



Life After Brain Injury

Manifesto for children, young people and offending behaviour

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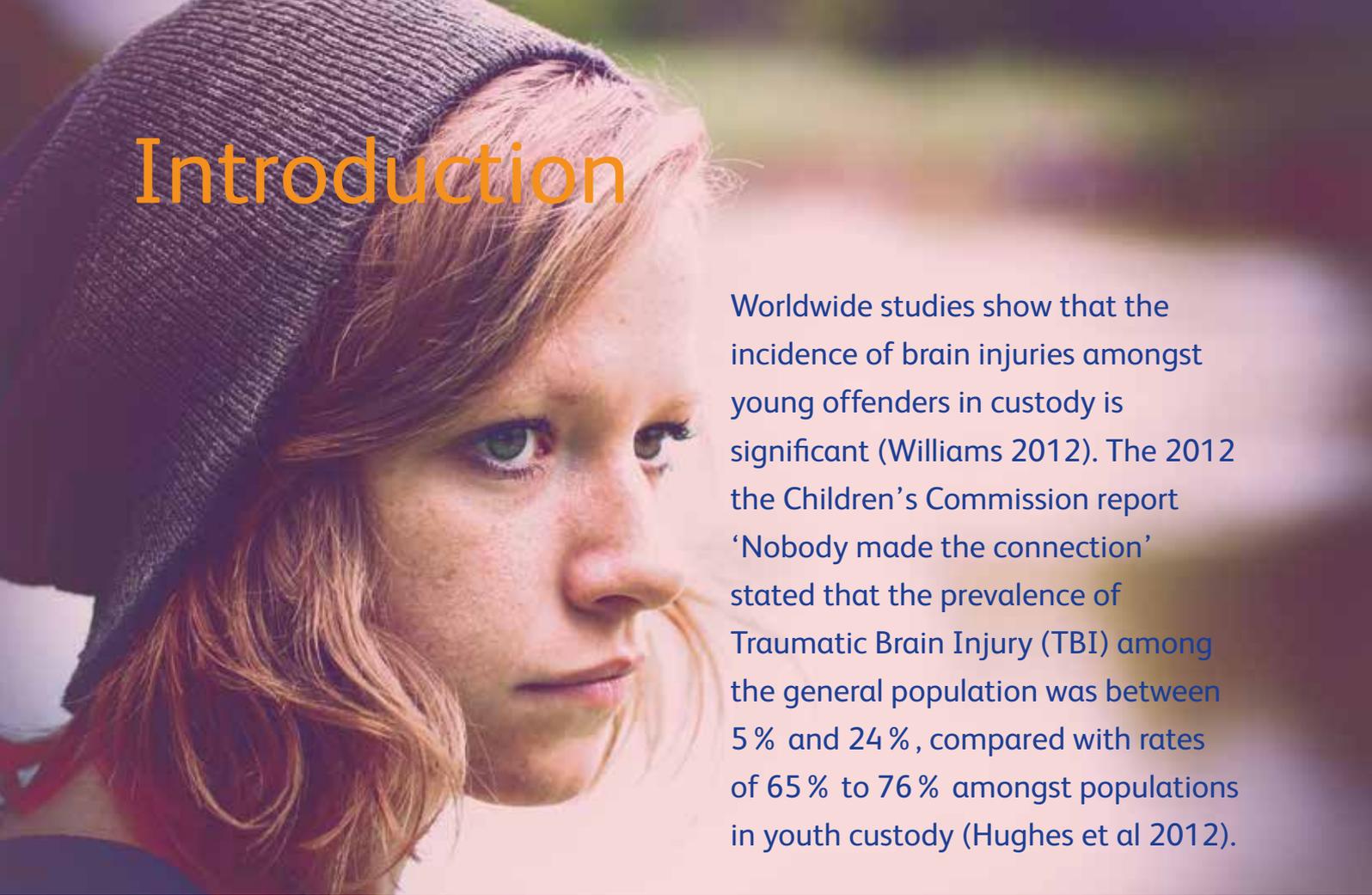
- The University of Exeter
- The Disabilities Trust
- The Child Brain Injury Trust
- The Ministry of Justice (NOMS)
- NHS England

Executive summary

- Brain injury is a significant variable in offending behaviour. Long-term brain injury in childhood and young adulthood is associated with an increased tendency of offending behaviour and, relative to the general population, there is a high prevalence of brain injury amongst young offenders in custody. Acquired Brain Injury is linked to earlier, repeated offences, a greater total time spent in custody and more violent offending
- Children and young people with Acquired Brain Injury are often failed by the health service, social care, education system and the youth and criminal justice system
- Acquired Brain Injury in children and young people should be considered a chronic health condition with associated ongoing, often life-long symptoms. It must be managed early to avoid long-term disability and to ensure rehabilitation is at its most effective. It must also be monitored long-term for problems arising post-injury
- Young people are not screened routinely for an Acquired Brain Injury until they enter a secure estate, by which time a cycle of re-offending may be triggered
- Children and young people in the Youth Justice System results in major personal, social and economic consequences

Recommendations

- Increased awareness and training is required about the prevalence of Acquired Brain Injury amongst children and young offenders throughout the youth and criminal justice system, together with an understanding and acceptance of the need for early assessment and management. Brain injury should be a key consideration when making decisions about children and young people on arrest
- Long-term, ongoing monitoring of children and young people with an Acquired Brain Injury is required. Early intervention is essential, by trained professionals within the school and healthcare environments, when problems arise that highlight individuals who may be 'at-risk' of offending behaviour
- An assessment tool should be used in schools to facilitate the identification of those children and young people with Acquired Brain Injury who are 'at-risk' of offending
- Practical guidelines are required for the management of children and young people with an Acquired Brain Injury who are 'at-risk' of offending for use across all sectors; health, education and social services



Introduction

Worldwide studies show that the incidence of brain injuries amongst young offenders in custody is significant (Williams 2012). The 2012 the Children's Commission report 'Nobody made the connection' stated that the prevalence of Traumatic Brain Injury (TBI) among the general population was between 5% and 24%, compared with rates of 65% to 76% amongst populations in youth custody (Hughes et al 2012).

Because of the hidden elements of Acquired Brain Injury (ABI), many young offenders enter the Youth Justice System (YJS) but receive little or no treatment, their differing needs and difficulties are not diagnosed or acknowledged, not understood or not taken into account when professionals are preparing cases and considering sentencing. Although the overall number of young people re-offending is decreasing annually, there is an increase in the re-offending rate in this cohort which results in a huge cost, personally, socially and financially, in the detention of young offenders. The evidence suggests that offending behaviour and re-offending can be prevented but is the system set up to facilitate this? The current answer is an emphatic 'no'.

There is beginning to be an appreciation of assessing children and young people when they first enter the YJS and this is to be commended. However, there is an urgent requirement to identify brain injury problems early, ideally before children and young people enter the YJS. If

children and young people can be identified as being 'at-risk' and are then supported, this may then prevent any offending behaviour occurring and/or reduce the likelihood of re-offending.

In 2013, The United Kingdom Acquired Brain Injury Forum (UKABIF) launched its campaign '**Life After Brain Injury? Improve Services Now**' with two Manifestos; one for adults with ABI and the second for children and young people with ABI. This Manifesto continues UKABIF's important campaign to raise awareness of the need for improved services and better care generally for all individuals with ABI.

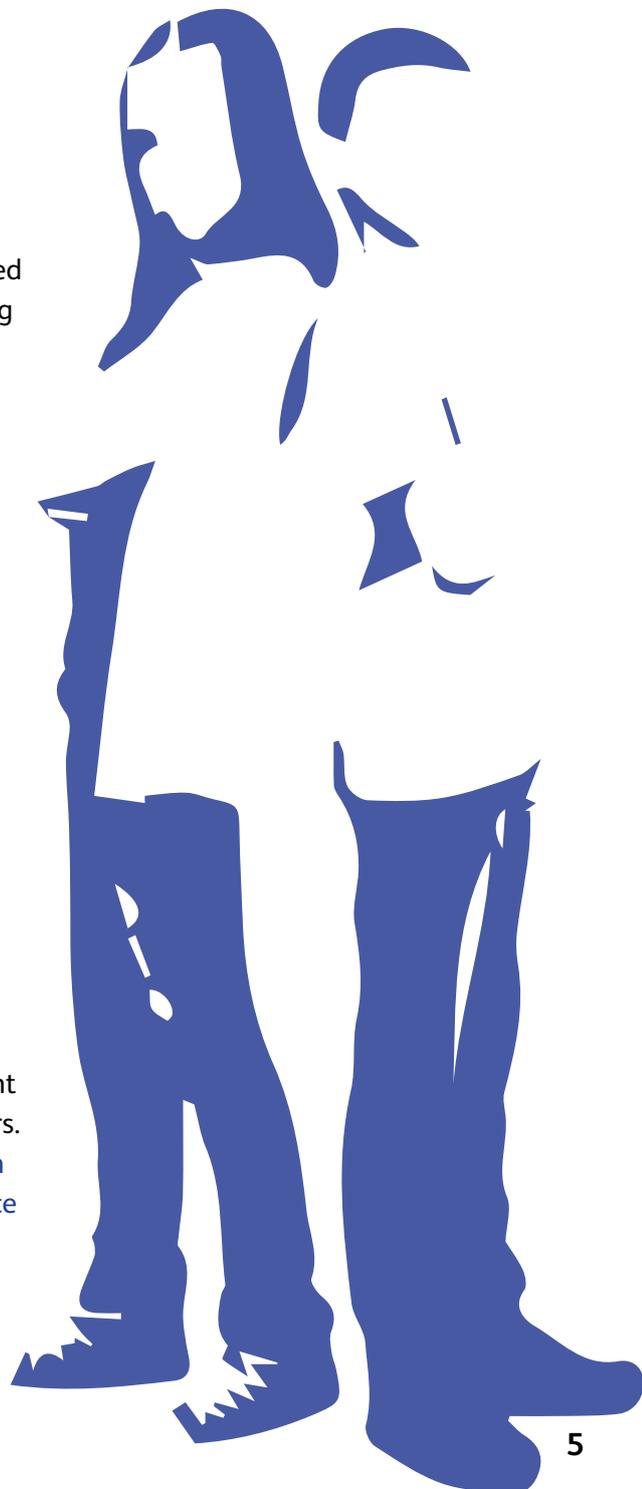
This document provides an overview of the evidence linking ABI and offending behaviour in children and young people and makes recommendations, in line with other organisations working to raise awareness in this area, with emphasis on taking advantage of the 'window' available to identify those 'at-risk' of offending and generally improve the outcomes for children and young people who have ABI.

The Youth Justice System

The YJS in England and Wales works to prevent offending and re-offending by young people under the age of 18 years. It ensures custody is safe and secure, addresses the causes of their offending behaviour and its priorities for 2014/2015 are to reduce re-offending.

In 2013/14, young people aged 10-17 years accounted for 126,809 arrests (11.8% of the total). Some of these do not enter the YJS because they are diverted through schemes such as Triage or restorative justice programmes. According to the Youth Justice Board (2014) there were 90,769 proven offences committed by young people that resulted in a caution or conviction in 2013/14, and although the overall number of young people in the YJS has continued to decrease, there were 22,393 first time entrants of which 30% were young people aged 10-14 years. In 2013/14 there was a reduction in those receiving sentences in and out of court, with 41,569 young people receiving a substantive outcome and 2,226 given custodial sentences averaging 14.5 months. The average length of time spent in custody was 90 days. Only a relatively small number of young offenders are persistent enough, or commit offences which are serious enough, to result in a custodial sentence, but this group of young offenders has a significant social and economic cost across England and Wales. Estimates from the National Audit Office (June 2011) suggest that just 5% of young offenders are responsible for nearly a third of all proven offences committed by under-18s. Yet when these offences result in a custodial sentence, 71% of young people released from detention go on to break the law again within 12 months (Ministry of Justice 2014). The re-offending rate has increased to 36.1% with an average of 1.08 re-offences per offender and 2.99 re-offences per re-offender (Youth Justice Statistics 2013/14). Four per cent of young people sentenced for an offence already had 15 or more previous offences.

In 2012/13 the Ministry of Justice and Youth Justice Board spent approximately £247 million on the detention of young offenders. The average annual cost of a youth custodial place ranges from £65,000 at a Young Offender Institution to £212,000 for a place at a Secure Children's Home; this represents a huge financial cost to society irrespective of the personal and social impact on the child or young person.



Acquired Brain Injury

Definition

Acquired Brain Injury is non-degenerative injury to the brain that has occurred after birth. It includes traumatic brain injuries (TBIs) such as those caused by road traffic accidents and non-TBIs, such as those caused by strokes and other vascular accidents, tumours and also infectious diseases. It is classified as mild, moderate and severe.

Effects

As a child recovers from the initial stages of ABI, and depending on which regions of the brain are injured, longer-term effects may become apparent e.g a loss of physical, emotional, or mental functioning, short-term memory or the ability to recognise faces (Anderson et al 2009, 2010). Often the cognitive, behavioural and personality deficits produce the greatest disruption to quality of life, rather than the physical deficits (Andrews 1998, Klonoff 1993). The extent of these impairments may only become apparent when the child or adolescent returns to education.

Consequences in children and young people

The consequences of brain injury in children and young people include loss of memory, loss of concentration, decreased awareness of one's own or others emotional state, poor impulse control and particularly poor social judgment. Brain injury is also associated with greater mental health problems, higher rates of depression or mood disorder and/or childhood developmental disorders including Attention Deficit Hyperactivity Disorder (ADHD) or disruptive behaviour difficulties. Behavioural problems such as conduct disorder, attention problems and increased aggression are prevalent.



Long-term effects of ABI

- Impaired memory
- Reduced concentration and attention capacity
- Disorders of the executive system e.g. poor initiation and planning, lack of self-monitoring, poor judgement and poor impulse control
- Decreased awareness of one's own or others emotional state
- Sleep disturbances
- Mental health problems
- Impaired social and communication skills
- Motor and sensory impairments
- Further medical conditions e.g. post-traumatic epilepsy, hormonal disturbances



Behavioural problems
Conduct disorder
Attention problems
Increased aggression
Impulse control problems
Cognitive problems and educational underachievement
Social/relationship difficulties

Figure 1: Effects of Acquired Brain Injury (Brower et al 2001, Grafman et al 1996, Joliffe et al 2004, Raine et al 2005, Timonen et al 2002, Tonks et al 2009)

Acquired Brain Injury and offending behaviour – the evidence

Brain injury is potentially more damaging in younger people because of the potential to disrupt cognitive development. The developing brain can show **remarkable resilience**, but in the cases of severe injury, it becomes more about ‘compensation’ rather than repair and brain development can be disrupted in the long term. It is now accepted that this disruption can lead to an **increased tendency** for offending behaviour.

Young people with brain injury, even if it is mild or moderate, are likely to grapple with the consequences of the condition throughout young adulthood and beyond (Tonks et al 2009). Disruptive or aggressive behaviour, poor memory and other cognitive problems that impact on learning will all require specialist management, particularly in the education system so that the young person does not feel alienated. This does not mean that all young people who suffer brain injury go on to become criminals, many do not. It is important to bear in mind that adolescents are more prone to risky behaviour and can find themselves in criminal situations where head injury occurs, meaning that for some the offending behaviour leads to the brain injury, not the other way round.

The evidence now emphatically links ABI to young people offending. Worldwide studies show that the level of brain injuries amongst offenders in custody is significant; a study in England found that 60 per cent of young people in custody reported experiencing a brain injury (Williams 2012). The Children’s Commission report ‘Nobody made the connection’ stated that the rates of TBI amongst the general

population were between 5 % and 24 % , with self-report measures of TBI often having higher prevalence rates; this compares with rates of 65 % to 76 % amongst populations in youth custody (Hughes et al 2012). A systematic review identified a significant prevalence of TBI among young people in custody with between 49.7 % and 71.2 % of incarcerated young people reported to have experienced some kind of head injury (Hughes et al 2015). Many young offenders also have neuro-development problems, ADHD or Asperger’s syndrome (Blake et al 1995).

Williams et al (2010) asked young male offenders aged 11 to 19 years to complete self-reports on head injury, crime history, mental health and drug use. Of those asked, 197 participants (94 %) took part. Traumatic Brain Injury, with a loss of consciousness, was reported by 46 % . This is higher than the estimates of between 5 per cent and 30 per cent in society as a whole, dependent on age group. The main cause of injury in the young offenders was violence. The frequency of self-reported Traumatic Brain Injury was associated with more convictions, and three or more self-reported Traumatic Brain Injuries were associated with greater violence in offences.



Those with self-reported Traumatic Brain Injury were also at risk of greater mental health problems and of cannabis misuse.

There is also evidence linking subsequent offending with brain injury (Williams et al 2010). A report published in 2012 by the Transition to Adulthood Alliance entitled 'Repairing Shattered Lives: Brain Injury and its Implications for Criminal Justice' looked at the worldwide research and showed that [people with brain injury are over-represented in prison and that brain injury is associated with earlier, repeated and greater total time spent in custody](#). Several studies have also demonstrated an association between brain injury and antisocial behaviour including earlier onset of offending, a greater number of convictions and more violent offending.

Research in Finland showed that a brain injury acquired during childhood or adolescence was associated with a four-fold increased risk of developing mental health problems in adult male offenders with co-existing offending. Those who had a Traumatic Brain Injury earlier than age 12 years were found to have committed crimes significantly earlier than those who had a head injury later.

Traumatic Brain Injury has been shown to play a significant role in increasing the risk of offending in women. A USA study of 113 female prisoners (Brewer-Smyth et al 2004) found that 42% had a history of TBI, and those who had committed violent offences had suffered an average of two TBIs. Further analysis revealed that the number of years since their last episode of domestic abuse, the number of prior suicide attempts, and TBIs with loss of consciousness, were significantly associated with current violent convictions.

Identifying and managing young offenders with Acquired Brain Injury

Early identification, intervention and management of brain injury is key to reducing offending behaviour and re-offending; it is also important for improving health outcomes. Education can play a major role to play in reducing the incidence of offending. If education professionals understand, recognise and can support young people with an ABI, the less likely the young person is to enter into the youth and criminal justice system in the first place. The educational difficulties that result from this lack of awareness are the biggest risk factor in the crime/ABI equation.

Early identification of neurodisability in young people with behavioural difficulties is important to ensure that secondary impairment due to school failure and social exclusion do not contribute to increased risk of offending through detachment from education and the influence of other antisocial peers. However, for some young people with unidentified needs, contact with the YJS, as long as the professionals are aware of the symptoms of brain injury, can provide an opportunity for screening and referral for specialist assessment and support.

Taking account of a young person's brain injury could help reduce repeat offending in those affected and/or manage the factors that contribute to the criminal behaviour.

For example, adolescence is a developmental period that provides a critical 'window' of opportunity and could help divert young offenders who are 'at risk' of injury and of further offending, into non-offending lifestyles.

What happens now?

Despite the prevalence of ABI in children and young people, it is rare for youth justice professionals to consider whether an offender may have a brain injury. Currently children and young people are not generally screened for brain injury and not referred for the necessary neurorehabilitation. The primary contact that many young people with brain injury have with service providers is via the YJS, which is not adequately trained, or equipped, to manage brain injury. In addition restorative justice will be ineffective if the young person has an ABI because they often lack the empathetic ability and consequential thinking required to empathise with the victim, and/or with the situation caused by the offender's actions.

The NHS England Liaison and Diversion services have been around in a variety of different forms for many years. The service refers offenders who are identified with having mental health, learning disabilities, substance misuse or other vulnerabilities to an appropriate treatment or support service.



A standard service specification has now been developed to reflect the need for services to be available at all relevant points of the youth and adult justice systems and is currently being piloted. Acquired Brain Injury is included in the new service specification which is currently being piloted at 10 locations.

Comprehensive Health Assessment Tool (CHAT)

The Offender Health Research Network developed the Comprehensive Health Assessment Tool (CHAT) for children and young people. There is a version for the Children's and Young People's Secure estate and a community version, both with sections addressing neurodisability e.g. ADHD and brain injury.

The tool facilitates standardised holistic screening and assessment, early identification of needs, improved continuity of care and reduced duplication during transition periods within the YJS. The assessment can be used for probation pre-sentence reports, court process and sentencing, custody and probation settings and forensic services.

Brain Injury Screening Index (BISI®)

The Disabilities Trust, a leading national charity providing innovative services, rehabilitation and support solutions for people with ABI, complex physical impairments and autism has developed a Brain Injury Screening Index (BISI®). The tool was piloted at HMP Leeds to identify adult offenders who had a TBI. The research showed that of the 613 offenders screened, 47% were found to have had a history of TBI; of a sample of 139 prisoners who reported a TBI, 70% had experienced their TBI before

their first offence (Pitman et al 2015). As a result of the pilot, a specialist brain injury Linkworker Service has been established for prisoners in HMP Leeds and young offenders in Wetherby and Hindley to work with those individuals identified as having a brain injury, to address their problems, assist in their engagement with rehabilitation programmes and generally improve re-offending outcomes. Training has also been delivered to frontline staff and the BISI used at all locations.

What should happen in the future

The recent position paper from the British Psychological Society (2015) proposes six 'Calls to Action' including early intervention, screening and rehabilitation, training and guidance, commissioning, data sharing and further research. UKABIF would like to see increased awareness and training about the prevalence of ABI amongst children and young offenders throughout the youth and criminal justice system, and an acceptance and understanding of the need for assessment and management in community e.g. Youth Offending and Probation Teams and custodial settings. The children and young people with an ABI should be monitored long-term by trained professionals using appropriate methods, with early intervention in the school environment when problems occur.

An easy-to-use assessment tool e.g. BISI should be used to facilitate the identification of those children and young people with ABI who are 'at-risk' of offending. Having identified the relevant individuals, guidelines for the management of children and young people with an ABI who are 'at-risk' of offending should be developed for use in the health and education system and social services.

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