Project Report: DFV/ABI Intersection

Improving awareness of and responses to the intersection of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI).

July 2018

If you, a child, or another person is in immediate danger, call 000.
For sexual assault, Domestic and Family Violence counselling service call 1800 RESPECT 1800 737 732.
24/7 phone and online services.

CONTENTS

This project and project report has been designed and documented by Domestic Violence Service Management (DVSM) a registered charity which aims to prevent and to provide support for people escaping/experiencing Domestic and Family Violence and homelessness.

DVSM provides client services in an urban context (Inner Sydney), in a suburban context (Western Sydney) and in remote rural NSW (Wilcannia). DVSM also provides professional services (**Sightlines**) to build capacity and share learning about Domestic and Family Violence within the Community Services sector and more broadly with the wider ecosystem of corporations, organisations, institutions, online and local communities.
www.dvnswsm.org.au

EXECUTIVE SUMMARY

In early 2018, an Australian play named 'Lethal Indifference', by playwright Anna Barnes, presented a valuable reflection about two contrasting beliefs that influence our responses to violence. Namely, that there are people who believe Domestic and Family Violence happens to 'others', and there are people who know Domestic and Family Violence can happen to 'anyone'.

Domestic and Family Violence (DFV) is in every postcode and every community and is one of the most urgent social issues of our time. For people who experience violence, being safe is no simple task, or single decision. Domestic and Family Violence is not defined by or limited to physical assault, and can take many and multiple forms of behaviour used to exercise coercive control. This control is applied directly and/or through networks and systems, deliberately limiting a person's rights, choice and agency, undermining their safety and wellbeing.

The issue of Acquired Brain Injuries occurring as a result of physical violence is easily overlooked, misunderstood, and thought to be experienced by but a few 'others'. It's perhaps easier for our attention to be drawn to those extreme acts of violence that lead to death, or severe physical impairment. But what about the adult, child or young person who experiences regular assaults that cause concussions or minor head injuries? What about the woman who has been strangled to the point of passing out but then woke, and continued living, unaware of the long-term health risks associated with that assault? Does the difficulty in identifying mild and moderate Acquired Brain Injury mean that we overlook this health risk when supporting these people in practice?

Physical assault can result in lasting harm to a person's health, including: physical injury, disability and death. Any assault to the head, neck or airways can be a cause of Acquired Brain Injury. The probability of a person sustaining an acquired brain injury increases where these assaults are frequent and repeated.

Why did Domestic Violence Service Management start this project?

Domestic and Family Violence is recognised internationally as a human rights abuse and in Australia contributes to more burden of disease (the impact of illness, disability and premature death) than any other risk factor for women aged 25–44 (AIHW 2018). The right to health includes the right to highest attainable quality of health care as well as the right to health related education and information.

Whilst Australia has made great strides nationally in the public conversation about the prevalence of Domestic and Family Violence, there are still significant and costly 'awareness' and 'response' gaps.

We all have a responsibility to respond to people in an informed manner that increases a person's safety and wellbeing. Living with violence, leaving violence and living after violence is fraught with complex decision making. The intersection of Domestic and Family Violence and Acquired Brain Injury may add another level of complexity in all stages of a person's experiences of and responses to violence.

In order to identify ways that we, DVSM, and the broader response system can be more prepared to support people experiencing this intersection the project has sought answers to two key questions:

1. **What are the barriers to responding to the intersection of DFV and ABI?**
2. **What needs to change to make it easier to respond to this issue?**

How do we keep Domestic and Family Violence central to the picture?

When talking about Acquired Brain Injury we must hold central that people experiencing this intersection face a range of risks to their safety and wellbeing caused by Domestic and Family Violence.
Domestic and Family Violence informed responses are based on an understanding of violence being a social issue, that (i) people resist violence to uphold their dignity and to manage risk and safety (ii) are already navigating their safety before they ever reach out for support. They are self-assessing the risks they face and use strategies to mitigate the risk of harm (iii) that any advice given or action taken by a practitioner may unintentionally or unknowingly increase the harm and threat that a person may face as a result of not fully understanding a person's situation and context.

What does the project reveal?
The purpose of this project report is not to argue that there is a link between Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI). That issue has been the subject of numerous international research studies and has previously been outlined by DVSM in Reflections Paper (2.1) *An exploration of the intersections between Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI).* The aim here is to summarise the issues, priorities and opportunities that have emerged as part of DVSM's project on exploring the intersection of Domestic and Family Violence and Acquired Brain Injury through a 'practice up' project in Western Sydney. This approach has been outlined in Section 1: 'Project Framework and Methodology'.

Contributing practitioners told us that brain injury, in its many forms, is a potential health impact for people who experience Domestic and Family Violence. We also heard that Domestic and Family Violence related Acquired Brain Injury is difficult to recognise and difficult to respond to. These and other reflections from frontline responders have been captured in Section 1: 'Issues and Barriers'.

The 'DFV/ABI Awareness and Response Table' in Section 2 within 'Mapping Pathways for Progress' is the centrepiece of this project report, providing a picture of the 'awareness needs', 'available resources' and 'untapped opportunities' that relate to key practitioners that respond to the intersection of Domestic and Family Violence and Acquired Brain Injury.

In addition, a number of information resources and maps have been included in the 'Project Related Resources' in Section 2. These aim to support practitioners working both in the DFV and health sectors to understand and navigate support pathways for people facing the intersection of Domestic and Family Violence and Acquired Brain Injury. These resources are not exclusive to these responder services and may have direct (or adapted) benefits for other responders.

Key Insights
Project insights indicate that meaningful work relating to the intersection of DFV/ABI will require:

1. *Improving awareness* about safety and the wellbeing needs of people with lived experience of DFV; the potential health risks from types of violence and injury; and the significance of 'awareness' about both DFV and ABI in order to have informed responses.

2. *Improving understanding* of how to identify and respond to DFV-related ABI both at the acute stage, and as a long-term health impact of DFV.

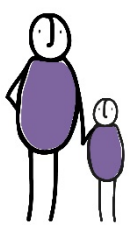
Although this project has focused on the Western Sydney context, conversations with practitioners in other parts of NSW suggest that the issues and ideas raised here are relevant to other contexts as well. We encourage readers to reflect on how the opportunities and issues presented relate to their own region. [*See: Getting Started | Getting Involved in Section 2*]

Note: This project report does not address how responses and opportunities might differ across diverse communities. DVSM recognises that all responses and opportunities that are developed around the intersection of DFV and ABI should be culturally safe, accessible and non-discriminatory for people who are more likely to experience discrimination and inequality in Australia. This includes: Aboriginal and Torres Strait Islander people, people who identify as lesbian; gay; bisexual; transgender; intersex and queer; older people; people from culturally and linguistically diverse communities; people with disabilities; and children and young people.

DVSM would like to acknowledge and thank the individuals and organisations that contributed to this project and project report. The combined insights and practice experience of contributors has enriched the work and has revealed significant interest, enthusiasm and commitment to strengthening awareness and responses to people experiencing Domestic and Family Violence who may experience a possible or resulting Acquired Brain Injury.

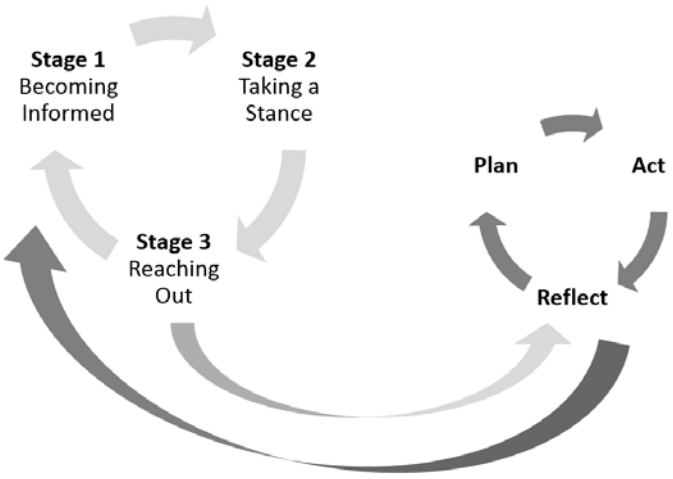
SECTION 1

PROJECT FRAMEWORK & METHODOLOGY



PROJECT FRAMEWORK – A STAGED APPROACH

The framework used to inform the methodology of this project draws from the work of Margot Rawsthorne (2014). It includes a staged approach, which is cyclical in order to continuously improve, and can be applied broadly to guide the development of other services who are engaging with this intersection or are seeking to undertake change within what they do.



The framework stages are:

Stage 1: 'Becoming Informed'
– undertaking a self-assessment about where we are at and what is needed.

Stage 2: 'Taking a Stance'
– determining an organisational position and commitment to change.

Stage 3: 'Reaching Out'
– proactively working with others to achieve and share in the change process, which includes 'giving before receiving', taking a community development and action learning approach.

The stages work at several levels - individual, practice and organisational - with each level influencing and being influenced by the other levels.

The purpose of this project report is to present the themes, issues, and opportunities that have emerged as we have explored current responses and practitioner perspectives around the intersection of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI).

This report also includes information and resources that aim to strengthen our collaborative responses for people who experience this intersection.

Two key questions shaping the project have been;

- What are the barriers to responding to the intersection of DFV and ABI?
- What needs to change to make it easier to respond to this issue?

It is our hope that the information and resources shared here may lead to improved responses and increased wellbeing for people experiencing DFV who have sustained an ABI, or are at risk of sustaining an ABI.

Rawsthorne, M. (2014), "Helping Ourselves, Helping Each Other": Lessons from the Aboriginal Women against Violence Project Advances in Social Work & Welfare Education, Volume 16, No.1, 2014, 7-21

In order to answer these questions DVSM undertook formal and informal interviews with over 35 stakeholders working across various services that respond to DFV or respond to ABI. This included:

- Forensic Medical Examiners
- Hospital Social Workers
- Emergency Department Specialists
- Brain Injury Specialists
- Strangulation Prevention Advocates
- Brain Injury Awareness Advocates
- DFV Case-workers
- Neuropsychologists
- Psychologists
- Trauma Counsellors
- After Hours DFV Responders
- Legal Practitioners
- Child and Youth Counsellors
- DFV Service Managers/Coordinators
- General Practitioners.

STAGE 1: BECOMING INFORMED

- **Analysis and Development** of Reflections Paper 2.0: An Exploration of the Intersection of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI).
- **Stakeholder Interviews:** more than 35 stakeholders were engaged from the DFV and Health sectors in Western Sydney and beyond (through one to one meetings, phone calls, and small group meetings).
- **Mapping** of the different aspects of the system currently responding to the intersection of DFV and ABI in Western Sydney (assisted by practitioners from across the DFV and Health sectors).
- **Interviews** with 10 frontline DVSM staff for one to one interviews to understand their experiences of the intersection of DFV and ABI.
- **Scoping** of existing resources and opportunities that build awareness for practitioners in the health and DFV sectors who may be working with people experiencing the intersection of DFV & ABI.

STAGE 2: TAKING A STANCE

- **Directions Workshop** held with DVSM Refuge Outreach Action Response (ROAR) team leaders and organisational management to discuss opportunities, barriers, and organisational positioning about this issue. A directions report was developed to summarise decisions made in this meeting.
- **Tools and Resources** are identified for development to support improved responses. An iterative resource development process begins.
- **Identification of Barriers and Opportunities** for responding to the DFV/ABI intersection, based on reflective analysis of interviews and maps.
- **Continued Championing** of the issue with stakeholders across and beyond Western Sydney.

STAGE 3: REACHING OUT

- **Externally share** project learnings (via the project report with accompanying responses) with contributing stakeholders and other services/sectors seeking to engage in this intersection.
- **Continue to host/share improvements** learned through implementation and review for the benefit of all services/stakeholders engaged over time.
- **Further Development** of practice based tools and resources drafted in stage 2.

Who has been part of the conversation about Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI) during this project?

Practitioners from Services within NSW Health (Western Sydney Local Health District)

- Blacktown Hospital Emergency Department
- Forensic Medical Unit, Western Sydney & Nepean Blue Mountains
- Westmead Hospital, Brain Injury Outreach
- Liverpool Hospital, Brain Injury Rehabilitation Unit
- Westmead Children's Hospital Institute of Sports Medicine
- Western Sydney Integrated Violence Prevention Response Service
- Westmead, Auburn Hospitals Department of Social Work
- Blacktown, Mt Druitt Hospitals Department of Social Work
- Safer Pathway Senior Clinician, Western Sydney LHD

Western Sydney NGOs & services responding to DFV

- Mt Druitt Family Violence Service (FACS)
- West Connect Domestic Violence Services Inc.
- Blacktown Women's & Girl's Health Centre
- Bonnie Support Service (South West Sydney)
- Rosie's Place Inc.
- The Outer Western Sydney Domestic Violence Network
- Victims Services, Specialist Trauma Counsellor, Western Sydney
- Frontline workers and managers from DVSM's Western Sydney services

Private Practice Practitioners

- Two Neuropsychologists at Dr Susan Pullman & Associates
- Medical Educator, working with the Royal Australian College of General Practitioners (RACGP)
- Five General Practitioners (RACGP)
- Rehabilitation Specialist, Brain Injury Specialists PTY LTD
- Clinical Psychologist, Gertler Psychological Services PTY LTD

Other NSW Health and NSW Government services/practitioners

- Sydney LHD – Concussion/m-TBI Clinic, Royal Prince
  Alfred Hospital (RPA)
- Sydney LHD – Manager, Domestic Violence and Women's Health, Community Health
- Sydney LHD – Medical Director, Sexual Assault
- Manager, Domestic Violence Death Review Team, NSW Department of Justice
- NSW Police Force - Domestic and Family Violence Team, Performance & Program Support Command
- Network Manager, Brain Injury Rehabilitation Directorate, Agency for Clinical Innovation
- Hunter/New England LHD – Social Worker, Hunter Brain Injury Service
- Senior Clinical Neuropsychologist, Brain Injury Unit, Royal Rehab NSW

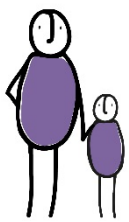
Organisations and Practitioners from other areas

- People with Disability Australia
- Clinical Neuropsychology Supervisor and Placement Coordinator, Macquarie University Psychology Clinic
- Health Education Specialist, Pennsylvania Coalition Against Domestic Violence
- Women's Domestic Violence Court Advocacy Program - Legal Aid NSW
- Clinical Associate, University of Sydney
  (also: Medical Director, Ambulatory & Primary Health Care - Illawarra Sexual Health)

Project Consortium Members

- Brain Injury Australia
- Education Centre Against Violence, NSW Department of Health
- No To Violence NSW
- Domestic Violence NSW
- Women's Health NSW
- Women's Domestic Violence Court Advocacy Services NSW Inc.

FOUNDATIONS
WHOLE OF PERSON & PERSON CENTRED



Domestic and Family Violence (DFV)
DFV includes any behaviour, in an intimate or family relationship, which is violent, threatening, coercive or controlling, causing a person to live in fear and to be made to do things against their will. DFV can happen to anyone and can take many forms. It is often part of a pattern of controlling or coercive behaviour.

An intimate relationship refers to people who are (or have been) in an intimate partnership whether or not the relationship involves or has involved a sexual relationship, i.e. married or engaged to be married, separated, divorced, de facto partners (whether of the same or different sex), couples promised to each other under cultural or religious tradition, or who are dating.

A family relationship has a broader definition and includes people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, sibling and extended family relationships. It includes the full range of kinship ties in Aboriginal and Torres Strait Islander communities (see below – Family Violence), extended family relationships, and family of choice within lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ) communities.

People living in the same house, people living in the same residential care facility and people reliant on care may also be considered to be in a domestic relationship when one or both people in the relationship try to create an imbalance of power to establish coercive control and commit violence.

The behaviours that may represent DFV include:
- Physical violence including physical assault or abuse
- Reproductive coercion
- Sexualised assault and other abusive or coercive behaviour of a sexualised nature
- Emotional or psychological abuse including verbal abuse, threats of violence, threats of self harm or suicide, blackmail and bribery
- Economic abuse; for example denying a person reasonable financial autonomy or financial support
- Stalking; for example harassment, intimidation or coercion of the other person's family in order to cause fear or ongoing harassment, including through the use of electronic communication or social media (NSW Government, 2014).

Women and children are overwhelmingly the victims of DFV and those who use violence are overwhelmingly male. DFV can be perpetrated by a partner, family member, carer, house mate, boyfriend or girlfriend. Women also commit DFV against men, as do same-sex partners. DFV is also committed by and committed against people who identify in non-gender binary terms. (Domestic Violence NSW, 2018)

What is Family Violence?
The term 'Family Violence' is preferred in an Indigenous context. It is used to describe the range of violence that takes place in Aboriginal and Torres Strait Islander communities including the physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that may be perpetrated within a family. The term also recognises the broader impacts of violence; on extended families, kinship networks and community relationships. It has also been used in the past decade to include acts of self-harm and suicide, and has become widely adopted as part of the shift towards addressing intra-familial violence in all its forms.[1]

1. Gordon, S Hallahan, K, Henry, D (2002) Putting the picture together, Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities, Department of Premier and Cabinet, Western Australia.

Acquired Brain Injury (ABI)
'Acquired Brain Injury' is the term used to describe multiple disabilities arising from damage to the brain acquired after birth. It results in the deterioration of cognitive, physical, emotional or independent functioning. ABI can occur as a result of accident, assault, stroke, brain tumour, infection, poisoning, lack of oxygen, and degenerative neurological disease. An ABI can be caused by physical violence that involves one or more of the following events: *assault to the head (involving a weapon or bodily force), shaking a person vigorously, hitting someone with a vehicle, causing someone to fall, drowning a person, poisoning a person, strangulation or suffocation.*

ABIs can occur acutely at the time of a physical assault, or can develop later as a person's violence-related injuries lead to health problems such as stroke or chronic traumatic encephalopathy (CTE). For example, a person who is shaken repeatedly as a child may have injuries to their vertebral artery that causes early stroke as a young adult. The stroke causes them to have a brain injury that was preventable.

The term ABI includes a range of ways that a person's brain can become injured by violence, including, but not limited to:

Traumatic Brain Injury (TBI)
A common cause of ABI is Traumatic Brain Injury (TBI) – which means an injury that is caused by a physical trauma to the head such as an accident or an assault. A TBI can be mild, moderate, or severe, reflecting different levels of functional impairment. The majority of TBIs that occur are concussions or mild-TBIs.

Concussion/ m-TBI
Concussion is a form of mild-Traumatic Brain Injury (m-TBI) caused by a blow or jolt to the head. The term 'concussion' is used interchangeably with m-TBI and may be preferred by some people who believe it is less stigmatising. The use of the term concussion may also cause people to not fully recognise the fact that they have a permanent brain injury. People who have experienced multiple concussions are at higher risk of a negative cumulative impact on their brain.

Anoxic & Hypoxic Brain Injury
Our brains need a continuous flow of oxygen to function and periods of reduced oxygen can lead to a range of injuries ranging from long-term mild brain injury to acute fatal brain injury. *Anoxia* occurs in circumstances in which all oxygen to the brain is cut off completely. *Hypoxia* occurs when there is a partial supply of oxygen to the brain, but not enough to support regular brain function (From: Headway UK).

Symptoms of anoxic/hypoxic brain injuries include: problems with concentration, attention, coordination and memory; visual problems, hormonal changes, speech difficulties, headaches, personality changes, muscle weakness and tiredness amongst other changes. How could Domestic and Family Violence cause an anoxic or hypoxic brain injury? The primary mechanisms are:

- **Strangulation**
  Strangulation involves applying pressure to someone's neck using one hand, two hands, ligature (i.e. a rope or belt), or it can occur through the placement of body weight or pressure on a person's neck by other means. Strangulation cuts off the oxygen in a person's airways and blood vessels causing asphyxia and leading to anoxic/hypoxic brain injury, stroke, and other problems.

- **Suffocation**
  Suffocation can involve the use of bodyweight, hands, or objects (i.e. plastic bag, pillow) to block someone's airways, limiting their breathing. It usually involves covering a person's mouth and nose, but can include sitting on a person's chest, or restraining a person by holding them around the chest, or being on top of a person who is lying on their stomach. Suffocation also causes asphyxia and can lead to an anoxic or hypoxic brain injury.

Plain language descriptions:
It is very unlikely that a person will use words like 'strangulation' or 'suffocation' to describe assaults that put them at risk of a possible Acquired Brain Injury resulting from anoxia or hypoxia. Listen out for descriptions such as: "choked me"; "pressed me up against..."; "held me by the neck"; "squeezed my neck"; "hands around my neck"; "tied me up around the neck"; "throttled me"; "had me in a choke hold"; "sat/ lay on top of me/on my chest"; "pinned me down"; "held me around the chest and squeezed"; "covered my mouth with..."; "smothered me"; "gagged me"; "tried to drown me" (note: drowning is not suffocation, or strangulation, but can have the same effect as these assaults – causing asphyxia, and possible ABI).

Dignity forms the basis of human rights

'Human rights recognise the inherent value of each person, regardless of background, where we live, what we look like, what we think or what we believe. They are based on principles of dignity, equality and mutual respect, which are shared across cultures, religions and philosophies. They are about being treated fairly, treating others fairly and having the ability to make genuine choices in our daily lives. Respect for human rights is the cornerstone of strong communities in which everyone can make a contribution and feel included.' [1]

The Australian Human Rights Commission

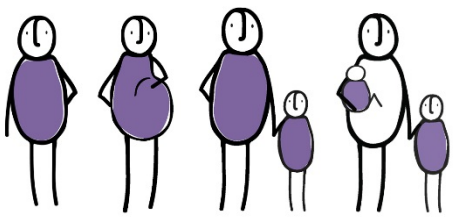
Domestic and Family Violence (DFV) is an injustice. It is an offence to a person's dignity, it compromises a person's safety and undermines their wellbeing. This is true of adults, children and young people. The concept of **dignity** expresses the idea that all people have the right to be valued and respected, and to be treated ethically.

Our commitment is to uphold the dignity of the people we support. We do this by practicing in ways that enable us to learn what people already know, feel, believe and do. Listening to and learning from people in this way, informs how we respond.

Acknowledging resistance and responses to violence

"Whenever individuals are subjected to violence, they resist. Along side each history of violence, there runs a parallel history of resistance…
'Victims' resist in a myriad of ways that are not successful in stopping violence but nevertheless are profoundly important as expressions of dignity and self respect." [2]

Dr Coates and Dr Wade



Commonly, the dialogue on DFV focuses on the violence used by the perpetrator and the impact on the person experiencing violence. However, by only focusing on these things we don't get a full picture of what happened and how or why a person has resisted and responded to violence in order to uphold their dignity. Whenever people are abused, they do many things to try and reduce, prevent or stop the abuse in some way. Resistance can take many forms – from overtly standing up to a perpetrator, to small acts or thoughts that go unnoticed by others.

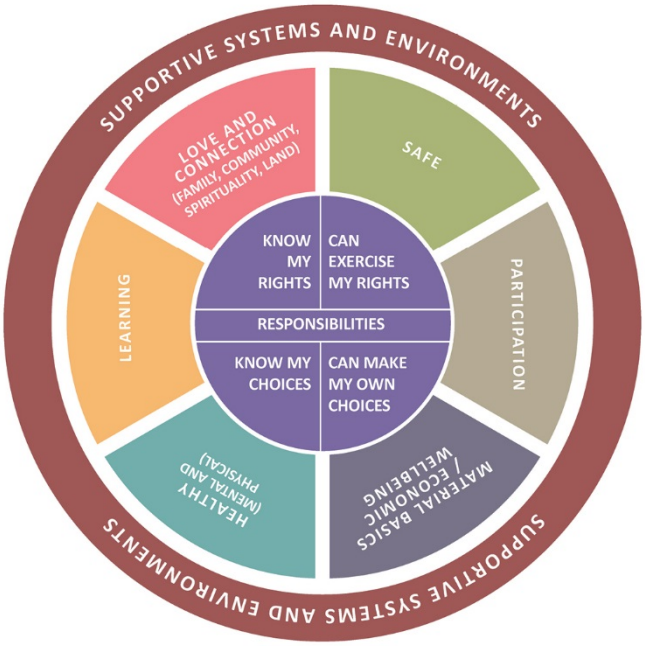
Some of the ways we work to uphold people's dignity within our practice include:

- exploring and acknowledging people's resistance and responses to the violence they have experienced.
- asking questions to better understand the context within which the violence has occurred.
- exploring and acknowledging that children and young people also resist and respond.
- using language that exposes violence, reveals the perpetrator's responsibility for violence and contests victim blaming.
- recognising that all people exercise caution, creativity, deliberation and awareness in navigating DFV.

We understand that people's responses and resistance to violence are their efforts to keep hold of and reassert their dignity.

1 Australian Human Rights Commission What are human rights? retrieved from https://www.humanrights.gov.au/about/what-are-human-rights (11/1/18)
2 Coates, L. and Wade, A. (2007) Language and Violence: Analysis of Four Discursive Operations, Journal of Family Violence 22: 511. https://doi.org/10.1007/s10896-007-9082-2

Wellbeing matters to adults, children and young people and this includes their safety. Being 'safe' is more than being physically safe – it includes all aspects of wellbeing.



DVSM defines wellbeing as being made up of interdependent areas each of which will look different in each person's life.

The value and weight of these will also change over time as a person's needs, priorities and circumstance change.

Rights, responsibility and choices

We work to support people's rights, responsibilities and choices, working with their capacity to act and make decisions – this can be described as a person's 'agency'.

When a person is aware of their rights they are able to make informed choices.

It is important to recognise that people's choices are not only informed by their rights but also by their responsibilities (which may be linked to their civil, cultural, family, community, spiritual connections including to land).

For a person experiencing DFV, the coercive control they are experiencing can limit and undermine their capacity to make choices, exercise their rights and fulfil their responsibilities.

Safety

Means feeling free from violence or the threat of it (violence could be psychological, verbal, physical, sexual, reproductive control, social, financial, property damage, stalking, image based or technological abuse).

Love and connection

Encompasses family relationships, friends and connections with community, spiritual connection and connections to land.

Learning

Is a continuous process throughout life. Elements of learning include the value of self-development for wellbeing.

Health

Includes physical health and nutrition, as well as mental health and self-esteem. Mental health is a key aspect of what it means to be healthy.

Material basics and economic wellbeing

Includes the provision of food, safe and adequate shelter, money and other basic human needs. Includes the economic resources the person has available to support not only their material living conditions, but the control over these resources and conditions.

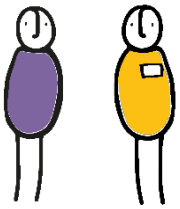
Participation

Includes having opportunities to have a voice and be involved as a citizen and in the community.

Supportive systems and environments

Sitting across all areas, is the presence and provision of supportive systems and environments which support an individual's wellbeing.

How do we create a foundation of safety within our practice?



People accessing support services, are at times, disclosing and making decisions about some of the most personal and intimate details of their lives.

We are very mindful that this not only requires personal courage on their part, but this requires us as a service and as practitioners to create 'safe' conditions so that the person can be as open as they need to, in order to get the support they are seeking.

Creating and understanding safety

We know that perceptions of, and/or experiences of using a support service can mean different things to different people. For some this can mean an increase in safety and to others decrease in safety. Each service experience can either reinforce prior experiences or offer something new.

We make every effort to support people's sense of safety by acknowledging the importance of their choice and control. We explore with the people we support:

> "What would **having control** over this support look like to you?"
>
> "What would **experiencing safety** and **feeling safe** look like to you in our work together?"

Being open and honest

We explain to people who are accessing our services where our role and responsibilities start and stop. We remain open about our role as circumstances, needs and responses change within the work together.

> A person's desired level of support and their choices might be different from what we **hope** or **wish** for the person. We remain committed to supporting the person's **agency** and to fulfilling our **duty of care**.

Building trust and being respectful

We seek to learn about people's existing safety awareness, experiences and strategies. Listening to people and learning from them in this way informs what we understand and how we respond.

Being communicative

We keep attuned to what is and isn't working well for the person, regularly checking in on their sense of safety, the boundaries and capacity of our role and the person's experience of us and with us.
We actively invite informal and formal feedback on how to improve our practice so that we can make quick adjustments that reflect a person's individual needs and wishes.

An excerpt from DVSM's Practice Framework March 2018 – available on www.dvnswsm.org.au

People experiencing Domestic and Family Violence (DFV) are already navigating their safety before they ever reach out for support. They are self-assessing the risks they face and use strategies to mitigate the risk of harm.

Any advice given or action taken by a practitioner may unintentionally or unknowingly increase the harm and threat that a person may face as a result of not fully understanding a person's situation and context.

Follow My Lead is a resource designed for all social and service responders to build awareness of concepts of safety in order to improve and inform responses.

***Follow My Lead* speaks from the voices of people with lived experience of Domestic and Family Violence who need the professionals and their social networks to be more prepared to respond effectively. More prepared to respond in ways that uphold dignity and build on safety.**

This resource is for any person who may at some point be listening to and responding to their friends, family members, colleagues, peers or to the people who use their service, who are experiencing Domestic and Family Violence.

Follow My Lead may also have benefits for people who are;

- thinking about their own relationships, safety and their experience of Domestic and Family Violence
- seeking support about their own lived (or live) experience of Domestic and Family Violence
- working as a service responder to people experiencing Domestic and Family Violence.

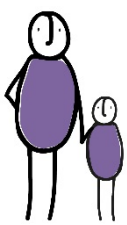
DVSM welcomes continued feedback in order to improve future editions of *Follow My Lead*.

You might want to give feedback as someone who has;
- read this resource and want to comment, or
- read the resource and over time, something has changed in what I know, see or do, or
- experienced Domestic and Family Violence and want to comment on what this resource means to you and any ideas you may have.

Building awareness and improving responses across contexts:
Follow My Lead is designed to be useful and applicable across society. Organisations, Institutes or communities may wish to introduce and distribute *Follow My Lead* in its current format, or may wish to rebrand the resource (not content) to enhance your communication with your focus population.

If you would like explore the opportunity to change the branding get in touch with the DVSM to seek permission and to talk about how.

AN INTERSECTION IN FOCUS



The lived-experience stories presented here represent just a few Australian examples of Domestic and Family Violence in which people experienced assaults to the head, neck or airways that put them at risk of sustaining an Acquired Brain Injury. There are countless more examples evident in Australian media reports about Domestic and Family Violence.

"He began taking his anger out on the kids, and would push and shove them around, or **hold them down and smother them** to try and stop them crying. I often tried to intervene but my attempts always blew up in my face. He'd only get angry at me, and would tell me I was "too soft" with them or accuse me of undermining his parenting. He also started sexually abusing me. He **would physically hurt me during sex by strangling me** or pulling my hair. **Sometimes I worried I was going pass out, or die**, because he wouldn't know when to stop."

Story of 'Rebecca' in, 'Raped, Tracked, Humiliated: Clergy Wives Speak Out About Domestic Violence', Julia Baird, 2017.

"Yvonne told ambulance officers and the social worker that she had 'had it' with Don and was planning to leave him. After being discharged from the hospital, police officers took Yvonne to the police station, where she spoke to the DVLO [Police Domestic Violence Liaison Officer]. Yvonne told the DVLO about the assault and said that Don had **held her down** on the mattress in the lounge room and refused to let her get up and go to the toilet. **She urinated** on the mattress and **he then punched her in the face**. Sometime later that evening, Yvonne was in the bathroom talking to her father on the phone when Don came in and **struck her on the head with the toilet brush, causing a laceration** to her scalp. Yvonne also told the DVLO that a week earlier Don **had attempted to strangle her**, and that **he had again punched her in the face**. The DVLO observed that Yvonne had a swollen cheek, marks around her neck and various injuries (including the laceration to her head) that were consistent with her disclosures." *Yvonne later died of a head injury inflicted by Don. Urination during assault is an indication that the brain & body are under serious stress & may be nearing death.*

Case 3223, NSW Domestic Violence Death Review Report 2015-2017

"It was like walking on eggshells, but I loved him. His continual physical abuse ceased the day **he belted me so hard I lost partial hearing in one ear** and then he raped me. Afterward he felt remorseful and I was grateful for the cessation of physical abuse. Within months, I saw my children withdraw from their father. In the final futile weeks I remained with him, I narrowly stopped him from a sexual advance on our daughter, and watched in horror as he threw a knife at our son."

Anna's Story, Domestic Violence Resource Centre Victoria

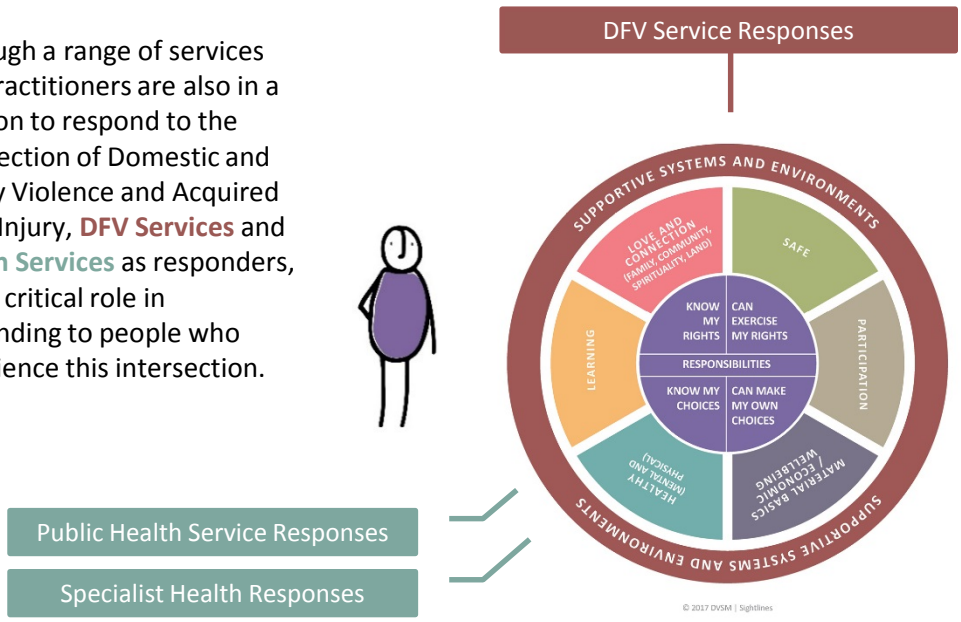
"Around this time Ash also noticed that her keys kept disappearing, and her property was vandalised and damaged. In one episode Seb **physically assaulted Ash at her parents' house and she passed out.** When she regained consciousness she tried to escape but he chased her and threatened to kill her. **He tried to strangle her**, but she managed to kick him and escape. She called his family, who came and intervened."

Case 3452, NSW Domestic Violence Death Review Report 2015-2017

This section outlines the key issues/barriers for DFV Services and Health Services in identifying and responding to the intersection of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI).

The issues and barriers outlined on the following pages are those that have been described by 35+ stakeholders in the DFV and Health sectors in Western Sydney, and in some cases representatives from broader state-based or national organisations. They reflect the views of people working in practice who see, or are aware of, this intersection as an ongoing challenge faced by the people they support. These issues and barriers are not exhaustive, and in some cases may or may not be relevant to other areas of NSW.

Although a range of services and practitioners are also in a position to respond to the intersection of Domestic and Family Violence and Acquired Brain Injury, **DFV Services** and **Health Services** as responders, play a critical role in responding to people who experience this intersection.



Perpetrators of Domestic and Family Violence can manipulate systems and services, and use negative stereotypes or stigma as a part of their coercive control. Some examples of these tactics that may be particularly relevant to this intersection include;

- Threatening a person for accessing medical support, or controlling when and what a person shares with health practitioners.
- Threatening to harm the children or loved ones of the person if they disclose about violence to health practitioners.
- Undermining the person by 'gaslighting' – saying that violence didn't occur by using stigmas about 'brain injury' or 'cognitive impairment' to excuse/hide the perpetrators use of violence.
- Undermining the person's confidence and/or credibility as a parent by saying they have a cognitive impairment and can't parent well.
- Limit a person's access to specialist services through economic abuse, physical intimidation or other abuse and control so a person may not be able to access an assessment or support for an Acquired Brain Injury.

Concussion/Mild Traumatic Brain Injury (m-TBI)
A person can experience health issues as a result of only one concussion/m-TBI or as a result of cumulated harm caused by a number of concussions/m-TBIs. The issues and barriers reported in this section may also be relevant when a person is experiencing more severe forms of brain injury, but were highlighted more often by practitioners in regards to responses for concussion/m-TBI.

DFV Service Responses

1. The various complex and compounding stressors of Domestic and Family Violence (DFV) can impede someone's physical recovery from concussion/m-TBI

- A person's physical recovery from concussion/m-TBI can be negatively impacted by factors such as chronic stress, further assaults, sleeplessness, and coping responses to violence that might involve regular use of alcohol or other drugs (AOD).

2. Emergency Accommodation options for a person escaping violence cannot always provide safe responses for the health risks associated with recent assault such as concussion/m-TBI

- A person being discharged from an emergency department after concussion/m-TBI is advised to remain in the care of an adult for the first 24 hours after injury – yet a person experiencing DFV may not be able to safely access the care of an adult for 24 hours once discharged. For example, Emergency accommodation programs, such as Temporary Accommodation or Women's Refuges, are not designed or resourced to provide 24 hour monitoring for health risks.

- A person experiencing/escaping violence may choose to access emergency accommodation instead of a hospital or medical service as they may view housing/shelter as more essential to their overall wellbeing when facing a crisis.

3. The requirements of a complex service system for people escaping DFV are not always conducive to recovery from concussion/m-TBI

- A physical recovery-focused response to someone who is experiencing a concussion/m-TBI would advise them to slowly return to a normal level of activity, and to be aware of their symptom threshold (the point when stress/activities are causing an increase in symptoms).

- The current service system, in its response to a person that is experiencing and/or escaping violence, requires them to be intensively engaged and active with many service providers in order to increase their safety supports and secure shelter (i.e. Centrelink, Police, legal processes, housing programs, financial institutions).

- Many DFV providers have commented that health is often, and understandably, de-prioritised by people escaping violence due to the number of competing priorities, and resulting stressors, that are present at that time.

4. The symptoms of concussion/m-TBI are similar to other health concerns

- Some practitioners in DFV services had questions about whether symptoms that could relate to concussion/m-TBI were more likely to be somatic, emotional and behavioural responses to violence, often described as 'trauma' or 'PTSD'. [See: *'Mental Illness' 'PTSD' and the 'effects' of Violence and Adverse Life Experiences*, pages 24-25]

- It is important to include concussion/m-TBI risk in our understanding of a person's wellbeing. This understanding keeps responders alert to any worsening physical symptoms, and aware of the potential for physical injuries to impact a person's recovery from physical injury.

1. Medical knowledge about concussion/m-TBI treatment is changing but practice varies

- A 'wait and see' approach to concussion/m-TBI recovery is common amongst community medical responders, however, there is a growing consensus that more can be done to support people experiencing concussion/m-TBI in the early stages.

- The existence of specialist clinics and services for concussion/m-TBI in some hospitals in NSW shows that there are other evidenced-based interventions that support people to reduce the impact of concussion/m-TBI. Such interventions can decrease the long-term health impacts of concussion/m-TBI and can help identify if environmental/social factors are influencing a person's recovery.

2. There is a discrepancy between rates of head injury and access to specialist services

- Practitioners agreed that concussion/m-TBI as a result of head injury is probably common amongst people who experience Domestic and Family Violence (DFV) that involves physical violence targeted at their head or neck.

- Australian Institute of Health and Welfare (2017) data highlights that the majority of DFV assaults that reach a hospital are targeted at the head or neck.

- Yet practitioners from two services that provide support for concussion/m-TBI responded that they rarely receive community referrals for people who have experienced violence related injuries.

3. Concussion/m-TBI screening is not a common response for people experiencing Domestic and Family Violence (DFV) who access their doctor for health concerns caused by DFV

- The Manager of the NSW Domestic Violence Death Review Team indicated that to date, in their case review analysis, there was no documented evidence that a domestic violence homicide victim had received a concussion/m-TBI response from their treating doctor following a disclosure of physical assault. In a number of the cases reviewed by the DVDRT, when a domestic violence victim disclosed their experience of abuse (including physical assaults) where they were treated for depression/and or anxiety, there was no record of them being screened for concussion/m-TBI.

- Various practitioners in DFV services who have supported service users to access a doctor for health issues caused by DFV stated that service users were more likely to be treated for mental illnesses than screened for current or historical m-TBI. [See: *'Mental Illness' 'PTSD' and the 'effects' of Violence and Adverse Life Experiences*, pages 24-25]

- Representatives that represent the experience of General Practitioners indicated that this is likely related to patients disclosing about symptoms only, and not always disclosing about violence or injuries.

Australian Institute of Health and Welfare 2017. *Hospitalised assault injuries among women and girls fact sheet*. Cat. no. INJCAT 184. Canberra: AIHW.

4. Specialists who are able to treat concussion/m-TBI are limited in the public system, and costly in private practice

- In Western Sydney there are children's concussion services at Children's Hospital Institute of Sports Medicine (CHISM) Westmead, and a brain injury outreach clinic at Westmead for people experiencing any severity of brain injury, including concussion/m-TBI. There are referral criterion for both services that may inhibit access for people experiencing Domestic and Family Violence (DFV), especially where co-morbid health concerns are also affecting neurocognitive functioning.
- Rehabilitation specialists in private practice can be costly to access which could be a barrier for people experiencing DFV.
- Information targeted at bulk-billing General Practitioners (GPs) on how to provide medical interventions for concussions/m-TBI would be beneficial in supporting people experiencing violence who cannot afford to access a private specialist.

5. The role of community practitioners, especially GPs, in responding to the intersection of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI) may be underestimated by colleagues in the field

- GPs may be seeing up to five women a week who are experiencing violence and abuse (Hegarty, 2006). This means that GPs have a unique opportunity to provide a safe response.
- Despite existing training and tools for GPs about DFV, there is great variability in how GPs respond to people experiencing DFV.
- Practitioners in DFV services report that that the women who access their services have mixed experiences of talking about violence with their GPs. These practitioners desire more information and certainty about where they can refer a person for medical support from a GP who is DFV-aware. This begs the question: how can we develop stronger connections between GPs who have engaged in training about DFV (and have skills in responding to DFV) and local services who support women that may be experiencing DFV?
- Australian Medical degrees include very little information about DFV. Though GPs are likely to have regular contact with people experiencing DFV (and related health impacts) information and training around responding to DFV are not a core part of early learning for future doctors.
- The practice of asking about DFV comes down to the discretion and training of the individual GP. Training and professional development for GPs about DFV is not mandatory.
- There are concerns that making information and training about DFV mandatory for GPs would result in poor engagement with the issue.

Reference: Hegarty K. What is intimate partner abuse and how common is it? In: Roberts G, Hegarty K, Feder G, editors. *Intimate partner abuse and health professionals: new approaches to domestic violence*. London: Elsevier, 2006;19–40.

6. Use of specialist brain injury services is limited because of cost, referral criterion, and lack of awareness that these services exist

- Practitioners that can conduct neuropsychological assessments (neuropsychologists) are expensive to access in the community. This can be a barrier to people accessing these services.

- There is only one public service available in Western Sydney that offers these services – through the NSW Brain Injury Community Outreach Team at Westmead – it became apparent through the interviews that many health responders are unaware of this service, or are unaware that the service can work with people experiencing concussion/m-TBI as well as more serious forms of brain injury.

- Practitioners from various NSW Brain Injury Community Outreach Teams noted that these services can have high patient loads and this can affect timeframes for responding to patients as well as how much support can be offered. The majority of resources invested in Brain Injury Rehabilitation Programs are focused on responses to severe brain injury not moderate TBI or concussion/m-TBI. Support provided for concussion/m-TBI in these services usually involves assessment and advice only. These services cannot provide ongoing support or cover the cost of support plans that may include a range of specialist responses such as clinical psychologists, physiotherapists, occupational therapists etc.

7. Integrated, Whole of Person Responses are needed

- Concussion/m-TBI can be unseen or overlooked where there is also a diagnoses of alcohol and other drugs use, depression, anxiety, or a diagnosis of a post-traumatic stress disorders (PTSD).

All levels of ABI (Including Mild, Moderate & Severe)
This category includes any ABI that causes serious physical and neurocognitive impairment that might be diagnosed, undiagnosed or misdiagnosed.

DFV Service Responses

1. The tension of supporting informed choice, yet sensitively timing the giving of information

- Many Domestic and Family Violence (DFV) service responders acknowledged that sometimes they were unsure if a person's presentation was due to physical or psychological experiences of trauma, alcohol or other drug use concerns, or undisclosed disability, and felt there were barriers to exploring this with service-users such as the 'need to let a person disclose in their own time.' This is an important ethical boundary, yet the health risk for any person in the first days and weeks after an assault may mean that practitioners have a duty of care to check-in about the person's changing health needs and ensure that they have all the information they need in order to make informed choices about their health.

- In situations where there is no urgent medical attention needed, DFV service responders can still be prepared to explore the health impacts of DFV with the person when the person is ready.

- Making the information about this intersection more accessible earlier, sensitively and across contexts may also support increased awareness and informed choice.

2. The challenges of providing a whole-of-person response in a siloed response system

- A person may be engaged with multiple services responding to different concerns they are experiencing (i.e. mental health services, drug and alcohol services). This can lead to a complex web of diagnoses and referrals in which the intersection of DFV/ABI is not recognised, or is overlooked.

- DFV services who work with a person already engaged in other service assessments and responses can play a role in building on the awareness of the person about their broader safety and wellbeing needs. DFV services can build levels of awareness about the possible health impacts of assaults to the head, neck or airways, and where support is available.

3. Cost barriers to assessment and to supports

- Referrals for ABI assessment and treatment can be costly, and do not ensure that a person will be able to access the disability support pension (DSP) or the National Disability Insurance Scheme (NDIS). Several practitioners in the brain injury sector stated that many people with brain injuries struggle to access the DSP and the NDIS.

- Many practitioners in the DFV sector acknowledged that it is very difficult to enable some people to access the DSP and the NDIS due to criterion that stipulate a disability must be permanent (lifelong) – this is very difficult to prove when a person has brain injury that affects cognitive functioning only and has not lead to a physical disability.

- DFV service responders need to be aware of these barriers if supporting a person to access brain injury support.

- DFV service responders also need to be person centred, led by the person seeking support and prepared to make strong applications and advocate on behalf of the person, working in an informing way with health practitioners as much as possible.

1. Awareness of Domestic and Family Violence (DFV) and safety varies and this may impact assumptions/conclusions about patients engaged with brain injury services

- Not all brain injury practitioners and specialists have awareness about the **range of behaviours that constitute DFV** or the difficulties a person may experience in accessing health services while experiencing DFV. Brain injury practitioners may believe that the person is disengaging from treatment when in fact the person is making choices that prioritise their safety.

- Information about Concepts of Safety and DFV is not part of regular professional development for practitioners working in public or private brain injury services.

2. A person can experience secondary brain injury days and weeks after strangulation

- Some GPs are aware about the serious health risks of strangulation and best practice in strangulation screening but there are many who are not aware.

- The everyday (plain language) used by a person to disclose strangulation or suffocation assaults is not readily recognised or identified across sectors.

- GPs must all be trained in appropriate screening and referrals after strangulation, especially about the importance of referring strangulation patients for a CT-Angiogram to reduce the risk of stroke and secondary brain injury.

3. Increased risk factors for people with disability experiencing DFV

- People with disabilities, (potentially including people with an acquired brain injury) experience higher rates of Domestic and Family Violence. This could lead to a person with an ABI experiencing further physical harm (including brain injury) and/or reduced ability to manage their brain injury if they are targeted by a perpetrator of violence.

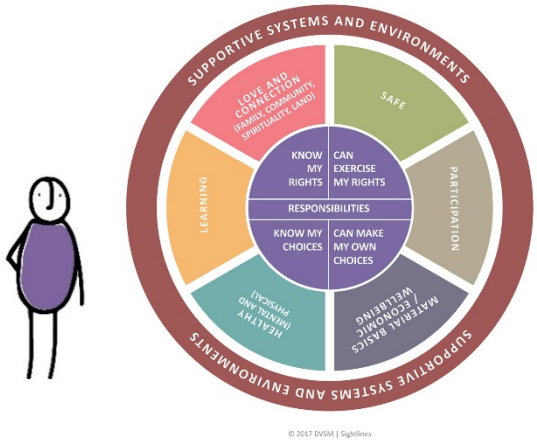
- As people with disabilities experience higher rates of DFV, services that support people with a brain injury need to be aware of the behaviours that constitute DFV, concepts of safety and contextual stressors that might be affecting a person's ability to physically recover from brain injury.

- People who have a disability can find it more difficult to access services and have their voices heard due to organisations, institutions and communities not always being accessible. This can influence a person's decisions not to report Domestic and Family Violence or to seek medical attention. Thus people experiencing untreated/undiagnosed brain injury (even a m-TBI) may be especially at risk of experiencing diminished choice and control, and of finding it more difficult to access support for DFV at times of crisis.

4. Treatment limitations and/or eligibility barriers

- Some specialist brain injury responders state that anoxic and hypoxic brain injury is more difficult to diagnose and treat, and furthermore these injuries may not meet the criterion for their services, as many brain injury services are responsive to traumatic brain injury.

- It is unclear if there is a need to differentiate treatment and intervention programs for anoxic/hypoxic brain injury from TBI treatment programs, and this question needs further exploration by brain injury experts and researchers.



A whole of person, person-centred approach to support is needed for each individual. Practitioners particularly where referring to or working in mental health services rely on a strong foundational understanding of violence as a social issue. This understanding assists and informs the importance of avoiding further re-victimisation of people with lived experience of Domestic and Family Violence and keeps accuracy and accountability for violence where it belongs.

The Issues and Barriers section in this project report presented frequent references to mental health issues and use of the diagnosis Post Traumatic Stress Disorder (PTSD). Below is a reflections piece on '**Mental Illness' 'PTSD' and the 'effects' of Violence and Adverse Life Experiences**' which can support critical thinking and analysis of practitioners in this work.

'Mental Illness' 'PTSD' and the 'effects' of Violence and Adverse Life Experiences

PTSD may be a useful heuristic for classifying symptoms of distress that sometimes occur in response to very adverse life events and experiences. "The label groups symptoms of re-experiencing, avoidance/ numbing and a range of disturbances in self-regulatory capacities". The latter can be further grouped into five broad domains when complex PTSD is discussed: "(a) emotion regulation difficulties, (b) disturbances in relational capacities, (c) alterations in attention and consciousness (e.g., dissociation), (d) adversely affected belief systems, and (e) somatic distress or disorganization" (Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A., Van der Hart, O. (2012), The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults).

However, it is important to remember that mental health labels are socially constructed and change over time. (Note: There is only a 30% correspondence between diagnostic labels in the first Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952 and the DSM V in 2013). Although this shifting meaning of mental illness is widely acknowledged in some fields, in mental health practice itself the system of mental health classification tends to be applied as if it were built on a universal and abstract truth, (a truth that that can be un-problematically applied across time and regardless of context). This matters because language and labels, (different ways of representing and classifying experience) don't just directly represent abstract and universal social facts. Rather our language and labels work to both express and structure, and to constrain and enable different meanings/understanding of our experiences.

In the case of violence there are both:

a) Effects of violence such as, homelessness, financial insecurity, loss of relationship … etc. and

b) Responses to violence … responses include the ever-present and ongoing awareness, assessment and action taken to minimise harm and to negotiate safety, and the many subtle, complex and careful efforts to resist, protest and push back (efforts to uphold ones dignity) in the face of mistreatment, indignity and abuse.

There is little room in the conceptual structure of PTSD and (or other mental health) symptom list(s) that reflects these material effects or agentic responses to violence and other forms of adversity.

Rather, the real world experience of violence and the social and interactional responses to violence are constructed/represented as individual psychological difficulties – effects of trauma. Thus even when labels accurately describe symptoms of distress in response to adversity, no label on its own is a fully accurate representation of people's experience.

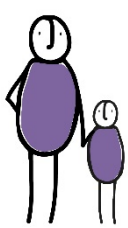
We can actually further undermine dignity and social justice in not thinking more critically about mental health labeling in responses to violence. As Richardson (2016) notes "One particular act of solidarity is to 'take back' the problem of violence, contest its representation as mental illness, affirming that victims act to affirm their dignity and their actions make sense in the context of both the violent crime and the social response received." (Richardson. C, (2016) p. 209, The Role of Response Based Practice in Activism. In M. Hyden, D. Gadd, & A. Wade (Eds.), Response-Based approaches to the study of interpersonal violence. London, England: Palgrave MacMillan).

In the dominant model, rather than talking about violence and responses to violence, the discourse is an individual medical one about mental illness diagnosis, treatment and recovery. However PTSD risk and recovery are highly dependent on social phenomena and *perceptions and experience of social support before and after are important factors in determining vulnerability to the development of PTSD symptoms* (Charuvastra, A. and Cloitre, M. (2008). Social Bonds and Posttraumatic Stress Disorder. Annual Review of Psychology, 59: 301–328).

Again we can see that approaches that are focused on individual effects or psychological wounds only, advance dominant frames of diagnosis, treatment and recovery and obscure the material effects and interactional responses (and resistance) to violence.

It is also an often overlooked fact that the vast majority of people who experience very adverse life events do not go on to develop symptoms consistent with classifications of PTSD. Litz (2004) points out that "epidemiological studies show that *8 to 9% are at risk for chronic mental health problems stemming from all forms of trauma*" … and this suggests that a "variety of complex, interrelated (and yet to be researched) factors moderate the form and rate of recovery from trauma across the lifespan" (Litz, B. T., (2004). Introduction, In B. Litz (Ed.), Early intervention for trauma and traumatic loss (pp. 1-2). New York: Guilford).

WHERE TO FROM HERE?
READINESS, RESPONSES & OPPORTUNITIES



This **'DFV/ABI Awareness and Response Table'** is comprised of three sections that summarise an in-depth contextual analysis of the 'awareness needs', 'available resources' and 'untapped opportunities' that relate to key responders to the intersection of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI). Each table reflects a different key responder in focus, namely: DFV responders, people who experience DFV, and Health Service responders.

DVSM acknowledges, however, that not all relevant options and opportunities will be captured in this map.

Who is the DFV/ABI Awareness and Response Table for?

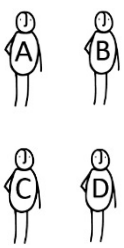
As explained in the preceding section on Issues/Barriers, DFV Services and Health Services are the responders in focus in this project, however they are not the only responders, and some of the awareness areas, resources, and elements of the opportunities have a useful (direct or adapted) application for other sectors/services.

Central to the DFV/ABI Awareness and Response Table is what can be developed with and for people experiencing DFV.

Importantly, people experiencing DFV are already navigating their safety ahead of seeking support. Resources and information designed for people who experience violence should aim to build on a person's existing level of safety awareness, their assessment of their safety, and to support them to build on the ways (strategies) they adapt to changing risk. This includes a need for information that helps them to understand and respond to the ways that DFV can impact on their health.

Note: This map does not address the important issue of adapting responses in ways that are culturally safe and non-discriminatory for people in specific populations who face high rates of discrimination and inequity in Australia, including; Aboriginal and Torres Strait Islander people, those who identify as LGBTIQ, people from CALD communities, older people, and children & young people.

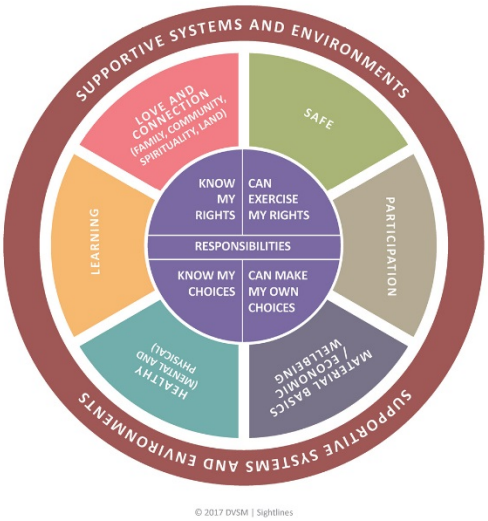
How to navigate the DFV/ABI Awareness and Response Table:



DFV/ABI presentations have been plotted in four stages, A – D. These stages are explained in more detail within **Map 01 DFV/ABI Intersection – Responses and Service Pathways (Western Sydney).**

**Covers mild/moderate ABI only because these levels of severity currently have few access pathways. People who sustain a severe brain injury as a result of DFV are not included under Persons B & C because this document does not explore best practice responses for this cohort. The reason for excluding this cohort is that the NSW Health Brain Injury Rehabilitation Programs (BIRPS) currently provide integrated early/late responses for all people who sustain a severe brain injury in NSW.*

A Response to Urgent Health Risks	B Early response to harm from physical assault/s (Potential ABI)	C Late response to harm from physical assault/s (Potential ABI)	D Entitled to Disability Supports
Requires immediate medical care to manage brain injury, or injuries that could lead to an ABI.	Would benefit from early support to reduce the long-term impact of mild/moderate ABI.*	Is experiencing long-term symptoms that could reflect mild/moderate ABI.*	Requires individualised disability supports due to an ABI caused by DFV. Or has a pre-existing ABI and requires accessible DFV support.



KEY RESPONDERS IN FOCUS:

Domestic and Family Violence and Health responders play a critical role in responding to people who experience this intersection.

All supports for people experiencing this intersection need to be **informing, empowering** and **supportive of a person's long term wellbeing**.

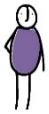
Our collaborative efforts need to uphold a person's dignity, support their rights and choices relating safety and wellbeing, including their health.

Information is organised in tables that focus on the role and opportunities of DFV Services, the person experiencing Domestic and Family Violence (DFV), and the role and opportunities of Health Services against the four stages (A-D).

Each section has a focus on awareness, resources and opportunities for improvement or development.

Mini-Model of the DFV/ABI Awareness and Response Table	A	B	C	D
Responses of people who experience violence and are at risk of ABI	*Information in these boxes outlines the 'awareness needs'; 'available resources'; 'existing options for response-enhancement' & 'untapped opportunities' that currently exist for key stakeholders responding to the intersection of DFV and ABI.*			
What knowledge do I have the right to know about DFV and my health?				
What resources are currently available for me that address health and DFV? Do they provide me with all the information I need?				
What options and opportunities exist to improve my understanding?				
Responses of Domestic and Family Violence Responders NSW (Western Sydney Focus)				
What awareness do these responders need?				
What resources are currently available for these responders? And how do these resources relate to awareness needs?				
What options and opportunities exist to strengthen this response?				
Medical and Health Responses NSW (Western Sydney Focus)				
What awareness do these responders need?				
What resources are currently available for these responders? And how do these resources relate to awareness needs?				
What options and opportunities exist to strengthen this response?				

Responses of people who experience Domestic and Family Violence (DFV) and are at risk of Acquired Brain Injury (ABI)



Any person who experiences DFV and sustains injuries or is at risk of sustaining injuries that could cause ABI.

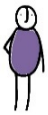
Person Experiencing DFV

What knowledge do I have the right to know about health risks caused by physical assault?

AW (Awareness needs): Awareness issues identified in this section are based on interviews and reading conducted in stage one of the DFV and ABI Project.

 Responding to Urgent Risks	 Early Response	 Late Response	 Entitled to Disability Supports
AW1. Know that assaults to the head, neck or airways can cause serious health issues in the short-term and long-term. AW2. Know what serious symptoms to watch out for in the days and weeks after an assault. AW3. Know how to access screening, assessment and support for urgent health risks caused by physical assaults. AW4. Know that certain perpetrator behaviours increase the risk of serious injury, disability or death.	AW1. Know that assaults to the head, neck or airways can cause serious health issues in the short-term and long-term. AW4. Know that certain perpetrator behaviours increase the risk of serious injury, disability or death. AW5. Know how to access screening, assessment and support for any ongoing health impacts of physical assault. AW6. Aware of their physical symptoms related to ABI and what works best for them in managing those symptoms.	AW1. Know that assaults to the head, neck or airways can cause serious health issues in the short-term and long-term AW5. Know how to access screening, assessment and support for any ongoing health impacts of physical assaults. AW6. Aware of their physical symptoms related to ABI and what works best for them in managing those symptoms.	AW5. Know how to access screening, assessment and support for any ongoing health impacts of physical assault. AW6. Aware of the physical symptoms related to ABI and what works best for me in managing those symptoms. AW7. Know that changes in their day-to-day functioning caused by DFV might mean they are entitled to disability support. AW8. Know who they can go to for advocacy around accessing disability support.

Resources for people who experience Domestic and Family Violence (DFV) and are at risk of Acquired Brain Injury (ABI)



Any person who experiences DFV and sustains injuries or is at risk of sustaining injuries that could cause ABI.

Person Experiencing DFV

What resources are currently available for me that address health and DFV? Do they provide me with all the information I need?	
DVSM Resources	Relates to Awareness Needs:
DVSM DFV/ABI Resource 02: DFV & Concussion/m-TBI	AW1, AW3, AW4,
DVSM DFV/ABI Resource 03: DFV & Strangulation	AW1, AW2, AW3
DVSM DFV/ABI Resource 04: DFV & Neurocognitive Difficulties	AW6
DVSM Maps	Relates to:
Map 01: DFV/ABI Intersection – Responses and Pathways (Western Sydney)	AW1, AW3, AW5
Map 02: Accessing a Forensic Medical Unit after physical or sexual assault - Western Sydney	AW3
Map 03: Neurocognitive Changes after Physical Assaults – When and How to See a Neuropsychologist	AW5, AW6
Existing Resources for Person Experiencing DFV/ABI Intersection	Relates to:
NSW Institute of Trauma and Injury Management – Mild Head Injury Discharge Advice (available in 7 languages)	AW1, AW2, AW3
DFV telephone support: Domestic Violence Line: **1800 654 463** 1800 Respect: **1800 732 732**	AW4
Advocacy and Information for People with ABI: Brain Injury Australia, or Synapse	AW6, AW8
Disability rights information online: People With Disability, IDEAS, and Multicultural Disability Advocacy Association.	AW7, AW8
Resources by Training Institute on Strangulation Prevention: Facts Victims of Choking Need to Know Signs and Symptoms of Strangulation	AW2, AW4
Synapse Information and Referral Line: **1800 673 074**	AW5, AW8

Options and Untapped Opportunities relating to people who experience Domestic and Family Violence (DFV) and are at risk of Acquired Brain Injury (ABI)

Any person who experiences DFV and sustains injuries or is at risk of sustaining injuries that could cause ABI.

Person Experiencing DFV

What options and opportunities exist to improve my understanding? EO (Existing Option) | OP (Untapped Opportunity) OPs 1 – 12 are outlined on pages 41- 54	
 Responding to Urgent Risk	**OP6:** Creation of strangulation/suffocation injury management and guidance resource that can be accessed by people who experience DFV at key service points and online. I.e. Update existing head injury management advice sheets (variations available in NSW Emergency Departments) to include information about DFV. Share these resources at key DFV service points. [See description on page 48]
 Early Response	**OP7:** Creation of a tool or system that assists people who experience DFV and ABI to track their symptoms, monitor the impact of physical assaults on their health, and take note of their health management strategies, or specialist advice. [See description on page 49]
 Late Response	**EO5:** Synapse offer an information and referral service that can support a person living in NSW to understand what options they have in terms of accessing support for ABI. Call: **1800 673 074**. Synapse also offer brokerage that can be used to access neuropsychological assessment (referral criterion apply).
	EO11: A person who thinks they may be suffering from brain injury as a result of previous DFV assaults can access their doctor and ask for a referral to a private neuropsychologist or university clinic for neuropsychological assessment to confirm which functions of their brain have been reduced.
 Entitled to Disability Supports	**EO2:** Organisations such as People with Disability Australia have an advocacy program that can assist individuals with a disability to access the supports they are entitled to, including the National Disability Insurance Scheme, the Disability Support Pension and other essential services. Examples of other organisations that may provide support to a person experiencing disability as a result of DFV include: IDEAS; and the Multicultural Disability Advocacy Association.

Responses of Domestic and Family Violence Responders NSW (Western Sydney Focus)

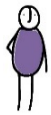
Domestic and Family Violence (DFV) Service Responses

What awareness do these responders need?

AW (Awareness need): Awareness issues identified in this section are based on interviews and reading conducted in stage one of the DFV and ABI Project.

 Responding to Urgent Risks	 Early Response	 Late Response	 Entitled to Disability Supports
AW1. Understands ABI-related, emergency health risks and presentations caused by DFV such as concussion, head injury complications, strangulation and suffocation. AW2. Understands how local health responses work and how to advocate for victim to access appropriate medical care when they may have serious injuries.	AW3. Understands signs and symptoms of concussion and other forms of ABI. AW4. Understands which medical services can provide early response support to reduce the impact of ABI. AW5. Understands the potential intersectionality of ABI, disability, AOD use, & mental health diagnoses. AW6. Awareness of ABI as a health impact of DFV and knowledge of strategies for supporting a person with their physical and emotional wellbeing.	AW3. Understands signs and symptoms of concussion and other forms of ABI. AW5. Understands the potential intersectionality of ABI, disability, AOD use, & mental health diagnoses. AW6. Awareness of ABI as a health impact of DFV and knowledge of strategies for supporting a person with their physical and emotional wellbeing. AW7. Knowledge of where to refer someone if they desire definitive evidence of 'cognitive impairment' or 'brain injury' in order to access needed services.	AW7. Knowledge of where to refer someone if they desire definitive evidence of 'cognitive impairment' or 'brain injury' in order to access needed services. AW8. Awareness of local disability advocates that can support a person to access the responses they are entitled to. AW9. Understands the social model of disability and the intersectionality of DFV and disability. AW10. Knowledge of strategies to adapt service-provision and casework that may increase accessibility for a person with ABI, and understanding that strategies should be explored with and led by the person who has an ABI.

What resources are currently available for these responders? And how do these resources relate to awareness needs?	
DVSM DFV/ABI Resources	Relates to Awareness Need:
DVSM Social/Service Responder Resource: Follow My Lead (Concepts of Safety)	AW6
DVSM DFV/ABI Resource 01: DFV & ABI Information	AW4, AW5, AW6
DVSM DFV/ABI Resource 02: DFV & Concussion/m-TBI	AW1, AW2, AW3, AW4
DVSM DFV/ABI Resource 03: DFV & Strangulation	AW1, AW2, AW3, AW4
DVSM DFV/ABI Resource 04: DFV & Neurocognitive Difficulties	AW5, AW6, AW7, AW10
DVSM Maps	Relates to Awareness Need:
Map 01: DFV/ABI Intersection – Responses and Pathways (Western Sydney)	AW2, AW4, AW6
Map 02: Accessing Forensic Medical Services in Western Sydney	AW2
Map 03: Neurocognitive Changes after Physical Assaults – When and How to See a Neuropsychologist	AW7
Map 04: Community Medical Responses to Neurocognitive Symptoms that could reflect possible ABI	AW5
Map 05: Emergency Medical Responses to assaults involving strangulation and/or head injury – Western Sydney	AW2
Existing Resources Relevant to DFV Service Responders	Relates to Awareness Need:
Training Institute on Strangulation Prevention: Signs and Symptoms of Strangulation	AW1
Family Justice Center Alliance: Strangulation Assessment Cards	AW1
People With Disability Australia: Guide to Reporting Disability	AW9
PWD Training on improving accessibility of services for people with disabilities	AW8, AW9, AW10
DVNSW: Women with Disability and DFV: A guide for policy & practice	AW9, AW10
Women, Disability and Violence: Knowledge Translation and Exchange Workshop (Online resource)	AW9, AW10
ACI & FACS have created online training tools for practitioners and services working with people who have a diagnosed ABI. www.abistafftraining.info & www.tbistafftraining.info	AW6, AW10



Domestic and Family Violence (DFV) Service Responses

What options and opportunities exist to strengthen this response? EO (Existing Option) | OP (Untapped Opportunity) OPs 1 – 12 are outlined on pages 41- 54	
 Responding to Urgent Risks	**E01:** DFV responders in Western Sydney can access strangulation response training through the Blacktown Forensic Medical Unit – *At the time of this report the Blacktown FMU is the only FMU/Sexual Assault clinic in NSW that offers training about strangulation to local DFV and health services.*
	OP1: Training for DFV responders about ABI & health impacts of DFV. [See description on page 42]
	OP2: partnerships between DFV responders & community GPs to support people who experience ABI symptoms and DFV. [See description on page 43]
	OP3: Information Cards provided by key responders in the days after a physical assault. [See description on page 44]
 Early Response	**OP1:** Training for DFV responders about ABI & health impacts of DFV. [See description on page 42]
	OP2: partnerships between DFV responders & community GPs to support people who experience ABI symptoms and DFV. [See description on page 43]
	OP4: Increase understanding of DFV and ABI amongst future psychologists. [See description on page 45]
	E02: DFV services can access online training, webinars and tools about the intersection of DFV and traumatic brain injury or strangulation via the following organisations: • Office for the Prevention of Domestic Violence, New York • Pennsylvania Coalition Against Domestic Violence • Training Institute on Strangulation Prevention *Note: these resources are unable to provide information about the pathways, rights, access barriers and services available to people experiencing this intersection in Western Sydney as they relate to international contexts.*
	OP11: Medical Advocacy Program in Western Sydney for the DFV Sector. [See description on page 53]

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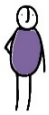
Domestic and Family Violence (DFV) Service Responses

What options and opportunities exist to strengthen this response? EO (Existing Option) | OP (Untapped Opportunity)	
 Late Response	**OP1:** Training for DFV responders about ABI & health impacts of DFV. [See description on page 42]
	OP2: partnerships between DFV responders & community GPs to support people who experience ABI symptoms and DFV. [See description on page 43]
	OP4: Increase understanding of DFV and ABI amongst future psychologists. [See description on page 45]
	OP5: See Research Focus Area 1: Exploring the use of Neuropsychological Testing in assisting people who have experienced DFV and may have an ABI. [See description on page 46]
	OP11: Medical Advocacy Program in Western Sydney for greater coordination between the DFV and Health sectors. [See description on page 53]
 Entitled to Disability Supports	**EO2:** People with Disability Aust. (PWD) have developed an audit and training program for DFV services to improve their service provision for people who have a disability and experience DFV. *At the time of this report this is the only training of its kind in NSW that addresses the DFV/Disability intersection.*
	EO3: DFV services seeking to learn strategies for supporting a person with cognitive impairment could access supervision with a clinical psychologist or neuropsychologist who specialises in providing therapeutic supports and cognitive remediation for people that have a cognitive impairment (and can provide supervision to other practitioners).
	EO4: There are some community based ABI support services in Western Sydney that work with people who have experienced a severe brain injury. These programs can provide coordinated support alongside DFV services. *At the time of this report ABIS was the main provider of community based ABI support in Western Sydney.*
	OP5: Research Focus Area 1: : Exploring the use of Neuropsychological Testing in assisting people who have experienced DFV and may have an ABI. [See description on page 46]
	EO2: DFV practitioners can collaborate with organisations such as People with Disability Australia that provide advocacy and advice for individuals with a disability in accessing the supports they are entitled to. Other organisations that may provide support to a person experiencing disability as a result of DFV: IDEAS; and the Multicultural Disability Advocacy Association.



Medical and Health Responses NSW (Western Sydney Focus)

Medical/Health Responders - Doctors, medical specialists, mental health practitioners, AOD practitioners and allied health professionals.

Health Service Responses

What awareness do these responders need?

AW (Awareness needs): Awareness issues identified in this section are based on interviews and reading conducted in stage one of the DFV/ABI Project.

 Responding to Urgent Risks	 Early Response	 Late Response	 Entitled to Disability Supports
AW1: Awareness about Domestic and Family Violence (DFV) • AW1.1 Understands types of DFV • AW1.2 Awareness of Safety Risk Factors • AW1.3 Awareness of referral options for DFV • AW1.4 Understands Concepts of Safety and Response			
AW2. Understands ABI-related health risks caused by physical assault, including: concussion, other head injury, harm from strangulation & harm from suffocation. AW3. Awareness of best practice in responding to: concussion, other head injury, harm from strangulation & harm from suffocation. AW4. Knowledge of specialist supports for brain injury in the local health district (LHD). AW5. Knowledge of Local Forensic Medical services.	AW2. Understands ABI-related health risks caused by physical assault, including: concussion, other head injury, harm from strangulation & harm from suffocation. AW3. Awareness of best practice in responding to: concussion, other head injury, harm from strangulation & harm from suffocation. AW4. Knowledge of specialist supports for brain injury in the local health district (LHD). AW6. Knowledge of ongoing concussion/ m-TBI management strategies.	AW3. Awareness of best practice in responding to: concussion, other head injury, harm from strangulation & harm from suffocation. AW4. Knowledge of specialist supports for brain injury in the local health district (LHD). AW6. Knowledge of ongoing concussion/ m-TBI management strategies. AW7. Understanding about the potential intersectionality of DFV, mental illness, ABI and AOD use. Knowledge about treatment options for dual-diagnosis.	AW3. Awareness of best practice in responding to: concussion, other head injury, harm from strangulation & harm from suffocation. AW4. Knowledge of specialist supports for brain injury in the local health district (LHD). AW7. Understanding about the potential intersectionality of DFV, mental illness, ABI and AOD use. Knowledge about treatment options for dual-diagnosis.

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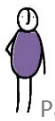

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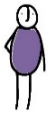
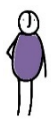
Health Service Responses

What awareness do these responders need?			
AW (Awareness needs): Awareness issues identified in this section are based on interviews and reading conducted in phase one of the DFV/ABI Project.			
 Responding to Urgent Risks	 Early Response	 Late Response	 Entitled to Disability Supports
	AW7. Understanding about the potential intersectionality of DFV, mental illness, ABI and AOD use. Knowledge about treatment options for dual-diagnosis.	AW8. Knowledge of referral pathways for neuropsychological assessment if evidence of impairment is desired by patient.	AW8. Knowledge of referral pathways for neuropsychological assessment if evidence of impairment is desired by patient. AW9. Understanding that every person with an ABI is unique and that health responses should embrace the individual rights and choices of the person receiving support.



What resources are available for these responders? And how do these resources relate to awareness needs?	
DVSM Practitioner Resources	Relates to Awareness Need:
DVSM Social/Service Responder Resource: Follow My Lead (Concepts of Safety)	AW1.1, AW1.4
DVSM Table 01: Immediate, Short-Term and Long-Term Harms of Strangulation	AW2
DVSM Reflections Paper 2.1 An Exploration of the Intersection of DFV and ABI	AW2, AW7
DVSM Maps	Relates to Awareness Need:
Map 01: DFV/ABI Intersection – Responses and Pathways (Western Sydney)	AW1.3, AW1.4, AW4, AW6
Map 02: Accessing a Forensic Medical Unit after physical or sexual assault - Western Sydney	AW1.3, AW5
Map 03: Neurocognitive Changes after Physical Assaults – When and How to See a Neuropsychologist	AW4, AW8
Map 04: Community Medical Responses to Neurocognitive Symptoms that could reflect possible ABI	AW2, AW4, AW7, AW8
Map 05: Emergency Medical Responses to assaults involving strangulation and/or head injury – Western Sydney	AW3
Existing Resources Relevant to Health Service Responders	Relates to Awareness Need:
NSW Health Closed Head Injury Management Policy NSW Health Children and Infants – Acute Management of Head Injury	AW3, AW6, AW4
WSLHD Procedure for the Management of Victims of Assault who have Suffered Attempted Strangulation (Version 3)	AW1.3, AW2, AW3
Royal Collage of Pathologists of Australasia Guidelines: Clinical Forensic Assessment and Management of Non-Fatal Strangulation	AW1.3, AW2, AW3
Strangulation Training Institute Resources: Signs and Symptoms of Strangulation Recommendations for the Medical/Radiographic Evaluation of Acute Adult Non-Fatal Strangulation	AW2, AW3
Family Justice Center Alliance Resource: Strangulation Assessment Card	AW2, AW3
Health NSW Domestic and Family Violence Policy	AW1.1, AW1.3
The RACGP Whitebook - Abuse & Violence: Working with our Patients in General Practice	AW1.1, AW1.2, AW1.3
When She Talks to you About Violence: A Toolkit for GPs in NSW	AW1.1, AW1.3
The University of Sydney 'Clinical Practice Guidelines for the Care of People Living with Traumatic Brain Injury in the Community', 2006	AW7
ACI & FACS have created online training tools for practitioners and services working with people who have ABI www.abistafftraining.info & www.tbistafftraining.info	AW6, AW9
NSW Government, Care and Support Pathways for People with an Acquired Brain Injury: Referral and Service Options in NSW	AW4, AW7, AW9



Health Service Responses

What options and opportunities exist to strengthen this response? EO (Existing Option) | OP (Untapped Opportunity) OPs 1 – 12 are outlined on pages 41- 54	
 Responding to Urgent Risk	**OP6:** Creation of strangulation/suffocation injury management and guidance resource that can be accessed by people who experience DFV at key service points and online. I.e. Update existing head injury management advice sheets (available via in NSW Emergency Departments) to include information about DFV. Share these resources at key DFV service points. [See description on page 48]
	OP8: Health Service Pilot Programs involving Streamlined Treatment Pathways. [See description on page 50]
	OP9: Concussion/m-TBI Screening Tool in EDs project. [See description on page 51]
	OP10: Training and information could be developed for '000' call operators and paramedics about DFV and health risks of specific assaults. [See description on page 52]
	EO1: Local GPs and medical practitioners can access strangulation training through the Forensic Medical Unit (WSLHD & NBMLHD).
 Early Response	**OP6:** Creation of strangulation/suffocation injury management and guidance resource that can be accessed by people who experience DFV at key service points and online. I.e. Update existing head injury management advice sheets (available via in NSW Emergency Departments) to include information about DFV. Share these resources at key DFV service points. [See description on page 48]
	OP8: Health Service Pilot Programs involving Streamlined Treatment Pathways. [See description on page 50]
	OP11: Medical Advocacy Program in Western Sydney for greater coordination between the DFV and Health sectors. [See description on page 53]
	OP12: Increasing access to Rehabilitation Specialists in private practice for ongoing treatment of Acquired Brain Injury – all severities. [See description on page 54]
	EO7: There is an available public health pathway for people with a mild/moderate brain injury through the NSW Brain Injury Community Outreach Teams, however these services have strict referral criterion and can offer limited services. Testing is available, as well as treatment recommendations, but treatment services are not available for people with mild/moderate ABI.

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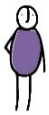

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Health Service Responses

What options and opportunities exist to strengthen this response? OP (Untapped Opportunity) | EO (Existing Option) OPs 1 – 12 are outlined on pages 41- 54	
 Late Response	**OP5:** Research ideas no. 3 & 4 which explore different angles about the care of and health history of people with m-TBI and lived experience of DFV. [See description on pages 46-47]
	OP11: Medical Advocacy Program in Western Sydney for greater coordination between the DFV and Health sectors. [See description on page 53]
	OP12: Increasing access to Rehabilitation Specialists in private practice for ongoing treatment of Acquired Brain Injury – all severities. [See description on page 54]
	EO7: There is an available public health pathway for people with a mild/moderate brain injury through the NSW Brain Injury Community Outreach Teams, however these services have strict referral criterion and can offer limited services. Testing is available, as well as treatment recommendations, but treatment services are not available for people with mild/moderate ABI.
 Entitled to Disability Supports	**EO9:** There is an available public health response for people with a severe brain injury causing disability through the NSW Brain Injury Rehabilitation Programs.
	EO10: Some clinical psychologists are skilled in providing therapy and cognitive rehabilitation or remediation for people with an ABI. Where a person is unable to access public brain injury services due to not meeting severity criterion, medical practitioners can refer the person to an ABI trained clinical psychologist.
	EO4: There are some community based ABI support services in Western Sydney that work with people who have experienced a severe brain injury. These programs can provide support for ABI, but where DFV is also a concern, practitioners should consult with the patient about providing a simultaneous referral to a DFV support service. *At the time of this report ABIS was the main provider of community based ABI support in Western Sydney.*

What opportunities exist to strengthen the responses to the intersection of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI)?

Whether we work in a public health service, a private practice, a community organisation or simply have influence in a particular social or cultural group, we all have a role to play in strengthening social responses to DFV.

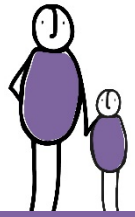
The opportunities listed in this report are for all practitioners working the fields of Health or DFV, and they reflect the view that we can all do something to strengthen responses for people who experience the intersection of DFV and ABI.

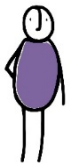
The following opportunities were identified during interviews with 35+ stakeholders from DFV services, Health services and community organisations in Western Sydney and beyond. Each of these opportunities can be adapted for other health districts and regions. Some have previously been initiated in other contexts and details are given where this is the case.

This is not an exhaustive list of every opportunity that is available to strengthen responses to the intersection of DFV and ABI. This list focuses on those ideas that emerged in relation to the awareness needs and gaps in service provision that have been identified during the project.

These opportunities are available (where relevant) for uptake by any stakeholder, practitioner or organisation that is open to engaging in the shared task of improving our collective responses to the intersection of DFV and ABI in the DFV and health sectors. These opportunities reflect the 'untapped opportunities' referred to in the **'DFV/ABI Awareness and Response Table'.**

Ref	Description
OP1	Co-development of a training program for DFV practitioners about DFV-related ABI
OP2	Strengthening pathways between General Practitioners (GPs) and DFV service providers
OP3	Health Information Cards provided by key assault responders
OP4	DFV awareness building for future psychologists
OP5	Formal research opportunities
OP6	Development of/adaptation of commonly used injury management information guides
OP7	DFV & My Health Individualised Recording System
OP8	Health Service Partnerships To Develop Streamlined Treatment Pathways
OP9	Emergency Department TBI Screening Tool Project
OP10	Training for Paramedics and '000' operators
OP11	Medical Advocacy Program in Western Sydney
OP12	Increasing Access to Rehabilitation Specialists in Private Practice





Goal:

- ***Increase the awareness of DFV services about the intersection of Domestic and Family Violence (DFV) & Acquired Brain Injury (ABI). Provide practitioners with information about head injury, concussion, strangulation, and suffocation as well as health impacts and response.***
- ***Increase the likelihood that service users will experience an ABI-informed response when disclosing about experiences of violence.***
- ***Ensure that ABI-informed responses are person-centred and uphold the dignity and rights of people who experience DFV.***

Co-development of a training program for DFV practitioners about DFV-related ABI

DFV advocates and ABI specialists could develop a joint training tool, workshop, or webinar, to be shared with DFV practitioners that provides information on;

- the DFV/ABI intersection,
- available medical responses (with localised information), and
- case-management tips for working with people who may be experiencing certain symptoms of DFV-related ABI.

Challenge:

"Nothing about us without us." People with a brain injury that was caused by violence are the best equipped to provide service feedback and advice about how services can adapt responses to increase accessibility and support them in their goals. Practitioners should be cautious about solutions or resources that are targeted for use with every person who has a brain injury – as every person is an individual and requires an individualised, person-centred response.

Strategies:

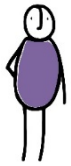
Source an appropriate group of service users through the relevant peak bodies, who could contribute knowledge and lived experience to the development of and training around DFV & ABI. Ensure that any training and resources about DFV-related ABI are founded upon person-centred, dignity-based models of care that seek to promote an individual's own strategies, choices and priorities in managing their health or disability.

Who has previously engaged in this type of project?

- **TBI & DFV Training:** Pennsylvania Coalition Against Domestic Violence; and, the New York State Office for the Prevention of Domestic Violence.
- **Strangulation & DFV Training:** Training Institute on Strangulation Prevention, San Diego.

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Liverpool Hospital, Brain Injury Rehabilitation Unit
- Dr Susan Pullman & Associates
- Forensic Medical Unit, Western Sydney & Nepean Blue Mountains
- Pennsylvania Coalition Against Domestic Violence
- West Connect Domestic Violence Services Inc.
- People with Disability Australia
- Blacktown Women's & Girl's Health Centre
- Bonnie Support Service
- The Outer Western Domestic Violence Network



Goal:

- ***Strengthen relationships and collaboration between General Practitioners (GPs) and Domestic and Family Violence (DFV) services in Western Sydney in ways that build understanding about DFV and DFV health risks such as Acquired Brain Injury (ABI).***
- ***Increase coordination between GPs and DFV services.***

Strengthening pathways between General Practitioners (GPs) and DFV service providers

Partnership opportunities could be developed between DFV advocates and willing community GPs in Western Sydney, where doctors are willing to participate in a conversation around DFV, and have an interest in making more links between DFV and health harms such as ABI. Project resources around DFV, Concepts of Safety, and DFV-related ABI, could be shared and discussed between participating practitioners.

Challenges:

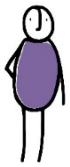
GPs self-select their learning and professional development activities. DFV service providers may not have capacity to engage with every GP in their region to assess their openness to collaborating and participating in shared learning.

Strategy:

The Primary Health Network could be asked to scope out 15-20 GPs that are geographically spread across Western Sydney who are committed to continued professional development about DFV and associated health risks. This list could be shared with DFV service providers in Western Sydney. DFV services could share resources and information about DFV with these GPs and discuss the health impacts of DFV including ABI. This would provide an opportunity for DFV services to connect with local community-based doctors who they can continue to collaborate with in order to improve responses for people experiencing DFV.

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- The Outer Western Domestic Violence Network
- Westmead Children's Hospital Institute of Sports Medicine
- Westmead Hospital, Brain Injury Outreach
- Mt Druitt Family Violence Service (FACS)
- Forensic Medical Unit, Western Sydney & Nepean Blue Mountains



Goal:

- ***To increase information provision about Domestic and Family Violence (DFV) and health impacts for people who experience DFV and engage with services after being physically/sexually assaulted by the perpetrator.***
- ***To ensure that key assault responders can recognise and identify high-risk symptoms or signs that a serious injury to the head, neck, or airways has been sustained.***

Health Information Cards provided by key assault responders that respond to DFV assaults (Paramedics, Domestic Violence Liaison Officers (DVLOS), Court Support Workers)

Concussion, strangulation and brain injury specialists could collaborate with DFV advocates or the organisations that represent emergency responders to develop information cards around key health impacts of any assault involving the head, neck, or blocked airways. These cards could outline red-flag symptoms to watch out for as well as explain the risks associated with multiple minor head injuries or the risks of strangulation.

Challenges: Police officers who arrive at the scene of an incident have a high amount of information gathering processes to conduct with the perpetrator and with people who experience or witness violence. This does not include providing medical advice to people who have been assaulted. Paramedics will be called when physical harm or injury is identified by police.

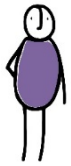
Strategy: Other stakeholders such as paramedics, or court support workers and DVLOs who engage with the person in the days after an assault, could share these information resources with the person and could explore the risks and concerns the person may be facing in regards to DFV and their health.

Who has previously engaged in this type of project?

- The Training Institute for Strangulation Prevention, San Diego, have created 'Strangulation cards' for first responders that can be freely adapted for other contexts.

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- NSW Women's Domestic Violence Court Advocacy Program
- NSW Police Force, Domestic and Family Violence Team, Performance and Program Support Command
- Training Institute for Strangulation Prevention, San Diego
- Domestic Violence Death Review Team, NSW Department of Justice



Goal:

- ***To provide specialist information to psychologists-in-training about Domestic and Family Violence (DFV) and about the intersections of DFV and health risks such as Acquired Brain Injury (ABI).***
- ***To encourage students to emphasise safety and whole-of-person wellbeing in their clinical and neuropsychological work with people who experience DFV.***

DFV awareness building for future psychologists

Domestic and Family Violence advocates and services might work with Universities in Western Sydney to provide information about DFV to their coursework students in the Neuropsychology and Clinical Psychology programs.

Challenges:

Course content and approaches taught in tertiary psychology courses focus on the assessment and treatment of disorders found in the **DSM-V** and the **ICD.** Domestic and Family Violence is a prevalent social issue that can undermine and harm all areas of an individual's wellbeing, not only mental health.

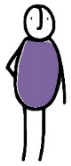
During the course of their career, Psychologists will engage with people experiencing Domestic and Family Violence. A whole of person, person-centred approach to support is needed for each individual. Psychologists wanting to uphold a social justice orientation rely on a strong foundational understanding of Domestic and Family Violence as a social issue. This understanding assists and informs the importance of avoiding further re-victimisation of people with lived experience and keeps accuracy and accountability for violence where it belongs.

Strategy:

Any training or information sharing with psychologists and other mental health professionals who may in the future work with people experiencing Domestic and Family Violence , could include information on the social context of DFV, the importance of social responses to DFV, as well as, concepts of safety and resistance to violence. Training in these concepts will ensure that future psychologists will receive a fuller picture of the broader context of violence, wellbeing and safety that a person experiencing Domestic and Family Violence will face, which includes, but is not limited to, mental health.

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Macquarie University Psychology Clinic
- NSW Victims Services
- Liverpool Hospital, Brain Injury Rehabilitation Unit



Goal:
To continue learning about the intersections of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI), with a focus on local research, relevant to NSW/the Australian context, seeking information that will improve service responses to this intersection.

Formal research opportunities

The following are research projects suggested during the course of the DFV/ABI project. Not all of these research ideas were listed in the Readiness and Response Table as this table focuses on responses in the DFV and Health sectors.

(1) Assessing outcomes of neuropsychological assessment and advice for people with a possible ABI caused by DFV.

Universities that offer neuropsychology programs may have postgraduate research students interested in conducting research around DFV and ABI. Possible research avenues might involve a direct referral stream between DFV services and university neuropsychology clinics where a person has identified that they have experienced neurocognitive changes and wants and consent to access assessment to learn more. Research might assess the outcomes of accessing neuropsychological assessment and advice for those who participate. This would help in ascertaining how information about neuropsychological impacts and proposed interventions are useful/utilised in the context of the social barriers that may exist for people who have experience violence.

(2) Asking if DFV homicide victims who experienced repeat physical assaults had been living with unrecognised brain injury prior to being murdered.

The coroner could be asked to examine for CTE (Chronic Traumatic Encephalopathy, a form of cumulative brain damage) in homicide cases where murdered victims have historically experienced multiple physical assaults as part of a pattern of perpetrator behaviours that constituted DFV. As it has previously been established that service systems and DFV responses are frequently not accessible for people with disabilities, the presence of unrecognised ABI could prove to be a factor in why some women are not receiving appropriate support before DFV escalates to homicide.

(3) Exploring a correlation between head injury or strangulation and increased access of mental health services.

A researcher could access the emergency department (EDs) data and the NSW Mental Health Services data to identify if people accessing NSW EDs with head injuries or strangulation injuries are going on to access Mental Health services after their head injury (a correlation study). This could highlight the need for Mental Health services to incorporate questions about head injury/strangulation into their assessments of DFV and wellbeing.

(4) Investigating outcome differences for people who experience DFV related m-TBI compared to those who experience DFV without m-TBI.

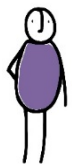
Brain injury advocates have expressed interest in partnering with a DFV service to do a cohort study of a group of women who experience m-TBI and DFV, comparing their journeys/outcomes to those who experience other types of TBI and/or experience DFV but no TBI.

Who has previously engaged in this type of project?

- Training Institute for Strangulation Prevention San Diego currently collect case studies that highlight CTE in people who have experienced strangulation (2)
- A number of research papers exist using data from other countries that highlight the links between head injury and receiving diagnoses of mental illness (see DVSM reflections paper on DFV and ABI) (3)

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Domestic Violence Death Review team, NSW Department of Justice (2)
- Brain Injury Australia (4)
- Westmead Children's Hospital Institute of Sports Medicine (3)
- Macquarie University Psychology Clinic (1)
- Dr Susan Pullman and Associates (1)
- Pennsylvania Coalition Against Domestic Violence (A)
- Training Institute for Strangulation Prevention, San Diego (2)
- Forensic Medical Unit, Western Sydney & Nepean Blue Mountains (3)



Goal:
To ensure that people who experience Domestic and Family Violence (DFV) have access to appropriate information about high risk injury symptoms and injury management, regardless of whether they disclose about violence, or assault symptoms.

Development of/adaptation of commonly used injury management information guides

- Creation of strangulation injury management and guidance that can be accessed by people who experience strangulation at key service points and online.
- Create an adapted version of the existing head injury management advice sheets available at Health NSW emergency departments, to include information about DFV.
- Share these resources at key DFV service points, medical centres, online on DFV websites, and at police stations and courts.

Challenge:

Where a person experiences mild head injury symptoms may decline over time. Anxiety/stress about one's symptoms can lead to an increase in symptoms and can hamper recovery. Some medical practitioners assert that too much information can have a negative impact on a person's health. Despite this, people still have a right to make informed choices about their health.

Strategy:

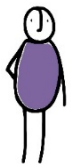
It is important for any information about injury risks/management to be reassuring and to use language that aims to reduce stress. This means highlighting that many people recover within a few weeks and that it's very normal for this process to take time. It is also important that the resources point a person to medical services and doctors who have knowledge of brain injury recovery and support so that these resources aren't available in isolation.

Who has previously engaged in this type of project?

- Training Institute for Strangulation Prevention San Diego have created 'strangulation symptom/check guides' that can be used/adapted by any organisation for free.
- NSW Institute of Trauma and Injury Management. See advice sheet: 'Mild Head Injury Discharge Advice' - and subsequent adaptations such as those by Motor Accident Authority NSW, South East Sydney Local Health District, etc.

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Forensic Medical Unit, Western Sydney & Nepean Blue Mountains
- Blacktown Hospital Emergency Department
- NSW Women's Domestic Violence Court Advocacy Program
- Training Institute on Strangulation Prevention, San Diego
- Bonnie's Support Service
- Brain Injury Australia
- Westmead Children's Hospital Institute of Sports Medicine



Goal:
To ensure that people who experience Domestic and Family Violence (DFV) have the option of keeping a record about their health/symptoms that can be used when engaging with medical practitioners and specialists, in order to receive appropriate health supports.

DFV & My Health Individualised Recording System

In many cases, ABI can be hard to diagnose as there is no record of a person's injuries and symptom history. If people who experience violence had information about the health impacts of violence, they may choose to keep track of their health and seek support when it is safe for them to do so. Creation of a tool or system that supports people who experience DFV to track health changes, monitor the frequency and impact of physical assaults, take note of health management advice and strategies, or anonymously access specialist advice, may be useful for them in managing their safety and responses to violence.

Challenge:

Health tracking and symptom management may not always be a priority for a person experiencing violence and it is possible to attribute health changes to other conditions due to the time lapse between physical assault and experiencing symptoms (especially with strangulation and brain injury as a result of multiple concussions).

Strategy:

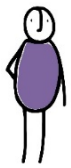
Ensure that people have access to information about the health impacts of violence, such as DFV-related ABI, so that they can make an informed choice as to whether to use a Health & DFV recording system.

Who has previously engaged in this type of project?

Previously a number of Apps, diaries & log-books have been created as ways for people experiencing violence to keep a record of the violence. It is unclear how well-used these tools are however, some of these tools could be adapted to include information/questions about a person's health changes after DFV assault.

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Eastern & Central Sexual Assault Service (Sydney LHD)
- Royal Rehab NSW
- Westmead Children's Hospital Institute of Sports Medicine



Goal:

- ***To implement targeted screening of people who have been assaulted and are at risk of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI).***
- ***To ensure that these people have access to early response targeted brain injury advice and support.***
- ***To record outcomes and impact in providing early supports for people who experienced a streamlined health response around DFV and ABI.***

Health Service Partnerships To Develop Streamlined Treatment Pathways

Leading practitioners within the public health service system, or community medical services, could explore opportunities to develop programs in which key health services implement a new response to the intersection of DFV and ABI. This could involve the creation of a streamlined response for people accessing the public health services or community medical services after a physical assault that injured their head, neck or airways. These services could conduct screening to identify risk of brain injury and could coordinate with brain injury services within their LHD. Examples of services that may see people at risk of ABI after a physical assault include: *Emergency Departments; General Practices; Women's Health Centres; Sexual Assault Clinics; Child Protection Units and Community Health Centres.*

Challenge:

Public health Brain Injury Rehabilitation Services have limited capacity and resourcing to work with people who have m-TBI or concussion, and it is common that a person may wait three months before referral to these services to allow for time to see if symptoms subside naturally. Some specialists assert that this is not best practice, however, as when a patient faces significant social stressors (such as DFV) their circumstances are more likely to impact upon their ability to recover from concussion and m-TBI.

Strategy:

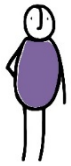
Health services interested in creating streamlined pathways might consider working with a rehabilitation service that responds specifically to concussion/m-TBI (such as a concussion clinic), or could work with specialists in private practice. Lead services may need to work collaboratively to develop a shared agenda around the need to respond early to patients who experience DFV and other circumstances that may affect their health.

Who has previously engaged in this type of project?

- Pennsylvania Coalition Against Domestic Violence
- Brain Injury Association of New York State

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Pennsylvania Coalition Against Domestic Violence



Goal:
To increase the likelihood that people who access Western Sydney EDs for Domestic and Family Violence (DFV) related injuries, will experience an Acquired Brain Injury (ABI) and DFV informed response.

Emergency Department TBI Screening Tool Project

Brain injury specialists could work with emergency department specialists to create a head injury/TBI screening tool to be used in Western Sydney LHD Emergency Departments (ED).

Currently not every person accessing EDs for assault is screened for head injury, as this is up to the discretion of the attending practitioner.

Challenge:

Hospital staff in Western Sydney state that due to the time constraints of ED work, as well as the high turn-over of staff and patients, tools are not used consistently within EDs. ED staff may require training about why and when to use the tool.

Strategies:

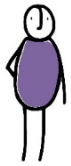
One way around this is to make the tool an electronic drop-down box on the existing patient information database being used in Western Sydney EDs.

Another way to balance this risk, could be to create promotional material to encourage ED doctors to use the tool, and to provide training in ED departments around the intersection of DFV and ABI.

A number of evidence-based concussion/m-TBI screening tools currently exist, though these do not generally explore DFV as a source of injury.

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Blacktown Hospital Emergency Department
- Brain Injury Australia



Goal:
To increase the likelihood that people who have experienced violence and access emergency responses receive a response that is Domestic and Family Violence (DFV) aware but also addresses key risk factors.

Training for Paramedics and '000' operators

Emergency responders who interact with people experiencing DFV at critical moments have an important role in providing responses that support a person's emotional and physical wellbeing and identify urgent safety risks caused by DFV.

Training could be developed that aims to equip '000' call operators and paramedics with information about DFV dynamics, concepts of safety, understanding resistance to violence, and, key risk factors that reflect key health and lethality risks.

Challenges:

There is a large amount of practitioners involved at this end of the service spectrum, and it could be a significant task to increase and maintain DFV awareness levels amongst this group of service responders.

Strategy:

DFV services and advocates could partner with key Health regulators and training providers who work internally with paramedics and '000' operators, to develop training that is rolled out regularly as part of ongoing professional development in these fields. In this way DFV services are able to contribute frontline knowledge but do not bear the burden of maintaining awareness levels amongst this large group of service responders.

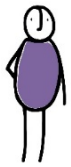
The *Australian Media and Communications Authority* could be an appropriate ally to target in this type of work as they regulate the provision of emergency call lines across Australia.

Who has previously engaged in this type of project?

The Training Institute on Strangulation Prevention have previously disseminated research on the low awareness of emergency responders in regards to DFV, especially around strangulation. This includes research from Australia that explored perceptions about DFV amongst students studying to become paramedics with the Emergency Medical Service.

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Training Institute for Strangulation Prevention, San Diego
- NSW Police Force, Domestic and Family Violence Team, Performance and Program Support Command



Goal:
To strengthen connections and awareness between the Health and Domestic and Family Violence (DFV) sectors so that people experiencing violence receive better, more coordinated responses that support their wellbeing.

Medical Advocacy Program in Western Sydney for responding to the links between DFV and various Health Issues, including ABI

The role of the Medical Advocate is to be informed about the intersections between DFV and health, provide knowledge and training to local doctors, nurses and DFV services in their area about these intersections, work with Health Professionals in their area to build access for people experiencing DFV, and influence policies and protocol at a local and state level.

DFV services could partner with NSW Health services to apply for funding to create two positions (due to the population density of Western Sydney) who could do this work in the region for three years and possibly on an ongoing basis.

Challenges:

A number of organisations are currently doing elements of this work in silos, advocating and creating awareness about specific health risks that relate to their work. There is a risk that the DFV and Health sectors are already over-committed in their partnerships and opportunities for learning.

Strategy:

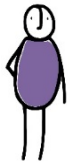
It will be essential for the Medical Advocates to connect with and work with the range of practitioners, services, and organisations within the Health and DFV Sectors who are already exploring some of the intersections between Health and DFV. For example: The Education Centre Against Violence, Women's Health NSW, NSW Health Domestic Violence Team, NSW Health Child Protection & Wellbeing, Domestic Violence NSW, Brain Injury Australia, People with Disability Australia etc.

Who has previously engaged in this type of project?

The Pennsylvania Coalition Against Domestic Violence has been using this model for several years. The coalition lobbied their state Health Department to fund a program that would employ a group of people to act as 'Medical Advocates' between the DFV sector and the Health sector in different parts of the state – there are now 35 Medical Advocates working across Pennsylvania who play a direct role in building relationships and awareness between and amongst DFV services and health services.

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Pennsylvania Coalition Against Domestic Violence



Goal: ***To strengthen connections between the community practitioners, Domestic and Family Violence (DFV) responders and specialist rehabilitation practitioners that result in increased treatment opportunities for people experiencing brain injury as a result of DFV.***

Increasing access to Rehabilitation Specialists in private practice for ongoing treatment of Acquired Brain Injury – all severities.

Alongside the vital response of public health services, private providers of brain injury rehabilitation or neurocognitive support also have a role to play in improving responses to the intersection of DFV & ABI. In the public system, options are limited for people experiencing concussion/mild or moderate TBI, and mild/moderate anoxic or hypoxic brain injury. Many of these patients are referred back to their private doctor, or advised to seek a specialist in private practice.

Access to rehabilitation specialists for people living in the community with forms of ABI that are not treated in the public system is dependant on factors such as: affordability, accessibility, and whether a person's doctor is aware of private rehabilitation services in their area.

Rehabilitation Specialists in private practice (including sports concussion clinics and head injury sleep clinics) can become prepared to support people experiencing the intersection of DFV and ABI in the following ways:

1. Learning about Domestic and Family Violence and safe responses to people who experience violence.
2. Making their services more well known amongst local doctors, Domestic and Family Violence services, and Women's Health Centres in their area.
3. Making their services accessible and affordable for a person experiencing DFV, considering that this person may not be able to afford private medical costs due to financial abuse or the financial pressures involved in escaping DFV.

Challenge:

Rehabilitation specialists are able to provide support for ABI but may not be equipped to provide information and support around Domestic and Family Violence.

Strategy:

Rehabilitation specialists who would like to provide services to people who experience DFV can access some of the resources outlined in this report to increase their understanding of DFV, concepts of safety and response, and risk factors, as well as referral pathways for DFV support.

Who has previously engaged in this type of project?

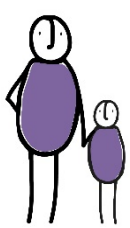
- Pennsylvania Coalition Against Domestic Violence (connecting DFV services with brain injury specialists in various communities across Pennsylvania)

DVSM thanks practitioners from the following organisations and services for their contributions in thinking about this idea:

- Brain Injury Specialists Sydney PTY LTD

SECTION 2

PROJECT RESOURCES



RESPONDER RESOURCES

DVSM DFV/ABI Resource 01: DFV & ABI Summary **(in development)*

DVSM DFV/ABI Resource 02: DFV & Concussion/m-TBI **(in development)*

DVSM DFV/ABI Resource 03: DFV & Strangulation **(in development)*

DVSM DFV/ABI Resource 04: DFV & Neurocognitive Difficulties **(in development)*

MAPS

Map 01: DFV/ABI Intersection – Responses and Service Pathways (Western Sydney)

Map 02: Accessing the Forensic Medical Unit (FMU) after physical or sexual assault (Western Sydney)

Map 03: Neurocognitive Changes after Physical Assaults – When and How to See a Neuropsychologist

Map 04: Community Medical Responses to Neurocognitive Symptoms that could reflect Acquired Brain Injury (ABI)

Map 05: Emergency Medical Responses After Assaults Causing Head Injury or Strangulation – Western Sydney

Table 01: Immediate, Short-Term and Long-Term Health Harms of Strangulation

OTHER RELATED DVSM RESOURCES

DVSM Social/Service Responder Resource: **Follow My Lead** (Concepts of Safety)

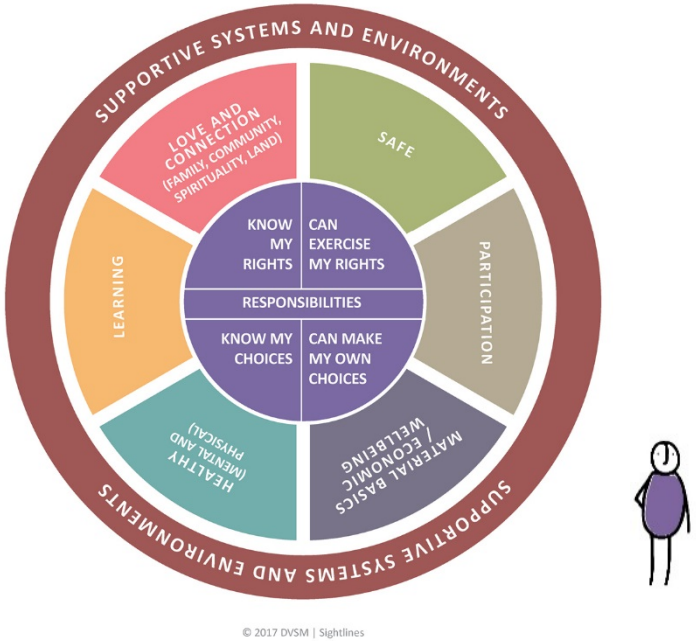
DVSM Social/Service Responder Resource: **'Mental Illness' 'PTSD' and the 'effects' of Violence and Adverse Life Experiences**

DVSM Social/Service Responder Resource: **Reflections Paper 2.1: An Exploration of the Intersection between DFV and ABI.**

**DVSM DFV/ABI Resources 01, 02, 03, & 04 are in development and will be made available via the DFV/ABI Report Website subject to a process of internal feedback and review with practitioners and people who use our services.*

Whole of Person, Person-Centred responses to the intersection of Domestic and Family Violence and Acquired Brain Injury

Wellbeing matters to adults, children and young people and this includes their safety. Being 'safe' is more than being physically safe – it includes all aspects of wellbeing.



Wellbeing can be defined as being made up of interdependent areas each of which will look different in each person's life. The value and weight of these will also change over time as a person's needs, priorities and circumstance change.

Domestic and Family Violence and Health responders play a critical role in responding to people who experience this intersection.

All supports for people experiencing this intersection need to be **informing, empowering** and **supportive of a person's long term wellbeing**.

Our collaborative efforts need to uphold a person's dignity, support their rights and choices relating safety and wellbeing, including their health.

How do we keep Domestic and Family Violence central to the picture?

When supporting people with a possible Acquired Brain Injury resulting from Domestic and Family Violence we must hold central that people experiencing this intersection face a range of risks to their safety and wellbeing caused by Domestic and Family Violence.

Domestic and Family Violence informed responses are based on an understanding of violence being a social issue, that:

(i) people resist violence to uphold their dignity and to manage risk and safety

(ii) people are already navigating their safety before they ever reach out for support. They are self-assessing the risks they face and use strategies to mitigate the risk of harm

(iii) any advice given or action taken by a practitioner may unintentionally or unknowingly increase the harm and threat that a person may face as a result of not fully understanding a person's situation and context.

Map 01 – Page 2 of 4 – DFV/ABI Intersection: Responses

This spectrum describes some ways that people accessing Domestic and Family Violence services may present.
These are based on descriptions by practitioners working in the DFV sector in Western Sydney. This is not an exhaustive list.

Person who requires immediate medical care

This is a person who is seen within seven days of experiencing an assault that was targeted at their head, neck, or airways (strangulation, suffocation) – serious health risks, such as stroke or death, are highest during this period. For further details about health risks see DVSM **Table 01 (DFV/ABI Project Report).**

The majority of people recover from minor head injuries, however, initial care of head injuries and strangulation injuries can influence the length and difficulty of a person's recovery.

If a person prefers not to access medical care at this time, services should provide information about health risks and medical options in a way that prioritises the person's safety, and upholds the person's dignity and choice.

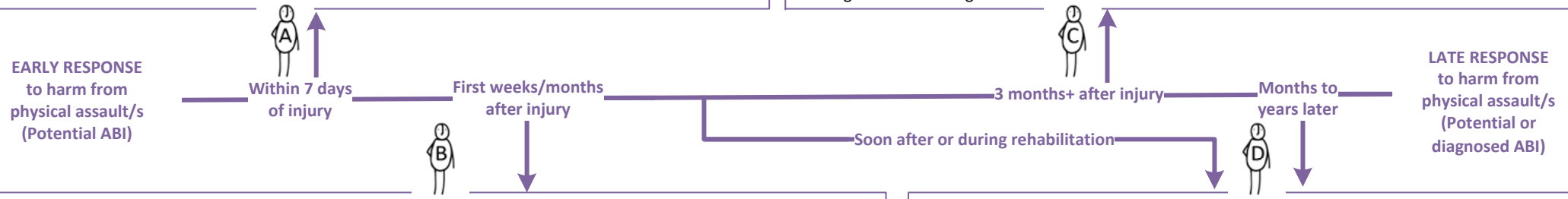
*This is also a key period for accessing forensic medical services to collect evidence of assault if this is desired by the person who was attacked. See DVSM **Map 02 (DFV/ABI Project).**

Person who may be experiencing undiagnosed ABI that has influenced their wellbeing for an extended period

This is a person experiencing Domestic and Family Violence (DFV) who has been experiencing neurocognitive changes and symptoms that may relate to physical assaults to the head, neck or airways that occurred in the past.

This person may not be aware that the assaults they experienced put them at risk of an ABI, and other 'diagnoses' or health concerns may be preferred by the person, or by the services they engage with. Nevertheless a person has a right to information and the opportunity to explore the possibility of brain injury further with health professionals. See DVSM **Map 03 (DFV/ABI Project)**.

DFV services may support a person in responding to the changes in health and wellbeing they have experienced as a result of violence. This may involve building on the existing knowledge of the person about the relationship between violence and their health, and supporting them in their strategies for wellbeing.



Person who may benefit from early intervention to reduce the long term impact of a possible ABI

This is a person who accesses support one week to three months after injury and has neurocognitive symptoms that developed after assault/s to the head, neck or airways. The early weeks and months after the assault/s are a key time for self-care and strategies that will reduce the long-term impact of brain injury. Strangulation in particular can cause serious harm weeks and months after an assault and the person should be informed about the risks and medical pathways for support.

This is a key period for the person to access a doctor or health practitioner who has knowledge of brain injury if they would like to support to reduce the long-term impact of assault/s on their health. See DVSM Map 04 (DFV/ABI Project).

The person may attribute their symptoms to other factors such as stress or illness. The simplest way to learn if physical attack/s may have affected a person's health is to ask about these experiences and if the person has noticed changes since the assault/s. This can be done in a way that explores a person's resistance and upholds their dignity.

Person with a diagnosed ABI who requires DFV Support

This is a person who may access DFV supports on exit from a brain injury unit in the hospital, or they may be living in the community with a diagnosed ABI and experiencing DFV. This person could have severe physical and cognitive impairments (i.e. limb paralysis, severe cognitive delay, hearing loss, visual impairment etc.) that may or may not have been caused by violence. The person may already have disability supports in place, or they may not be able to access disability supports due to the violence they are experiencing.

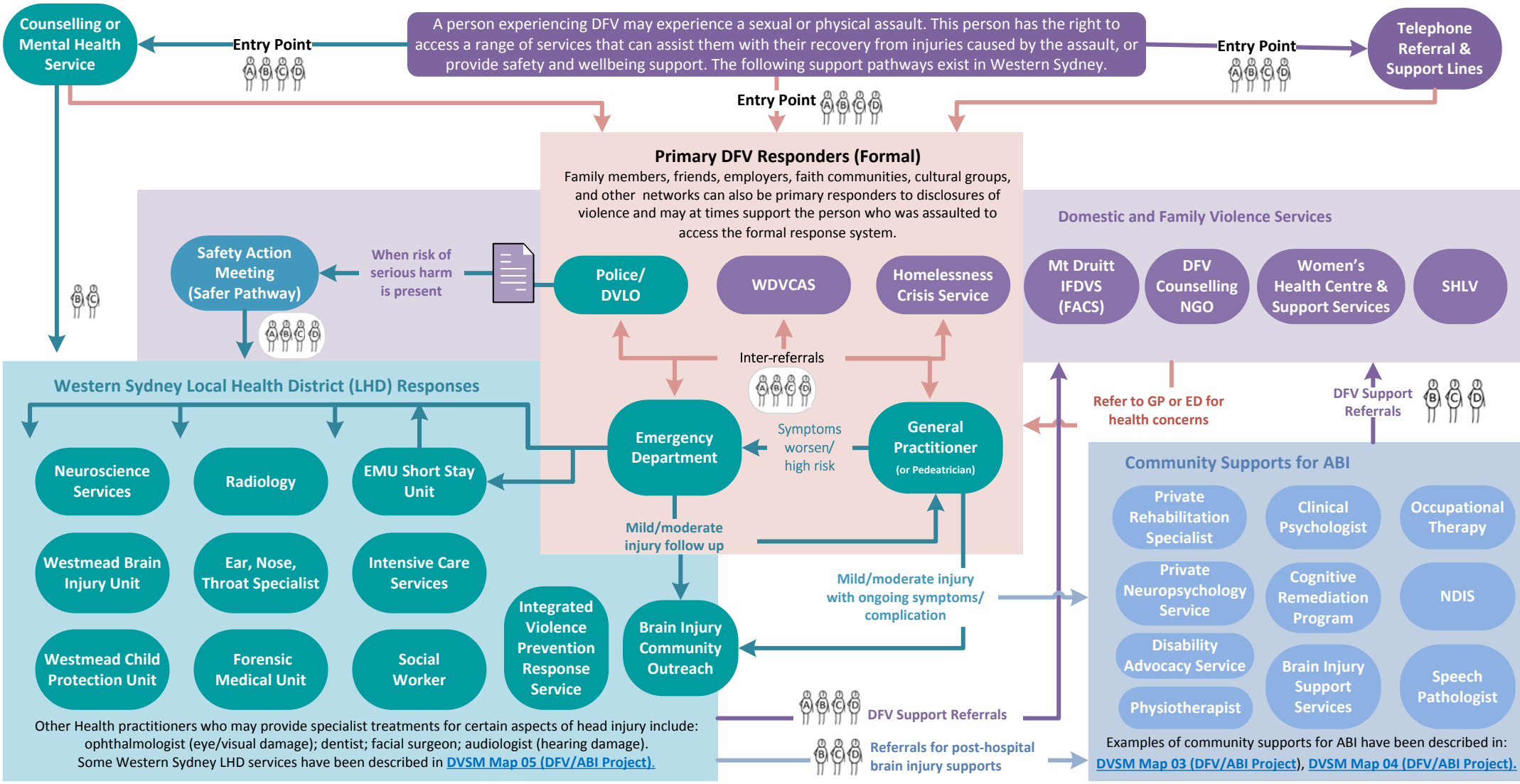
This person has the right to access DFV supports that are accessible for people with disabilities and understand the intersectionality of disability and violence. It is also crucial that they can access Disability Supports that have an understanding of:

- The range of behaviours that constitute DFV and risk factors for serious physical harm.
- Referral options for people experiencing DFV.

Acknowledgements – DVSM thanks practitioners from the following services for their feedback and contributions to this map: Liverpool Brain Injury Unit; The Education Centre Against Violence (NSW Health); Dr. Susan Pullman & Associates; Brain Injury Specialists PTY LTD.

Map 01 – Page 3 of 4: DFV/ABI Intersection: Responses and Service Pathways (Western Sydney)

Limitations: For more information on the intersection of DFV and ABI see Reflections Paper 2.1 An Exploration of the Intersection between DFV & ABI. The purpose of this map is to represent a menu of services and pathways that exist in Western Sydney for people experiencing the intersection of DFV and ABI. Access to these pathways is dependant on the awareness of organisations, institutions, and communities about the links between DFV and ABI. This is not an exhaustive menu of available services in Western Sydney. Access to some of these pathways and services is affected by service eligibility criterion. A person may access many or a few of the services in these pathways simultaneously. Coordinated, whole-of-person responses are key to supporting this person's wellbeing.



Safety: People experiencing Domestic and Family Violence (DFV) are already navigating their safety before they ever reach out for support. They are self-assessing the risks they face and use strategies to mitigate the risk of harm. Any advice given or action taken by a practitioner may unintentionally or unknowingly increase the harm and threat that a person may face as a result of not fully understanding a person's situation and context. Follow My Lead is a resource designed for all social and service responders to build awareness of concepts of safety in order to improve and inform responses.

Map 01 – Page 4 of 4: DFV/ABI Intersection: Responses and Service Pathways (Western Sydney) Professional Services

Telephone Support Lines (These are not exhaustive)

Link2home is a central referral line for anyone in NSW that is experiencing homelessness and requires emergency accommodation: 1800 152 152	**Domestic Violence Line** is a NSW state-wide telephone crisis counselling and referral service for women and persons who identify as female who are experiencing DFV: 1800 656 463	**Family Referral Service** provides referral information, advice and support for families with children who are at risk of harm but do not reach the threshold for FACS intervention: 1300 403 373	**1800RESPECT** provides telephone counselling, online counselling, information and referrals for people who experience sexual assault & DFV: 1800 737 732

Domestic & Family Violence Services (These are not exhaustive)

Women's Domestic Violence Court Advocacy Service (WDVCAS): provides information, assistance and court advocacy services for women and children experiencing DFV. The WDVCAS is also the Local Coordination Point for Safer Pathway referrals. Western Sydney WDVCASs are available at: Blacktown, Penrith and Parramatta. Referrals: 1800 938 227	**Mt Druitt IFDVS (FACS):** Integrated Family and Domestic Violence Service (IFDVS) is a multiagency response coordinated by FACS to prevent the escalation of Domestic and Family Violence among high risk target groups in targeted communities. The service is coordinated with Police, Health and non-government organisations.	**Homelessness Crisis Services:** includes (but is not limited to): Specialist Homelessness Services (SHS), emergency support services for people experiencing homelessness or at risk of homelessness; The Domestic Violence After Hours Response Service (DVAHS). DVAHS is the Domestic Violence Response Enhancement (DVRE) program for Western Sydney, providing flexible brokerage, wellbeing support, case management, assessment and referral after hours (weekends and week nights). DVRE funded programs are available in other areas also. For referral to SHS and DVRE programs call Link2Home: 1800 152 152.	**Women's Health Centres:** in Western Sydney these include: Blacktown Women's and Girl's Health Centre and Cumberland Women's Health Centre. Examples of other services that can provide support for women experiencing DFV in Western Sydney include: The Wash House and Immigrant Women's Speak Out.

DFV Counselling (NGO): A number of non-government organisations in Western Sydney can provide counselling services for people experiencing DFV. Examples include: Rosie's Place (children and young people); Blacktown Women & Girls Centre; Marrin Weejali Aboriginal Corporation; Relationships Australia.	**Staying Home Leaving Violence programs (SHLV):** aim to prevent homelessness by working with NSW Police to remove DFV perpetrators from the home so that women and children experiencing violence can remain (if that is their preference). SHLV programs in Western Sydney are run at Blacktown: 9677 1962, & Parramatta, Holroyd: 9636 8437

Western Sydney LHD Hospital Responses (These are not exhaustive)

Westmead Child Protection Unit: The Child Protection Unit provides forensic, medical and counselling health services for children, young people and their families following allegations of child abuse and neglect. CPUs provide NSW Sexual Assault services for children. CPUs works in partnership with FACS and the Police.	**General Practitioners (GPs) and paediatricians** in the community are likely to see people experiencing DFV who may also experience ABI. Resources are available to support doctors in having conversations about violence with their patients. See: DVSM Map 04 (DFV/ABI Project).	**Police / Domestic Violence Liaison Officers (DVLOs):** DVLOs are able to provide support and advice to people experiencing DFV. DVLOs are available in some Police Stations in Western Sydney.	**The Safety Action Meeting (SAM):** a part of the NSW Government's Safer Pathway response. The SAM is a meeting of local service providers to prevent or lessen serious threats to people experiencing domestic violence through targeted information sharing. The Domestic Violence Safety Assessment Tool (DVSAT) is used to identify risk of serious physical harm, and supports referrals to a SAM.

The Forensic Medical Unit (Western Sydney & Nepean Blue Mountains LHDs): provides forensic medical and nursing services. These services include examinations and collection of evidence for sexual assault cases and domestic violence cases. The unit also provides expert opinions for a range of assault matters. For information about accessing the FMU see: DVSM Map 02 (DFV/ABI Project).	**Westmead Brain Injury Unit:** one of the five inpatient Brain Injury Rehabilitation Programs (BIRPs) in Sydney. The unit provides multidisciplinary support for people recovering from a severe traumatic brain injury. Adult brain injury services exist at: Westmead Hospital, Liverpool Hospital, & Royal Rehab. Children's brain injury services exist at Sydney Children's Hospital & Westmead Children's Hospital.	**Brain Injury Community Outreach:** All Brain Injury Rehabilitation Programs in NSW have a community outreach service. The Brain Injury Community Outreach team at Westmead Hospital holds a clinic once a fortnight. The clinic will respond to any level of brain injury including concussion and mild-TBI. Referrals can be made by ED doctors, other hospital specialists, and general practitioners in the community. Written referrals required by Fax: 9635 8892 or Mail: Brain Injury Unit, Westmead Hospital, PO Box 533, Wentworthville NSW 2145

Community Supports for ABI (These are not exhaustive)

Private Neuropsychology Service: Neuropsychologists provides assessments that highlight any areas of cognitive, behavioural and emotional difficulty that relate to disorders of the brain, including ABI. See DVSM Map 03 (DFV/ABI Project) for processes around accessing a Neuropsychologist in Western Sydney.	**Cognitive Remediation program:** provides strategies, training and specialist support for people who have an impairment in cognitive domains such as memory, attention and problem solving etc. Some clinical psychologists can provide one to one cognitive remediation under Medicare.	**Private Rehabilitation Specialist:** Rehabilitation Specialists can work as practitioners in the community in private medical practices. An example of a brain injury rehabilitation service in Sydney that can bulk bill (in some circumstances) is: Brain Injury Specialists.	**Disability Advocacy Service:** can support someone living with brain injury to access the services they are entitled to as well as provide other forms of person-centred support. Examples include: People with Disability Australia; IDEAS and the Multicultural Disability Advocacy Organisation.

Brain Injury Support Services: In NSW there are various government and non-government services that provide support to people living with a diagnosed brain injury in the community. Some of these supports are outlined in the NSW Health - Care and Support Pathways for People Living with Acquired Brain Injury. Note: *The availability of some services in this document may have changed since the introduction of the NDIS*.	**NDIS (National Disability Insurance Scheme):** People with diagnosed brain injuries can sometimes access the NDIS, though this is very dependent on the severity of the injury, and on the provision of required evidence. To discuss the referral criterion and application process contact the National Disability Insurance Agency: 1800 800 110

Acknowledgements – DVSM thanks practitioners from the following services for their feedback and contributions to this map: Western Sydney Integrated Violence Prevention and Response Service; Forensic Medical Unit (Western Sydney/Nepean Blue Mountains); Blacktown Mt Druitt Hospitals Department of Social Work; Westmead Auburn Hospitals Department of Social Work; Westmead Hospital Brain Injury Unit; Hunter New England Brain Injury Unit; The Wash House and the Western Sydney Family Referral Service; Liverpool Brain Injury Unit; The Education Centre Against Violence (NSW Health); Dr. Susan Pullman & Associates; Brain Injury Specialists PTY LTD.

Safety: People experiencing Domestic and Family Violence (DFV) are already navigating their safety before they ever reach out for support. They are self-assessing the risks they face and use strategies to mitigate the risk of harm. Any advice given or action taken by a practitioner may unintentionally or unknowingly increase the harm and threat that a person may face as a result of not fully understanding a person's situation and context. Follow My Lead is a resource designed for all social and service responders to build awareness of concepts of safety in order to improve and inform responses.

A physical or sexual assault is committed

The person who was assaulted has the right to access forensic medical services to record evidence of the assault. This assault may have been part of a pattern of behaviours that constitutes Domestic and Family Violence (DFV). Specific DFV services also exist outside of the FMU to support this person with their safety and wellbeing. Forensic medical services for children are not accessed via the pathways portrayed here.

Key Referrers

- Police
- Emergency Department
- General Practitioner (or other doctor)
- Domestic and Family Violence Services

- The offence is reported to police and person who experienced violence consents to forensic examination at the FMU
- The offence is reported to police and no referral is made to the FMU (because of no consent or other reasons)
- The offence has not been reported to police but the person who experienced violence is supported to access the FMU by someone else or makes a self-referral

Medical evidence can be accessed at a later date for use in criminal proceedings/ ADVO applications

Forensic evidence collection in the FMU with counselling & support provided by the Integrated Violence Prevention Response Service (IVPRS)

- Integrated Violence Prevention Response Service (IVPRS)
- Forensic Medical Unit (FMU)

Forensic Evidence

- Kept on the medical record

AND

- Sent to police – with consent

OR

- Sent to police – without consent (due to risk of serious harm)

FMU Outward Referrals

Serious Health Issue/Risks

- Emergency Department
- General Practitioner (or other doctor)
- Domestic and Family Violence Services
- Other Support Services

Inter-referrals

Emergency Department

There are emergency departments at Westmead, Auburn, Blacktown and Mt Druitt Hospitals providing emergency medical services for the whole of Western Sydney Local Health District (LHD).
All of these emergency departments can refer to the Forensic Medical Unit (FMU) (Western Sydney LHD & Nepean Blue Mountains LHD). Pathways through emergency care after physical or sexual assault are outlined in DVSM **Map 05 (DFV/ABI Project).**

General Practitioner (or other doctor)

General Practitioners (and other doctors in the community such as specialists, paediatricians and psychiatrists) are likely to see patients with injuries caused by sexual or physical assault. There are a range of resources available to support community doctors in having conversations about violence with their patients. See DVSM **Map 04 (DFV/ABI project)**. General Practitioners can provide referrals to a FMU if the patient is an adult who wants and consents to have evidence of their injuries recorded. If the person with assault-related injuries is a child, reporting obligations apply, and referrals can be made to a Child Protection Unit for forensic evidence collection.

Forensic Medical Unit (FMU)

The FMU (Western Sydney & Nepean Blue Mountains LHD) – provides forensic medical and nursing services across Western Sydney (and the Nepean Blue Mountains). These services include examinations and collection of evidence for sexual assault cases and domestic violence cases. The unit also provides expert opinions for a range of assault matters. Referrals: **9881 7752**
Sexual Assault Assessments are available 24/7
Domestic Violence Assessments (Physical Assault) are by appointment only, in business hours.

Integrated Violence Prevention Response Service (IVPRS)

The Integrated Violence Prevention and Response Service (IVPRS) provides a coordinated approach to violence prevention and response across Western Sydney providing counselling and support services in the areas of: sexual assault; child protection; domestic violence, and for victims of crime. For referral to the sexual assault and domestic violence counselling programs:
Blacktown, Mt Druitt – **9881 8700** or Westmead - **8890 7940.**

Kept on the Medical Record

In situations where a service user decides that their evidence should not be sent to the police the evidence will become part of the medical record and can be accessed by the person who experienced violence at a later date, or can be subpoenaed by the courts for legal purposes.

Sent to Police – with consent

As the purpose of the FMU is to provide forensic assessments to assist with the judicial process, information and evidence collected is usually sent to police within 10 working days of being collected. This is fully explained to all service users and it is possible for a person to request that the evidence not be sent to police.

Sent to Police – without consent (due to risk of serious harm)

NSW Health Services have reporting obligations when there is risk of serious physical harm to a person experiencing DFV, for example: when the person has very serious injuries, has been assaulted with a weapon, or there is considerable threat to the person's or the general public's safety. These obligations are outlined in NSW Health Resource, **'Policy and Procedures for Responding to Domestic Violence.'**

Domestic and Family Violence Services

Domestic and Family Violence Services – there are a range of services across Western Sydney that can support a person who is experiencing DFV. DFV services exist to support the person with their safety and wellbeing and can build on a person's knowledge of safety and risks. A menu of DFV services in Western Sydney has been outlined in DVSM **Map 01 (DFV/ ABI Project).**

Other Support Services

For information about a range of other services in Western Sydney that may be able to support people experiencing violence and other social injustices, the following resources are helpful:

- **Community Resource Network**
- **Ask Izzy**
- **HS Net**
- **DVSM Services Directory**

Acknowledgements
DVSM thanks practitioners from the Forensic Medical Unit (WSLHD & NBMLHD) for their feedback and contributions to this map.

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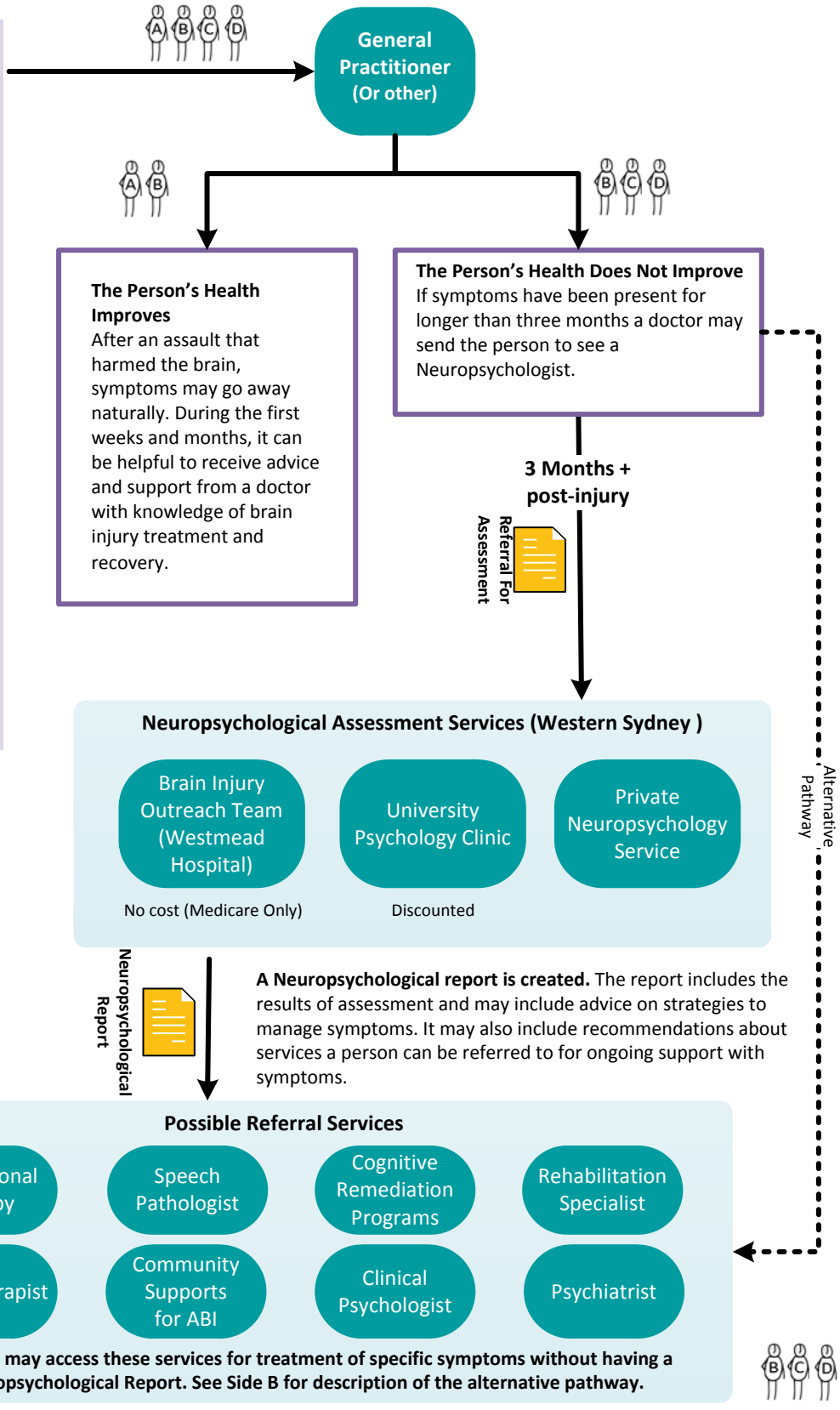
'Neurocognitive changes' means changes in parts of the brain used for everyday living. A person who has experienced DFV that included physical assaults to the head, neck, or airways, may be experiencing one or more of the following symptoms:

Headaches
Fatigue
Nausea
Insomnia
Low mood
Anxiety
Forgetfulness/memory problems
Difficulty with reading
Difficulty with communicating
Chronic pain
Difficulty with problem solving
Poor attention/concentration
Dizziness
Slow information processing
Seizures
Mood changes
Visual disturbances
Difficulty with planning
Loss of balance
Sensitivity to light

These symptoms may represent neurocognitive changes that reflect a possible Acquired Brain Injury (ABI).

A person may access many or a few of the services in these pathways simultaneously. Coordinated, whole-of-person responses are key to supporting this person's wellbeing.



These categorisations relate to DVSM Map 01 (DFV/ABI Project)

General Practitioner (or other)

All doctors can refer to a Neuropsychologist, this includes general practitioners, hospital or private specialists, psychiatrists and paediatricians. There are a range of resources available to support doctors, especially GPs, in having conversations about violence with their patients. These have been outlined on DVSM Map 04 (DFV/ABI Project).

The Person's Health Improves
Support from a doctor with awareness of concussion/mild-TBI and brain injury treatment and recovery, can help a person in managing their symptoms in the early stages of recovery. The person may ask their GP for referral to a doctor with specialist knowledge such as a brain injury rehabilitation specialist (see 'Private Rehabilitation Specialist' below).

Referral for Assessment
Referrals for Neuropsychological assessment can be made by a doctor only. If it is desired by the person being referred, non medical practitioners can provide supporting information that will support the Neuropsychologist in understanding the person's symptoms. A Neuropsychological assessment usually takes 3-4 hours. The person is asked to bring someone who knows them who will be asked questions about their level of neurocognitive functioning before the changes occurred.

The Neuropsychological Report
The Neuropsychological report outlines what areas of brain function have changed or have been impaired. The report may also make recommendations about what professionals or programs a person can access to treat or improve those areas that are impacted.

Neuropsychological Assessment Services (Western Sydney) (Not an exhaustive list)

Brain Injury Outreach Team (Westmead Hospital)

All Brain Injury Rehabilitation Programs in NSW have a community outreach service. Neuropsychological assessment can be accessed through the Brain Injury Outreach Team. Referral criteria apply. Written referrals required by Fax: 9635 8892 or Mail: Brain Injury Unit, Westmead Hospital, PO Box 533, Wentworthville NSW 2145.

Occupational Therapy

Occupational Therapy may be recommended to strengthen cognitive skills for certain day to day activities, for example: planning skills; or hand eye coordination.

Speech Pathologist

The report may advise a person to see a speech pathologist if a person's communication and voice have been affected by physical assaults that impacted the brain, and other organs that relate to speech.

Cognitive Remediation Programs

Cognitive Remediation Programs provide strategies, training and support for people who have experienced changes in certain areas of brain function, such as: memory, attention and problem solving. These are generally expensive programs but may at times be covered by the NDIS or private health insurance.

Physiotherapist

The report may advise the person to see a physiotherapist for support to strengthen muscles that will help improve a person's movements, balance and coordination.

University Psychology Clinic

Certain universities in NSW have psychological clinics through which a person can access neuropsychological assessment for a discounted price. The assessment is conducted by neuropsychology students under the supervision of senior practitioners. An example of a university offering these services is: Macquarie University.

Private Neuropsychology Service

A list of Neuropsychologists working in private practice in NSW can be accessed through the Synapse website. Synapse also provide brokerage for Neuropsychological Assessment in some circumstances.

Private Rehabilitation Specialist

Rehabilitation Specialists can work as practitioners in the community in private medical practices. One such private practice rehabilitation service in Sydney that can provide bulk billing in some circumstances is Brain Injury Specialists PTY LTD.

Clinical Psychologist

The report may recommend that a person see a clinical psychologist for counselling or for one-to-one cognitive remediation training.

Community Supports for ABI

Community supports for ABI may be recommended where a person requires ongoing supports to have their primary needs met. This could include assistance to access the Disability Support Pension, the NDIS and advocacy for systems and services to be more accessible for the person. See: DVSM Map 01 (DFV/ABI Project).

Psychiatrist

The report may advise the person to see a psychiatrist for medications or treatments for problems affecting a person's sleep and mood.

Alternative Pathway – If the person is able to access a doctor with knowledge of brain injury treatment and recovery, the doctor may be able to identify the primary symptoms of concern and refer the person directly to the appropriate practitioner from the list above. It can be difficult, however, to understand how a person's brain has been harmed by violence, especially when the assaults occurred a long time ago, or when a person has multiple health concerns and symptoms. In these circumstances **a Neuropsychological Assessment and Report** may be particularly useful in:

- Clearly identifying which functions of the brain are functioning well and which are in difficulty
- Outlining steps and a plan for treatment that the person can follow to improve overall brain health
- Providing evidence for NDIS applications, court cases, or other processes which require evidence that the person's brain has been harmed.

Acknowledgements – DVSM thanks practitioners from the following services for their feedback and contributions to this map: Liverpool Brain Injury Unit; Macquarie University Psychology Clinic; Dr. Susan Pullman & Associates; Royal Rehab NSW; and Hunter New England Brain Injury Unit.

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A person who has experienced DFV that included physical assaults to the head, neck, or airways, may be experiencing one or more of the following symptoms which could reflect a possible ABI:

Headaches
Fatigue
Nausea
Insomnia
Low mood
Anxiety
Forgetfulness/memory problems
Difficulty with reading
Difficulty with communicating
Chronic pain
Difficulty with problem solving
Poor attention/concentration
Dizziness
Slow information processing
Seizures
Mood changes
Visual disturbances
Difficulty with planning
Loss of balance
Sensitivity to light

A person experiencing Domestic and Family Violence (DFV) may be **punched** or **kicked in the head**, **hit over the head with an object**, **made to fall and hit their head**, **have their head shoved against a hard surface**, they may be **strangled**, **shaken**, **smothered**, **or sat on** in a way that causes **suffocation**. All such assaults put a person at risk of ABI. This risk increases with each subsequent physical assault.

A B C D

General Practitioner (or other)

Effective treatment and responses will be supported by knowledge of:

- The range of behaviours that constitute DFV and risk factors for serious physical harm
- Referral options for people experiencing DFV
- The patient's history of injury
- The patient's history of symptoms
- The ABI-related health risks caused by DFV, including: concussion and other traumatic brain injury (TBI), anoxic/hypoxic brain injury, and other harm from strangulation or suffocation. See DVSM DFV/ABI Project Report
- Best practice in responding to these health risks
- Which specialist services for brain injury exist (see below).

The following support pathways exist and can be explored with the person

Scans show evidence of injury OR person has ongoing complaints consistent with ABI symptoms

Brain Injury Services

- Brain Injury Community Outreach
- Private Rehabilitation Specialist
- Private Neuropsychology Service

Brain injury service or specialist may provide advice to referring doctor re: patient's ongoing treatment and referral needs.

Violence and Abuse: Has the person been supported re: their safety and wellbeing?

Support for safety (inc. physical, emotional, financial, social wellbeing)

Domestic and Family Violence Services

Serious health issue/risk

Emergency Department

Doctor provides a medical response for individual neurocognitive symptoms and these are effective in improving overall health.

Violence and Abuse: Has the person been supported re: their safety and wellbeing?

Alternative diagnosis or co-morbid health issue

Other Services

- Mental Health Service
- Drug and Alcohol Service
- Pain Specialist/ Treatment

Person's neurocognitive symptoms recede as they engage in treatments for alternative or co-morbid health issue.

Violence and Abuse: Has the person been supported re: their safety and wellbeing?

A person may access many or a few of the services in these pathways simultaneously. Coordinated, whole-of-person responses are key to supporting this person's wellbeing.

General Practitioner (or other)

Doctors working in a community setting are likely to see people experiencing the intersection of Domestic and Family Violence (DFV) and ABI. This includes general practitioners (GP), private specialists, psychiatrists and paediatricians. There are a range of resources available to support doctors, especially GPs, in having conversations about violence with their patients. This may include asking questions about a person's experiences of physical assaults that harmed their head, neck or airways.

These categorisations relate to DVSM Map 01 (DFV/ABI Project)

Emergency Department

In certain circumstances a person should be sent to the **emergency department (ED)**, especially if the assault was recent and the patient has high risk symptoms i.e. a changed voice within one week of being strangled; amnesia, nausea or fainting within one week of being hit on the head, or after asphyxiation by smothering.

Strangulation Assessment

Concussion/ TBI Assessments

The following guidelines provide instruction on medical assessment and referral to the ED after head injury or strangulation:

- The Royal College of Pathologists guidelines for 'Clinical Forensic Assessment and Management of Non-Fatal Strangulation', 2018.
- The NSW Motor Accidents Authority guidelines 'Mild Traumatic Brain Injury following Closed Head Injury', 2008.
- The Agency for Clinical Innovation guidelines for 'The Initial Management of Closed Head Injury in Adults', 2011.
- NSW Health Guidelines, 'Infants and Children: Acute Management of Head Injury', 2011.

At the time this map was developed, guidelines on medical response to asphyxiation by suffocation were not available.

Domestic Violence Services

DFV services can build on a person's awareness about DFV risks and safety, and provide responses that support their wellbeing, including their health. See DVSM Map 01 for a wider menu of services available specifically for people experiencing DFV. Or check the Health Pathways website for localised referral information around abuse and violence. Examples of state-wide services include:

Domestic Violence Line: a NSW state-wide telephone crisis counselling and referral service for women and persons who identify as female who are experiencing DFV: **1800 656 463**

Family Referral Service: provides referral information, advice and support for families with children who are at risk of harm but do not reach the threshold for FACS intervention: **1300 403 373**

1800RESPECT: telephone counselling, online counselling, information and referrals for people who experience sexual assault & DFV: **1800 737 732**

Brain Injury Services

All Brain Injury Rehabilitation Programs in NSW have a community outreach service. The outreach teams receive referrals for people living in the community who may be impacted by a brain injury but do not meet criteria for inpatient services. The Brain Injury Community Outreach team at Westmead Hospital holds an outreach clinic once a fortnight that can provide assessment and advice for a person with any severity of brain injury. Written referrals required by Fax: 9635 8892 or Mail: Brain Injury Unit, Westmead Hospital, PO Box 533, Wentworthville NSW 2145.

Rehabilitation Specialists with knowledge of brain injury can work as practitioners in the community in private practice. One example of a rehabilitation practice in Sydney that can provide bulk billing in certain circumstances is Brain Injury Specialists PTY LTD.

Neuropsychologists provide in depth assessments that highlight any areas of cognitive, behavioural and emotional difficulty that relate to disorders of the brain, including ABI. See DVSM Map 03 (DFV/ABI Project).

Responding to individual symptoms:

In some cases referral to brain injury services or other support services related to ABI may not be appropriate – for example, when a patient does not meet criterion for referral. In such cases the person's doctor can work with the them to monitor and treat individual symptoms. The doctor may also make referrals for specialist treatment of the individual symptoms that are the priority of the patient, for example, to a sleep specialist, or to a speech therapist. The Health Pathways site may have details about local specialist services for treatment of these symptoms.

Violence and Abuse:
Has the person been supported re: their safety and wellbeing?

Increasing awareness about violence and brain injury to support effective responses:

The range of behaviours that constitute DFV and risk factors for serious physical harm:

- Review The Whitebook - Abuse & Violence: Working with our Patients in General Practice (RACGP)
- Become familiar with the Domestic Violence Safety Assessment Tool Guide
- Use the NSW GPs Toolkit: It's time to talk, 2013

Referral options for people experiencing DFV:

- Look at DVSM Map 01 (DFV/ABI Project).
- Use the Health Pathways site to find out about DFV services in the Local Health District.

The ABI-related health risks caused by DFV, including: concussion and other traumatic brain injury (TBI), anoxic/hypoxic brain injury, and other harm from strangulation or suffocation:

- See: DVSM Reflections Paper 2.1 An Exploration of the Intersection between DFV & ABI
- See: DVSM DFV/ABI Project Report

Practice guides for responding to these health risks:

Partially addressed in ED Response Box – Alternative resources include:

- The University of Sydney 'Clinical Practice Guidelines for the Care of People Living with Traumatic Brain Injury in the Community', 2006. *Provides guidance for general practitioners on supporting people with co-morbid TBI and mental health or AOD concerns, includes concussion tools, symptom checklists, medication etc.*
- NSW Government, 'Care and Support Pathways for People with an Acquired Brain Injury: Referral and Service Options in NSW', 2011 – *At the time this map was developed this document was being updated.*

Acknowledgements – DVSM thanks practitioners from the following services for their feedback and contributions to this map: A medical educator (RACGP) five NSW general practitioners (RACGP); The Brain Injury Unit at Royal Rehab NSW; and, Sydney LHD Sexual Assault Service.

Safety: People experiencing Domestic and Family Violence (DFV) are already navigating their safety before they ever reach out for support. They are self-assessing the risks they face and use strategies to mitigate the risk of harm. Any advice given or action taken by a practitioner may unintentionally or unknowingly increase the harm and threat that a person may face as a result of not fully understanding a person's situation and context. Follow My Lead is a resource designed for all social and service responders to build awareness of concepts of safety in order to improve and inform responses.

About these Pathways: these pathways represent certain common responses for a person who attends an Emergency Department after an assault that caused head injury or involved strangulation or suffocation. Some other factors, such as the overall welfare of the patient, other serious injuries, or safety issues, may lead to alternative treatment pathways and hospital responses that are not represented here.

A person experiences a physical or sexual assault that caused harm to their head, neck or airways.
This assault may have been part of a pattern of behaviours that constitutes Domestic and Family Violence (DFV).

Western Sydney Emergency Departments (ED)

- Auburn ED
- Mt Druitt ED
- Westmead ED
- Blacktown ED

Information on WSLHD Responses & Policies on Side B

Symptoms worsen after discharge

Discharge & Follow-Up

- **General Practitioner (GP)** — Discharged with Mild Head Injury management advice sheet and advised to follow up with a GP

Symptoms improve over four hours

Mild Symptoms

Complex symptoms requiring specialised support

Serious Symptoms or High Risk Presentation

Symptoms Improve

Symptoms worsen or remain at risk level

Referred for Non-medical Reasons

- **Brain Injury Community Outreach** — Complex symptoms requiring ongoing support

Referred to services in Western Sydney Local Health District (LHD) according to injury severity/ patient needs

- Intensive Care Services
- Ear, Nose, Throat Specialist
- ED Short Stay Unit (EMU)
- Neuroscience Services
- Westmead Brain Injury Unit
- Vascular Specialist
- Child Protection Unit
- Social Work Services
- Integrated Violence Prevention Response Service

If Physical Evidence of DFV/ Sexual Assault Exists

- Forensic Medical Unit

See DVSM Map 02 (DFV/ABI Project)

Community Supports

- Brain Injury Support Services
- Domestic and Family Violence Services
- Other Community Supports

More information on Community Supports in Western Sydney, see: DVSM Map 01 (DFV/ABI Project)

Key Policies and Procedures in Western Sydney LHD Emergency Departments

NSW ETP Policy – the ETP is a state-wide target that stipulates the time-frame in which a certain number of patients must be admitted, referred or discharged after accessing any ED. This means that people may be discharged quite rapidly after a head trauma – potentially before some symptoms have developed.

'WSLHD Procedure for the Management of Victims of Assault who have Suffered Attempted Strangulation' (Version 3): all EDs in Western Sydney are subject to a strangulation screening policy and procedure. It stipulates how people who have been subjected to strangulation are to be investigated and managed in the ED. If external service providers have concerns for a person's wellbeing after strangulation they may consider advising them to access their local ED for strangulation screening.

NSW Health Management of Closed Head Injury in Adults Policy – this document highlights the processes and procedures by which head injury is initially assessed in NSW hospitals. Pages 28-29 hold a copy of the mild-head injury discharge advice sheet that is given to patients being discharged from an ED.

NSW Health Policy, Infants & Children: Acute Management of Head Injury – this document highlights the processes and procedures by which head injury of infants and children are initially assessed in NSW hospitals. See page 7: a process map for this patient group which differs slightly to this map. The mild-head injury discharge advice sheet that is given to parents/guardians of infants or children being discharged can be found on the websites of all three children's hospitals in NSW.

Westmead Brain Injury Unit

The Westmead **Brain Injury Unit** is one of the five inpatient Brain Injury Rehabilitation Programs (BIRPs) in Sydney. The unit provides multidisciplinary support for people recovering from a severe traumatic brain injury. Adult brain injury services exist at: Westmead Hospital, Liverpool Hospital, & Royal Rehab. Children's services exist at Sydney Children's Hospital & Westmead Children's Hospital.

Intensive Care Services

Intensive Care Services support patients who are in a critical condition and need intensive support and monitoring.

Neuroscience Services

Neuroscience services include: neurology, neurosurgery and neurophysiology – all specialities that relate to the functioning of the brain and spinal cord.

Ear, Nose, Throat Specialist

Referral to an **Ear, Nose & Throat Specialist (ENT)** may be required where a person has internal injuries to their neck and throat caused by strangulation. ENTs can conduct tests to rule out certain risks associated with strangulation.

Vascular Specialist

Referral to a **vascular specialist** may be required where a person has strangulation injuries or internal neck injuries of concern. Vascular specialists are skilled in treating diseases and injuries affecting a person's arteries and blood flow.

Child Protection Unit

The **Child Protection Unit (CPU)** provides forensic, medical and counselling health services for children, young people and their families following allegations of child abuse and neglect. The CPU incorporate NSW Health Sexual Assault Services for Children. The CPU works in partnership with FACS and the Police.

Brain Injury Community Outreach

The **Brain Injury Community Outreach** team at Westmead hospital holds a clinic once a fortnight. The clinic will respond to any level of brain injury including concussion and mild-TBI. Referrals can be made by ED doctors, other hospital specialists, and General Practitioners in the community. Written referrals required by Fax: 9635 8892 or Mail: Brain Injury Unit, Westmead hospital, PO Box 533, Wentworthville NSW 2145

Forensic Medical Unit

The **Forensic Medical Unit (FMU)** provides forensic medical and nursing services across Western Sydney and the Nepean Blue Mountains. These services include examinations and collection of evidence for sexual assault cases and domestic violence cases. As the FMU exists to document physical evidence of assault referrals can be made regardless of the severity of a person's head trauma, as long as physical evidence exists (i.e. bruises, swelling, cuts etc.). See DVSM Map 02 (DFV/ABI Project).

Social Work Services

Hospitals in the Western Sydney have **Social Workers** available to support people who access hospital services. They provide individual, couple and family counselling and practical support to assist patients in the management of illness, adjustment to changes related to health, or in increasing wellbeing.

Integrated Violence Prevention Response Service

The Integrated Violence Prevention and Response Service provides a coordinated approach to violence prevention and response across Western Sydney providing counselling and support services in the areas of: sexual assault; child protection; domestic violence, and for victims of crime. For referral to the sexual assault and domestic violence counselling programs: Blacktown Mt Druitt – 9881 8700 or Westmead - 8890 7940

Domestic and Family Violence Services

Domestic and Family Violence services – there are a range of services across Western Sydney that can assist women and children experiencing Domestic and Family Violence. These have been outlined in more detail on DVSM Map 01 (DFV/ ABI project).

Brain Injury Support Services

In NSW there are various government and non-government services that provide support to people living with a diagnosed brain injury in the community. Some of these supports are outlined in the NSW Government Resource: Care and Support Pathways for People with an Acquired Brain Injury. *Availability of some services in this document may have changed since the introduction of the NDIS.*

Acknowledgements – DVSM thanks practitioners from the following service for their feedback and contributions to this map: Forensic Medical Unit (WSLHD & NBMLHD), Blacktown Hospital Emergency Department & the Education Centre Against Violence (NSW Health).

SIDE A – Table 01: Immediate, Short-Term and Long-Term Harms of Strangulation

Safety: People experiencing Domestic and Family Violence (DFV) are already navigating their safety before they ever reach out for support. They are self-assessing the risks they face and use strategies to mitigate the risk of harm. Any advice given or action taken by a practitioner may unintentionally or unknowingly increase the harm and threat that a person may face as a result of not fully understanding a person's situation and context. Follow My Lead is a resource designed for all social and service responders to build awareness of concepts of safety in order to improve and inform responses.

Timeframe of risk or possible identification	Cervical Spine Injury	Neck Fractures	Heart Attack	Airway Swelling or Collapse	Voice Changes	Miscarriage	Foetal Brain Damage	Internal Bleeding (Hematoma)	Lung Disease (Pneumonitis)	Blood Clot (Thrombosis)	Swollen Blood Vessel (Aneurysm)	Limb Paralysis or weakness	Diagnosis of PTSD/ Anxiety / Depression	Dementia	Parkinsons Disease (Vascular)	Disability	Neck Pain	Headaches	Memory Loss	Hypoxic/ Anoxic Brain Injury	Stroke	Death
Moments to weeks after assault						*						***						***	***			
Weeks to months after assault												***						***	***			
Months to years after assault														***	***	***		***	***		*	

* = Indicates that a definitive causal link has not yet been established in the research, but a body of case studies exists.

*** = This could be a secondary symptom that may occur if strangulation has caused hypoxic/anoxic brain injury.

NOTE: this table does not provide a comprehensive list of all the health conditions and problems that can be caused by strangulation, however, it does cover a range of issues that have been consistently documented by practitioners working with people who have experienced strangulation.

Strangulation and Hypoxic/Anoxic Brain Injury

Strangulation has the effect of cutting off blood flow to the brain by restricting the blood vessels in the neck (blood vessels that carry oxygen-rich blood to the brain). When oxygen-rich blood is cut off from the brain the following things may happen:

After 7 seconds – the person being strangled can become unconscious or faints
After 15 seconds – the person being strangled can lose control of their bladder
After 30 seconds – the person being strangled can lose control of their bowels
After 1 minute – the person being strangled can die.

If a person survives a strangulation assault the brain may not fully recover, especially if a large amount of brain cells have died. This is called an anoxic brain injury.

A person may also experience hypoxic brain injury if they were unconscious for an extended period of time after being strangled, or if they have a stroke as a result of strangulation.

Hypoxic/anoxic brain injuries can lead to a number of health conditions and difficulties including: limb weakness and balance issues; physical tremors; changes in vision; memory problems; speech and language difficulties; mood changes; difficulty with planning and problem solving; headaches; vascular Parkinson's disease; dementia and other neurocognitive impairment. Suffocation can also cause Hypoxic brain injury.

The **DFV/ABI Project Report** provides more detailed descriptions of the differences between strangulation and suffocation.

Plain language descriptions to listen out for:

It is very unlikely that a person will use words like 'strangulation' or 'suffocation' to describe assaults that put them at risk of a possible Acquired Brain Injury resulting from anoxia or hypoxia.

Listen out for descriptions such as:

- "choked me"
- "pressed me up against..."
- "held me by the neck"
- "squeezed my neck"
- "hands around my neck"
- "tied me up around the neck"
- "throttled me"
- "had me in a choke hold"
- "sat/lay on top of me/on my chest"
- "pinned me down"
- "held me around the chest and squeezed"
- "covered my mouth with..."
- "smothered me"
- "gagged me"
- "tried to drown me"

(note: drowning is not suffocation, or strangulation, but has the same effect as these assaults – causing hypoxia, and possible ABI).

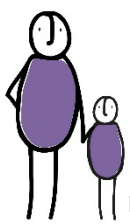
Resources for responding to disclosures that could reflect strangulation or suffocation are outlined in the **DFV/ABI Project Report.**

This resource is informed by:

- Queensland Health, '**Non-Lethal Strangulation in Domestic and Family Violence'**, June 2017
- Synapse, '**Types of Brain Disorders: Anoxic & Hypoxic Brain Injury**', date unknown.
- Headway UK, **Effects of Hypoxic/Anoxic Brain Injury**, date unknown.
- Victorian Order of Nurses (Canada) , **'Identification, Care and Advocacy of Strangulation Victims – Information for Frontline Workers and Crisis Advocates'**, 2010.
- Utley, **Katherine, Health Issues result from strangulation**, 2014.
- Smock, Bill, **'Dr Smock's Top 25 Medical Consequences resulting from strangulation and vascular neck restraint'**, 2017.

Acknowledgements: DVSM acknowledges and thanks the Medical Director, Ambulatory & Primary Healthcare, Illawarra Sexual Health (also a Clinical Associate Professor, University of Sydney & University of Wollongong) for providing ongoing feedback and significant contributions in developing this resource.
DVSM also thanks practitioners from the Forensic Medical Unit (Western Sydney & Nepean Blue Mountains LHDs) for their feedback.

GETTING STARTED | GETTING INVOLVED



The framework used for the methodology of this project (see Project Methodology) can be applied broadly to guide other services who are engaging with the intersection of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI), for the first time, and by those seeking to adapt what they already do.

GETTING STARTED:

STAGE 1 – BECOMING INFORMED

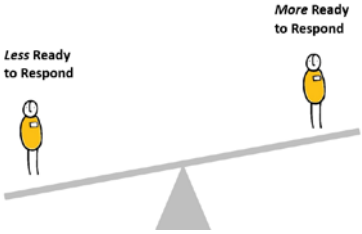
Becoming informed involves undertaking a self-assessment about where we are at and what is needed. We then have greater clarity on how much distance there is between where we are at and where we need to be.

This project report can be used as a resource to inform a self-assessment of awareness and response.

1. Build Awareness and Reflection re: Concepts of Safety:

Read and reflect on **Follow My Lead (for Social/Service Responders)**

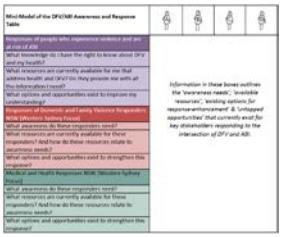
- What insights are offered in these messages?
- What might these messages mean for your processes and practice?
- Who in your context can support awareness, reflection and change?



2. Sense check how prepared you are re the DFV/ABI Intersection:

Read and reflect on the **Awareness Scenarios** (pages 76-84)

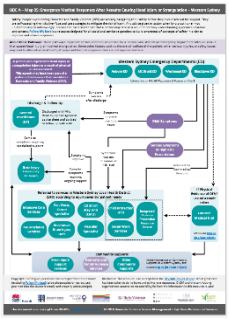
- What scenarios are useful within your context?
- What other scenarios do you need to become prepared for?
- Who in your context can develop these with you?



3. Take up or adapt the awareness menu and resources on offer

Read and reflect on the 'DFV/ABI Awareness and Response Table' (pages 27-40)

Explore and adapt the resources outlined in the 'DFV/ABI Awareness and Response Table'**:**



- Explore and reconcile the resources with what you already have that works, and/or
- Plan how to take them up as complimentary.

Explore and adapt the project maps:

- Identify who/what is in the map that you may not have known, and if/where you fit if your service is not already visible
- Consider if/how the equivalent maps can be made in your area to more accurately represent the names and pathways for your context.

STAGE 2 – TAKING A STANCE

4. Reflect on where you are up to and where you want to be

- How aware are your colleagues about the intersection of DFV/ABI?
- What might have contributed to where your organisation/service is up to?
- How open and ready are your colleagues to adapt/flex their practice?
- Where do you want to be as a responder to this intersection?
- Of all the things you could do next what would have the greatest returns for people experiencing DFV/ABI?

5. Set an aligned approach

- Who needs to be aware and involved in changing policy, process, practice?
- Who needs to be involved in any organisational decision? What doesn't need a decision?
- Who will be the people who implement the change?
- What will engage and align decision makers and implementers so that change is sustained?

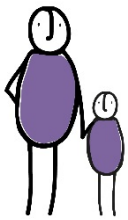
STAGE 3 – REACHING OUT

6. Seek support and secure collaborators

- Who can support you with changing current awareness levels?
- Who can support you with improving responses?
- Who can you work with more proactively to improve coordination of responses?
- Who can you seek feedback from to know that improvements have been made and what more needs to be addressed?

7. Explore opportunities

- Which of the identified opportunities in the project report can you contribute to or replicate in another area?
- What other opportunities can you see and who might you approach for collaboration?

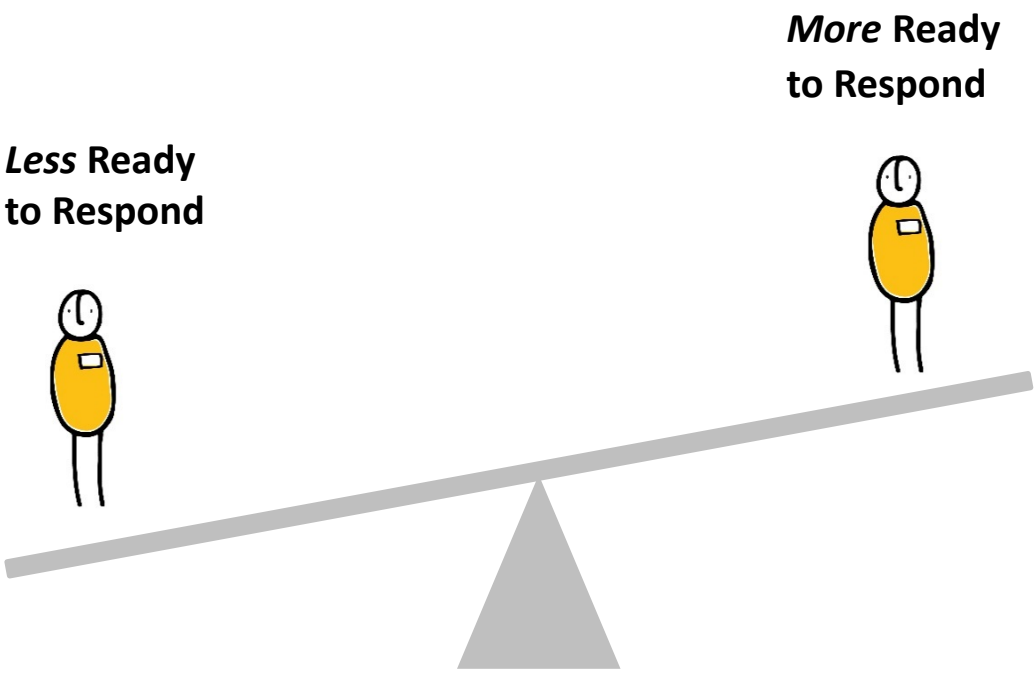


How informed are you about the intersection of Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI)?

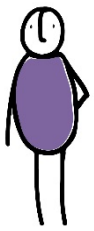
How might that impact your readiness to respond?

The following pages provide examples of scenarios where 'awareness' can significantly inform practice, identification, and response. These examples straddle a range of situations where a person experiencing the intersection of DFV/ABI may access support, however these are by no means exhaustive.

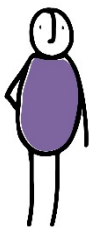
Making your own example scenarios to add to this collection may be a next step in considering how to enhance responses within your unique practice setting.



Ref	Description
01	Person discloses at Initial Assessment
02	Person in temporary accommodation
03	Person with undisclosed disability
04	Person having difficulties in finding work
05	Person seeking GP advice
06	Young person having difficulties at school
07	Person discloses DFV to GP
08	Person discloses DFV to Health Service
09	Person providing a DVEC Statement to police after a Physical Assault



Person discloses at Initial Assessment



A Case Manager from a DFV service is working through an initial assessment with a person who is experiencing Domestic and Family Violence (DFV) and has established a foundation of safety and confidentiality with the person. Together they explore the kinds of coercive control that the person is experiencing. When talking about sexualised and physical violence the person states:

"Well he choked me a little but he wasn't too rough. It's just a relief that I have no bruises or marks this time. That's something. I know other people get way more messed up than me by their partners."

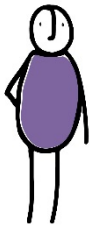
Practitioner who is *less* ready to respond

- Hears the person's descriptions of physical violence but underestimates the significance of strangulation.
- Hears the reference to strangulation but focuses on lethality risks and doesn't support the person to become aware of the potential health risks of strangulation and possible health supports.

Practitioner who is *more* ready to respond

- Knows not only about the lethality risks of strangulation, but is also informed of the health risks, and knows that a lack of bruising or external injuries does not mean there is no health risk.
- Sensitively works to build on the awareness of the person about the risks of strangulation both as a sign of lethality and as a risk for internal injuries and other harms to health.
- Knows about and can explain the importance of timing in seeking medical support for strangulation.
- Is able to support the person to access local health services.
- Knows what can be done to support a person to collect evidence that they were strangled, even when there are no external injuries (i.e. informs person of the forensic value of not washing soiled clothing and not showering before a medical examination).

Person in Temporary Accommodation



A DFV case-worker has decided to check in with a service user after being informed that the person was in Temporary Accommodation (TA) over the weekend after being physically assaulted by their partner and leaving their shared home. The case-worker goes and visits the person at TA. During the discussion the person reveals that she has been experiencing: *headaches, fatigue, difficulty falling asleep, jumpiness, and has generally been feeling really up & down since the assault.* The service user also said that she has been taking extra medication (a benzodiazepine) to try and get to sleep.

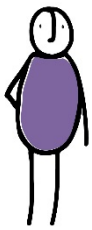
Practitioner who is *less* ready to respond

- Knows that the person has been assaulted, but does not know what questions to ask to ascertain what health risks the person may face as a result of the assault, and/or
- Knows the person has been assaulted but focuses on benzodiazepine use and trauma as the probable cause of the person's symptoms, and/or
- Supports the person to see a doctor, but does not provide the person with information about the specific risks/aspects of injury which it may be helpful to share with the doctor if the person feels safe to.

Practitioner who is *more* ready to respond

- Knows to ask the person about how they were assaulted, and what happened in their body during/after the assault.
- Knows what health risks are associated with physical assault and can discuss these sensitively with the person where relevant to their experience.
- Knows about the potential intersectionality of AOD use and ABI – and can support the person with timely information in their self-assessment of safety and medication use.
- Supports the person to access appropriate medical supports and to share relevant information about injuries if they feel safe to do so.
- Applies strategies for supporting person with their physical and emotional wellbeing.

Person with undisclosed disability



A person is referred to a Domestic and Family Violence (DFV) service and little information is provided about their health history in the referral. The person states that they have a disability but does not say which disability. After a few days of working with the person workers start to feel that they are struggling to communicate well with them. They notice that the person is often frustrated during interactions with workers; seems to forget many conversations, appointments and plans; and often presents as having slurred or delayed speech. The person seems to have no other services supporting them.

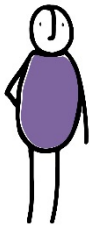
Practitioner who is *less* ready to respond

- Hears that the person has a disability but believes they cannot support the person well unless they know what the disability is.
- Sees that there is a communication barrier between worker and the person but does not change communication approach or tries new communication strategies without consulting the person.
- Sees that the person is frustrated with the service but does not adapt service provision.
- Assumes that alcohol or other drugs are the cause of difficulty when this has not been communicated by the person, or evidenced in any other way.
- Does not know that specialist disability advocacy groups exist that can help.

Practitioner who is *more* ready to respond

- Understands the social model of disability and aims to provide accessible, person-centred support to every person while respecting their right to privacy.
- Understands that there is a communication barrier between worker and person, can explore strategies with the person about how best to communicate with them, and is aware of some strategies that may work but consults the person about these.
- Understands that services can be adapted to increase accessibility for this person and is committed to doing this in their own work.
- Understands that person's slurred/delayed speech could relate to a number of health impacts of DFV or could be a feature of disability. Keeps an open mind about this.
- Is aware of/seeks information about local disability assessment, support and advocacy services that are available to the person if they choose to access further supports.

Person having difficulties in finding work



A service user and their case-worker have a good relationship and the person has started sharing about their current difficulties in finding work.

The person states: "*I used to run an office with over a hundred staff. It was crazy - I was an Executive Assistant managing appointments, running events and answering heaps of emails every day… and now I can't even get a job in a cafe. I can't do anything right anymore.*"

The worker has noticed that the person has memory problems, feels anxious often and struggles with writing. The worker has assisted the person in writing several job applications and notices that the person has difficulty with grammar, spelling and sentence structure. The person has previously shared that their ex-spouse used to physically assault them regularly and on one occasion smashed a glass bottle over their head.

Practitioner who is *less* ready to respond

- Hears about the person's difficulties, reflects on their history of experiencing DFV, and focuses on trauma and stress reactions as the main barrier for this person in accessing the work force.

- Notices the person's difficulties in written communication and offers assistance with this but does not explore this difficulty with them.

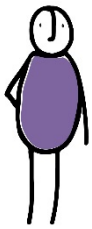
Practitioner who is *more* ready to respond

- Understands that certain types of DFV assault, such as those involving the face, head, neck or airways, can cause health impacts that result in neurocognitive changes for people who experience violence.

- Sensitively works to build on the awareness of the person about how their health has been affected by DFV, exploring the changes they have experienced and providing information without being diagnostic.

- Is able to support the person to access local health services that can assist them with further assessment of neurocognitive changes caused by violence.

Person seeking GP advice



A person decides to speak to their doctor about ongoing throbbing pain they have been experiencing in the left side of their head. The person states that the pain makes them feel really down, and sometimes they struggle to get out of bed in the morning. When the doctor asks questions about the history of the head pain, and what triggers it, the patient gives unclear answers and seems to be confused about the facts stating,

"I think I've had them for months but I don't really know what started them... I've just had a lot of stuff going on."

The doctor explores the possibility of Depression but the patient states that they feel they only need something to make the pain stop. The doctor writes a prescription for pain relief. The patient does not disclose to the doctor that their teenage child has been regularly punching them on that side of the head.

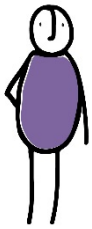
Practitioner who is *less* ready to respond

- Hears that the patient has had head pain for a few months but does not explore injury as a possible reason for head pain, and/or
- Hears about the patient's low mood and hypothesizes that this is a symptom of head pain without exploring other possible contextual causes, and/or
- Notices that the patient is unclear in their responses about pain and does not consider the possibility of DFV and/or makes negative conclusions about the patient (i.e. "hiding AOD abuse", "doctor-shopping", "non-compliant with mental health advice" etc.)

Practitioner who is *more* ready to respond

- Understands that assault, concussion/m-TBI and other head injury are under-reported to medical services, and is aware that DFV can cause injuries that cause long-term harm, exploring this as a potential cause of head pain.
- Works to build a positive relationship with the person so that it is safer for them to talk about violence and abuse with the GP.
- Understands the range of behaviours that constitute DFV and knows about risk factors for serious physical harm.
- Understands the potential intersectionality of DFV, mental health diagnoses and ABI – and provides a whole-of-person response.
- Knowledge of basic brain injury support and referral pathways for the person if brain injury emerges as a possible reason for head pain.
- Knowledge of DFV referral options if violence and abuse is disclosed.

Young Person having difficulties at school



A young person decides to talk to their local health worker about difficulties they are having at school. The young person states that they get really tired at school and don't want to go anymore because they get dizzy and tired in class and it feels really hard to read the documents the teacher gives them. The health worker knows this young person and knows that they were previously doing well at school, and that they live in a home where there is a history of family violence.

The worker asks the young person if they have recently been using any drugs or alcohol more than previously. The young person says *"Not really. Just the usual amount you know. On weekends and stuff."* The worker asks the young person if anything bad has happened at home recently. The young person states, *"Nah not for a few weeks. Mum and my uncle have been getting on pretty well. No huge blow-outs for a while."* The worker advises the young person to discuss the health issues with the doctor and possibly consider an optometry check-up.

Practitioner who is *less* ready to respond

- Hears that there has been no family violence incidents in the home for a few weeks and rules out family violence injury as a possible cause of health problems. Does not consider that previous injury could be a factor.

- Does not ask about other types of family violence outside of the home that the young person could be experiencing.

Practitioner who is *more* ready to respond

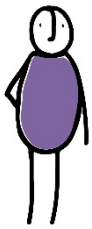
- Understands that assault, concussion/m-TBI, other head injury and strangulation are under-reported to medical services, and is aware that DFV can cause injuries that cause long-term harm, exploring this as a potential cause of the young person's dizziness and difficulties at school.

- Is able to support the person to access local health services that can assist the person with further assessment of the neurocognitive impacts of violence.

- Knows about the potential intersectionality of AOD use and brain injury, and can support the person with timely information in their self-assessment of safety and AOD use.

- Applies strategies for supporting the person with their physical and emotional wellbeing.

Person discloses DFV to GP



A doctor has built positive rapport with a patient and asks them about DFV due to the patient presenting for anxiety and insomnia regularly. The patient discloses that they have had a hard time in their relationship lately but they have only recently began to feel really anxious and stressed about the situation. The doctor explores immediate safety and support options with the patient. The doctor ascertains that the patient is sometimes physically assaulted, but that the perpetrator has never used a weapon, or threatened to kill them. There are no physical signs of current injuries to document. The patient shares that they feel they can manage the situation and might call 1800RESPECT before going home.

The doctor assesses that the patient is in the contemplative stage of change and makes a point of conveying that they are available to support the patient if they require any future assistance with this issue. The doctor records that "*intimate partner violence was disclosed*" and records what referral information was given to the patient as well as patient readiness.

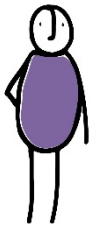
Practitioner who is *less* ready to respond

- Hears that the patient has experienced multiple physical assaults but does not check-in about the nature of assaults or the harms caused to the person's health.
- Assumes that a lack of external injuries means the person is safe from serious injury. Does not assess for concussion, other ABI (i.e. anoxic brain injury), or internal strangulation injuries (i.e. carotid artery dissection).
- Asks questions about immediate safety and serious risk factors but does not explore or listen to patient's own analysis of safety and risks.
- Records that DFV was discussed and focuses patient notes on practitioner response to patient disclosure (i.e. referral information provided) rather than on details of what exactly was disclosed by patient.

Practitioner who is *more* ready to respond

- Understands ABI-related health risks caused by physical assault, including: concussion, other brain injury (i.e. anoxic), harm from strangulation, and harm from suffocation.
- Explores history of physical assault, health impacts, and current symptoms, keeping detailed records of what the patient says.
- Understands the range of behaviours that constitute DFV and knows about risk factors for serious physical harm, sensitively offering information where relevant to build on patient's own awareness.
- Understands how to provide treatment for the health impacts of physical assaults or knows where to refer for appropriate treatment (i.e. local concussion clinic).
- Provides information about DFV support services, referral (where desired) and arranges a time to follow-up about health impacts and safety with the patient if they desire and consent to this.

Person discloses DFV to Health Service



A person has been coming to the local Women's Health service regularly for about six months. She is a familiar face around the service. Various workers have noticed that the person is very forgetful and often presents to the service as 'scattered' and overwhelmed. She seems to lose her balance at odd times and also has an occasional tremor, which can affect her ability to write. The patient chats with the health nurse about forgetting to take her oral contraception and being worried about that. The nurse suggests strategies for helping her to remember to take the pill, but also offers other contraceptive solutions that do not require memory.

After a few meetings she opens up to the nurse about her experience of DFV, and shares that in a previous relationship she was choked to the point of unconsciousness on at least three occasions and also had a miscarriage. The nurse shows empathy and support for the person but also offers to make a referral for trauma counselling.

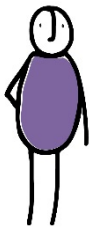
Practitioner who is *less* ready to respond

- Hears the person's descriptions of physical violence but underestimates the impact of strangulation on person's health.
- Hears the person's descriptions of 'choking' and assumes that person's presentation is trauma-related, and could be resolved through counselling.

Practitioner who is *more* ready to respond

- Understands ABI-related health risks caused by physical assault, including: concussion, other brain injury, harm from strangulation, and harm from suffocation.
- Understands that strangulation is serious and can sensitively discuss this with person to build on their awareness of how DFV may affect their wellbeing.
- Supports the person in their own goals and strategies for physical and emotional wellbeing.
- Knows where to refer someone for assessment and treatment for a potential anoxic/hypoxic brain injury caused by multiple strangulations.

Person providing a DVEC Statement to police after a Physical Assault



A person has called the police after an ex-partner broke into their house and assaulted them. Their ex-partner cornered them in the kitchen and punched them in the face and head a number of times. There are no bruises or swelling but the person is holding an ice pack on the side of their head. When telling police what happens the person says "He was hitting me two… three times maybe. I covered my head but I was seeing spots you know." The person's seems slow to speak and they present as tired and confused.

Officer A – not yet aware about which assaults can affect the brain

- Hears the person's descriptions of physical violence but underestimates the significance of the assaults to the head due to no visible injury.
- Notices the person's slow speech and fatigue but does not make a link to head injury.
- Hears the person say they 'saw spots' and is not aware that this symptom is a sign that their brain was affected by the assault.
- Takes a Domestic Violence Evidence in Chief (DVEC) statement without calling an ambulance.

Officer B – aware about which assaults can affect the brain

- Knows that certain types of assault, including assaults to the head can cause brain injury, and asks questions to learn if a person's brain was affected at the time of the assault. i.e. "What else do you remember about the assault?" "How did your body react to the assault?" "How have you felt physically since the assault?"

  Then Listens/observes for: confusion, dizziness, headache, 'seeing spots', slurred speech, nausea, amnesia, person seeming dazed or 'out of it', sleepiness, and memory or focus problems – these symptoms indicate that the brain may have been impacted by the assault.

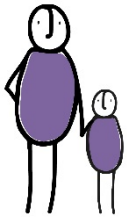
- Calls an ambulance so that the person can be medically assessed before providing a DVEC statement.

- Asks about how the person resisted violence, as this could highlight undescribed facts about the assault, i.e. they covered their face and the perpetrator grabbed their wrist to pull it down (track development of bruises on wrist to support this). Example questions to explore resistance: *How did you respond? Where were you when this happened? What did you do next?*

- Knows that bruising and swelling for assault can take a few days to show-up and informs the person that they can attend a Forensic Medical Unit, or their doctor to have those injuries recorded. Or advises that the person can take their own photos of injuries and provide them to police also.

- Records detailed information about the assault, the victim's resistance and symptoms that were reported by the victim so that the Domestic Violence Liaison Officer is fully informed and can check in with victim about their health in the days/weeks after assault.

OTHER RESOURCES



BUILDING ON YOUR AWARENESS OF DOMESTIC AND FAMILY VIOLENCE (DFV)

Reflection and Discussion Resources

Free online videos from '**Our Social Response'** Creating Conversations Event in Sydney (Nov 2017) with international key note speakers Dr Linda Coates and Dr Allan Wade from the Centre of Response Based Practice in Canada.

- **Link to Videos**: http://www.insightexchange.net/our-social-response/
- There are very simple **Creating Conversation Cards** that are available in PDF on the site - get in contact with DVSM for a print set if you are keen to foster discussions about the videos within your context.

Guidance

DVSM's Practitioner Toolkit
Practice Framework | Practice Review Guide | Conversation Tool | Conversation Card | Practice Questions | Reflections Sheet | Other resources will be developed/released through a staged process.

DV NSW (Peak Body)
http://dvnsw.org.au/

Fact Sheets and Best Practice Guidelines
http://dvnsw.org.au/work/resources/

Resource Library
http://dvnsw.org.au/work/resources/resourcelibrary/

National Initiatives | Resources

Our Watch – Ending Violence against women and their children
Our Watch has been established to drive nationwide change in the culture, behaviours and power imbalances that lead to violence against women and their children.
https://www.ourwatch.org.au/

ANROWS – Ending Violence against women and their children
Australia's National Research Organisation for Women's Safety Limited (ANROWS) is an independent, not-for-profit company established as an initiative under Australia's National Plan to Reduce Violence against Women and their Children 2010-2022 (the National Plan).
https://anrows.org.au/

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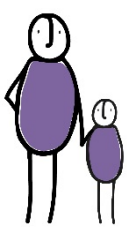

DVSM thanks the following practitioners for their contribution to the DFV/ABI Project.

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Who

To bring sustained focus to this intersection a small number of organisations have supported the release of the DFV/ABI Project Report to increase the likelihood of it being distributed and taken up more broadly across contexts, districts and states/territories. Organisations supporting the project report launch and progress on the intersection include:

Education Centre Against Violence (ECAV)	www.ecav.health.nsw.gov.au
Women's Health NSW	www.whnsw.asn.au
Brain Injury Australia (National Peak)	www.braininjuryaustralia.org.au
No to Violence (Peak Body)	www.ntv.org.au
Women's Domestic Violence Court Advocacy Service (WDVCAS)	www.wdvcasnsw.org.au
Domestic Violence NSW (Peak)	www.dvnsw.org.au
Domestic Violence Service Management	www.dvnswsm.org.au

This group does not reflect every organisation who already does and can play an important role in driving change

FAQs

ENGAGING IN THE PROJECT REPORT

Download the project report	Self-Service – Live FREE copies of full project report and related resources http://www.dvnswsm.org.au/our-work/resources/projects-and-initiatives/dfvabi
Download the project resources/maps	
I want to make adapted maps	

FURTHER DEVELOPMENT

Training - Specific Specialist	Contact the most relevant organisation listed above to pursue your questions or support
ECAV Training	
I want to engage in one of the opportunities	
I have a new opportunity I am initiating	
I want to undertake research	
I want to volunteer, sponsor or donate	

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