Acquired Brain Injury and Family Violence: Research Snapshot

Acquired Brain Injury (ABI) is an impairment arising from damage to the brain acquired after birth. It includes Traumatic Brain Injury (TBI) from an external blow to the head and non-TBI from lack of oxygen, for example from strangulation. Symptoms vary depending on the area of the brain implicated, but there may be deterioration in cognitive, emotional, physical or executive functioning (Gabbe, et al., 2018).

Prevalence of family violence related brain injury

40% of victims of family violence attending Victorian hospitals over a ten year period sustained ABI.

57% of family violence related major trauma cases over the same period involved ABI.

82% of family violence related deaths of a ten year period were due to ABI (Gabbe, et al., 2018).

Who is at the highest risk of sustaining a brain injury?

60% attending hospital for family violence were female and 31% were children under 15.

When the perpetrator of family violence is an intimate partner, the percentage of females attending hospital for family violence increases to 84% .

42% of people identifying as Aboriginal or Torres Strait Islander who attended Emergency for family violence, sustained an ABI (Gabbe, et al., 2018).

Perpetrators of family violence

Perpetrators of family violence are twice as likely to have an ABI as the rest of the community.

60% of male perpetrators of family violence have an ABI.

Having an ABI can increase the likelihood of perpetrating family violence, if the injury is to those parts of the brain that control emotions and regulate behaviour. However, it is not inevitable that a person with an ABI becomes a perpetrator of family violence, and they may also be more likely to be victimised (Rushworth, 2021).

Is brain injury being missed in family violence presentations?

80% of females attending hospital for intimate partner violence have facial injuries but mild brain injury is often missed.

It is likely the incidence and prevalence of family violence ABI is underestimated due to under-identification. Most pathways to diagnosis currently depend on victims self-identifying, and may require significant advocacy with health professionals (Gabbe, et al., 2018).

Why is brain injury an issue for family violence practitioners?

The family violence system plays a vital role in the detection and diagnosis of ABI. Repeated mild brain injuries can accumulate into significant impairment. Early intervention is vital.

References:

Gabbe, B., Ayton, D., Pritchard, E. K., Tsindos, T., O'Brien, P., King, M., Braaf, S., Berecki-Gisolf, J., & Hayman, J. (2018). The Prevalence of Acquired Brain Injury Among Victims and Perpetrators of Family Violence. Brain Injury Australia.

Rushworth, N. (201) Out of sight, out of mind: People with an acquired brain injury and the criminal justice system. Australian Institute of Judicial Administration. Sydney: Brain Injury Australia

Acquired Brain Injury and Family Violence: Practice support

1) **Screen for potential brain injury as a part of family violence risk assessment**
Physical abuse, such as striking, shaking and strangulation, can result in ABI, including where victims sustain repeated mild injury or facial injuries. The MARAM Practice Guides contain details to support identification and response to ABI [Comprehensive guide, Section 7.10].

- Ask the screening questions listed in the **modified MARAM Risk Assessment (available via CHIFVC)** and/or **CHIFVC General ABI/TBI Screening Questionnaire**
- Use the **Disability-Responsive Intake Process.** Questions with * relate to memory, judgement or problem solving, and may indicate executive function is impaired (a symptom of ABI).
- Additional symptoms of ABI which may be spontaneously disclosed include: vomiting; persistent severe headaches; memory loss; affected vision or dizziness; seizure; signs of cognitive or behavioural deterioration over time.

2) **What to do if you find indicators of ABI through screening and risk assessment**
Through screening, you may find indicators of ABI. There may be other causes of the same or similar symptoms, including trauma. Your role is not to diagnose ABI, but consider the impact of symptoms as part of risk assessment. The indicators of ABI and associated symptoms should be noted and included in referral to a service that has capacity to further explore the symptoms over time.

3) **Make appropriate referrals for exploration of ABI symptoms and formal diagnosis**
Refer to GP or ABI clinic for further exploration of ABI symptoms, comprehensive brain injury diagnosis and specialist supports for recovery. With appropriate supports and early diagnosis, symptoms can be decreased, emotional impact reduced and positive outcomes increased in all facets of life.

4) **Adapt family violence services and supports to suit the client's brain injury symptoms**
A person with an ABI may need adjustments made to service delivery. We recommend using the **CHIFVC Disability-Responsive Intake Process** to support this. Otherwise, adjustment options may include assistance with remembering appointments, focusing on one task at a time, support with working out how to travel to a new place, financial costs, information around risk of repeat ABI and/or easy read documents to assist with information comprehension.

5) **Consider increased risk posed by perpetrators with ABI during risk assessment**
ABI can manifest with reduced emotional regulation and/or impulse control. This must be factored into risk assessment. It is vital that people who use violence who have indicators of ABI are rapidly referred for diagnosis. Early intervention and rehabilitation for ABI can reduce offending behaviours.

General A/TBI Screening Questionnaire

Person using violence/victim survivor (incl. children)

Acquired or Traumatic Brain Injury is overrepresented amongst victim-survivors and perpetrators of family violence, but identification can take a long time or may never occur.

This questionnaire identifies key indicators that *may* be connected with Acquired or Traumatic Brain Injury, and can inform your referral to other services for further exploration. It should not be taken to definitively diagnose Acquired or Traumatic Brain Injury.

This questionnaire should be used in conjunction with **CHIFVC's Acquired Brain Injury Practice Support** and **Research Snapshot**.

Have you ever had any injuries from:

- ☐ car or bicycle accidents?
- ☐ being hit by something or someone?
- ☐ falling down?
- ☐ playing sport?
- ☐ military service or work?

☐ Have you ever had an injury to your head or neck, including strangulation?

☐ Have you ever gone to the hospital or emergency room?

If not disclosed, **stop** ABI screening questions here. Otherwise continue:

Were you ever knocked out or did you lose consciousness?

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_____

If so, what was the longest time you were knocked out or unconscious?

_____

_____

How old were you the first time you were knocked out or lost consciousness?

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Based on MARAM Practice Guidance, and Brain Injury Australia (2018) The Prevalence of Acquired Brain Injury among Victims and Perpetrators of Family Violence, page 2.