals would almost certainly work better. For example, the success achieved with outreach Blood Borne Virus clinics suggests that such a model could be more effective.

**The need for further research**

Research will undoubtedly continue to be an important part of the response. It would be useful to:

* compare levels of incidence of brain injury in those on community based disposals with those in custody;
* clarify the rate of serious levels of brain injury in the criminal justice system to help to further target interventions aimed at helping those affected to move away from offending; and
* identify areas of existing good practice within the criminal justice system and to find examples of good practice outside of Scotland that may usefully inform our own response to the problem.

However, the absence of further research should not preclude addressing this issue in the interim.

**Mitigating factor in sentencing**

Brain injury may be taken into account as a mitigating factor in sentencing by Scottish courts. The structure of the Criminal Procedure (Scotland) Act provides formal treatment and sentencing options for those with mental health problems of different severities. Those sentencing options generally require medical evidence from a registered medical practitioner.

Since their introduction, Assessment Orders have been relatively rarely used. They also require evidence from a registered medical practitioner.

It seems likely that a court might attach lesser weight to acquired brain injury as a mitigating factor where the nature of the injury and its effect on the person convicted are not certified in a formal medical report. In a routine summary case, constraints on legal aid may make it more difficult for a person convicted to fund the preparation of such a report.

It is important to recognise that brain injury may well constitute a disability in terms of the Equality Act 2010 and that it may be necessary for the courts and criminal justice agencies to take positive steps to avoid discrimination in each of its forms. In order to avoid indirect discrimination or discrimination arising from disability, public authorities should have due regard to the need to assess potential discrimination and, in some instances, allocate additional resources to services or functions used by those disabled by head injury. This is a complex area of law and each case should be considered on its own facts and circumstances. In general however, public authorities should be proactive in considering the equality implications of their policies and practices on disabled persons.

For example, in an application for judicial review presently pending before the Court of Session, a prisoner is challenging the decisions of the Scottish Prison Service and two local authorities responsible for through care services in relation to a substantial delay in preparing for his release on life licence. He has been diagnosed as suffering from Alzheimer’s disease and alleges that the delay in dealing with his case is unlawful discrimination under the Equality Act 2010. The Equality and Human Rights Commission have intervened in the application.

We look forward to participating in the round table oral evidence session on 12 August and would be happy to provide any further information then.

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