Reflections Paper 2.1

An exploration of the intersections between

Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI)

July 2018

About our heritage

Domestic Violence NSW Service Management (DVSM) was created as a non-profit company registered under the Australian Charities and Not For Profits Commission Act 2012.

DVSM recognises the many years of important work already established and achieved through the NSW Women's Refuge Movement since 1974. DVSM also recognises that there are many organisations working diligently and proactively to prevent, respond to and redress violence in society.

About our values and principles

DVSM has an established set of values and principles which are outlined on our website. The headings for our principles are outlined below:

- Violence is never acceptable or exclusive or excusable.
- Our approach is person centred.
- We uphold an individual's dignity.
- Respect and equality is critical.
- We are committed to the design and delivery of effective services.
- We respond justly.
- We collaborate.
- We work with integrity and excellence.
- We foster a supportive environment for staff wellbeing.
- It is necessary for all of us to take responsibility for making change happen.

About this Resource/Document

DVSM is committed to continuously learning and improving its work through enquiries that draw from communities, professionals and organisations to gather insight and to build new understanding. We capture and document our learning wherever we can for our own self-reflection and for the purpose of contributing to wider conversations that could assist in improving system and service design over time.

DVSM would like to acknowledge NSW Family and Community Services as a key funder of the programs through which this learning has been explored. The views, information, or opinions expressed within this resource are solely those of the individuals involved and do not represent those of NSW Family and Community Services.

We recognise that the work recorded in this resource represents only our 'point in time' knowledge and understanding which will grow and move through further learning and the contributions from others. The information contained in this resource is provided on an "as is" basis and is provided with no guarantees.

The purpose of making this resource available to others is to share our learning as a contribution toward wider progress and planning in addressing complex social issues. None of the authors, contributors, administrators, or anyone else connected with DVSM, in any way whatsoever, can be responsible for your use of the information contained in or linked from this resource.

Contact Us

Domestic Violence NSW Service Management (DVSM) welcomes interest and enquiries about this thinking and resources. To get in touch please contact us on (02) 9251 2405 or via our website www.dvnswsm.org.au.

Reflections Paper: 2.1
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Introduction

Since late 2015, Domestic Violence Service Management (DVSM) has been engaged in informal enquiries, reading, discussion and project work to better understand the intersection between Domestic and Family Violence (DFV) and Acquired Brain Injury (ABI).

In 2016 two DVSM frontline workers co-wrote Reflections Paper 1.0, which explored the intersection of DFV and ABI. Reflections Paper 2.0 was created in 2017 as a revised edition of this work that incorporated emergent research and provided additional information in regards to specific populations. Version 2.0 also provided a project brief that described work being completed by DVSM in 2017-2018. Reflections Paper 2.1 has had the project brief removed, and instead links to the final DFV/ABI Project Report (published by DVSM in July 2018) which outlines the project methodology in full.

The Reflections Paper provides an overview of some of the key issues relating to the intersection of DFV and ABI, including:

- questions and critical analysis;
- recommendations, from the perspective of DVSM's practitioners, that DVSM could reasonably undertake; and
- considerations on how the intersection of DFV and ABI may affect people that DVSM supports.

This Reflections Paper is also intended to be shared with any person, service, organisation or institution that may interact with people who experience the intersection of DFV and ABI. It is our hope that the information and issues presented within it will contribute to a wider conversation around opportunities for shared learning and collaboration to strengthen social responses for people working with people who experience violence and may have a possible ABI.

What is Acquired Brain Injury (ABI)?

'Acquired Brain Injury' (ABI) 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. 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.

Anoxic & Hypoxic Brain Injury

Our brains need a continuous flow of oxygen to function and periods of reduced oxygen can lead to 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. A person who experiences violence can suffer an anoxic/hypoxic brain injury if they experience assaults involving strangulation and suffocation.

ABIs that are caused by DFV can lead to a number of long and short term symptoms that can affect a person's wellbeing. Broadly, these symptoms can include:

- changes to personality and mood;
- cognitive delays or dysfunction;
- physical disability;
- changes in behaviour and coping strategies;
- problems with communication and speaking;
- chronic pain;
- memory loss;
- fatigue;
- headaches; and
- sensory changes, amongst other concerns.[1]

The information included in this paper is deemed to be relevant to the work of DVSM, as an organisation working with people who have experienced DFV. As the majority of people who experience DFV are women and children, the majority of the sources referenced in this paper explore the impacts of DFV-related ABI for women and children. The term TBI is used frequently in this paper.

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

[1] J. Corrigan et al., *Early Identification of Mild traumatic Brain Injury in Female Victims of Domestic Violence,* American Journal of Obstetrics & Gynaecology, Vol. 5, No. 8, 2003, p.72.; E.M Valera & H. Berenbaum, *Brain injury in battered women*, Journal of Consulting and Clinical Psychology, Vol. 71, No. 4, 2003, p.4.; ARBIAS, *Looking Forward Acquired Brain Injury,* (Brunswick VIC: ARBIAS, 2011) p.8.; C.E Murray et al., *What Professionals who are not Brain Injury Specialists Need to Know about Intimate-Partner Violence-Related Injury*, Trauma, Violence & Abuse, Vol. 17, No. 3, 2015, p.4.; Brain Injury Australia, *Fact Sheet 6*: *Family Violence & Acquired Brain Injury*; Northcote VIC: BIA, n.d., p.1.

- 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.[2]

Key issues in the existing research

The links between ABI, strangulation and DFV homicide:

The use of strangulation by perpetrators of DFV is surprisingly common and can have serious health implications for the person experiencing violence. Various studies suggest that around 50% of women who experience physical assaults in the context of DFV report that some of these assaults involved strangulation.[3] Strangulation risk increases during pregnancy for women experiencing physical assaults perpetrated by an intimate partner.[4]

There is a well-established link between strangulation and risk of homicide. Many DFV homicides are caused by strangulation and many are precipitated by the perpetrator previously using strangulation[5]. It is possible for the victim to die in the days following strangulation, with only a few predictive symptoms, such as dysphagia (difficulty swallowing).[6] First responders may not be aware of damage caused by strangulation as external physical signs of strangulation do not present in at least 50% of cases.[7]

When strangulation is not fatal, brain injury can occur due to the restriction of oxygen flow to the brain, these are known as hypoxic or anoxic brain injuries. Mild brain injury has been found amongst women who report histories of strangulation.[8] An ABI caused by strangulation will not show up immediately, but can develop in the weeks and months after strangulation. Women who experience brain injury caused by strangulation assaults may not receive appropriate treatment due to being unaware of the

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[2] 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.

[3] M. Joshi et al., *"I Didn't Know I Could Turn Colors": Health Problems and Health Care Experiences of Women Strangled by an Intimate Partner*, Social Work in Health Care, Vol 51: No.9, 2012, p.799.

[4] A. Brownridge et al., *Pregnancy and intimate partner violence: risk factors, severity, and health effects.* Violence Against Women, 17, 2011.

[5] S.B Sorenson et al., *A Systematic Review of the Epidemiology of Nonfatal Strangulation, a Human Rights and Health Concern.* American Journal of Public Health 104, no. 11, 2014, p. 54; H. Douglas. & R. Fitzgerald, *Strangulation, Domestic Violence and the Legal Response,* Sydney Law Review, 2014, p.232; NSW Domestic Violence Death Review Team, *Report 2015-2017,* NSW Government, Camperdown, 2017 p. 9.

[6] M. Di Paolo et al., *Unexpected Delayed Death after manual strangulation: need for careful examination in the emergency room,* Monaldi Archives Chest Dis, 2009, p. 133; R. Zilkens et al., *Non-fatal strangulation in sexual assault: A study of clinical and assault characteristics highlighting the role of intimate partner violence*. Journal of forensic and legal medicine, 43, 2016, p.2.

[7] Joshi et al., 2012, p.799; Zilkens et al., 2016, p.5.

[8] L. E. Kwako et al., *Traumatic Brain Injury in Intimate Partner Violence: A Critical Review of Outcomes and Mechanisms*. Trauma, Violence & Abuse, 2011, p.117.

link between these assaults and delayed symptoms, or because they may not feel comfortable to disclose about strangulation.[9]

ABI amongst Aboriginal and Torres Strait Islander Australians

Rates of disability, including ABI, are significantly higher amongst Aboriginal and Torres Strait Islander people compared to the general population. Aboriginal and Torres Strait Islander women are more likely to be the victim of assault than other Australian women: 4.2 times more likely in NSW in 2013.[10] Of particular concern is that Aboriginal and Torres Strait Islander women experience 69 times more head injuring assaults than other Australian women.[11] Furthermore, Aboriginal and Torres Strait Islander people who live in rural and remote settings also experience greater rates of hospitalisation due to head injuring assaults, which is of concern due the lack of accessibility to services in these spaces.[12] Although few studies explore this issue, it is possible that rates of ABI are higher amongst Aboriginal and Torres Strait Islander children than other children due to the fact that they experience higher rates of physical assault.[13] Culturally safe assessment and treatment programs are needed to better respond to the issue of ABI in Aboriginal and Torres Strait Islander communities.

Children and ABI

There is strong evidence for a correlation between mild-TBI in early childhood (0-5 years) and receiving diagnoses of hyperactivity and conduct disorders in childhood, as well as increased likelihood of psychiatric diagnoses as a teenager.[14] This evidence is highly important in light of the fact that children under the age of three are most likely to experience TBI as a result of child abuse.[15] Untreated or misdiagnosed ABI has effects on educational outcomes and social functioning throughout the lifespan and it is important for institutions and organisations who work with children to implement appropriate strategies for working with children affected by ABI.[16]

Difficulties in identifying ABI

ABI can be difficult to identify and is easily missed when mild. Concussion/mild-TBIs, which are by nature metabolic and not structural, do not show-up on brain scans, but are identified only by symptoms, cognitive testing and history of physical trauma.[17] Approximately 30-47% of people with concussion/mild-TBI after assault experience changes in the brain that result in negative outcomes at three months to a year later.[18] This is a concerning statistic considering the reality that most TBIs are mild, and symptoms can mirror many other disorders in the DSM-V (Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition).

ABIs can develop over time and are often cumulative, occurring as a result of multiple events.[19] The cumulative development of some ABIs, as well as the fact that many head traumas are never reported

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[9] Joshi et al., 2012 p. 808; R. Snyder, '*No Visible Bruises: Domestic Violence & Traumatic Brain Injury*', The New Yorker, 2015, p. 1.

[10] Productivity Commission*, Overcoming Indigenous Disadvantage Key Indicators Report 2014*, 2014, Section 4.93; 4.92; Table 4A.11.31; 4A.11.37.

[11] L. M Jamieson et al., *Hospitalisation for head injury due to assault among Indigenous and non-Indigenous Australians, July 1999-June 2005*. Medical journal of Australia, 2008, p. 578; T. Bowden, *Family violence: Three women hospitalised per week with traumatic brain injuries, advocate says*, ABC News*,* 2015, p. 1.

[12] Jamieson et al., 2008, p.578; J. Berry et al. *Head and traumatic brain injuries among Australian children, July 2000–June 2006*, BMJ Publishing Group, 2010, p. 5.

[13] Brain Injury Australia, *Frequently Asked* Questions' (N.D.), p.2;

[14] Ashworth, J., *How can children with ABI achieve their potential*? Social Care and Neurodisability, 2013, p. 62; McKinlay, A. *Long-term outcomes of traumatic brain injury in early childhood.* Australian Psychologist, 49(6), p. 325; Davis, N. *Childhood concussion linked to lifelong health and social problems*, The Guardian*,* 2016.

[15] Brain Injury Australia, *Fact Sheet 6: Acquired Brain Injury & Family Violence*, n.d., p.1.

[16] See Ashworth, 2013, for case study on ABI behaviour management strategies for child with ABI.

[17] Murray et al., 2015, p. 2; Brain Injury Australia, *Fact Sheet 6,* n.d., p1.

[18] E. Yuh et al*., Magnetic resonance imaging improves 3-month outcome prediction in mild traumatic brain injury. Ann Neurol*. 2013; M. Holloway, '*How is ABI assessed and responded to in non-specialist settings? Is specialist education required for all social care professionals?*' Social Care and Neurodisability, 54, 2014, p. 202.

[19] Corrigan et al., 2003, p 72; Murray et al., 2015, p 1.

to a doctor (at least 20%), makes early diagnosis and treatment difficult.[20] ABI as a result of multiple concussions or head traumas is a particular risk for people who experience repeated physical assaults over long periods of time.

Some of the symptoms of ABI are similar to symptoms of certain mental illnesses that people who experience violence are commonly diagnosed with, such as: Post Traumatic Stress Disorder (PTSD), Depression and Substance Abuse Disorder. This can further complicate the process of identifying an ABI. When commonly available scans such as CTs and MRIs, are unable to provide physical evidence of injury, the process for verifying the presence of cognitive impairment involves neuropsychological assessment. These assessments are time-consuming and costly to the consumer (approximately $2500 outside of the public system in NSW), which may be a barrier for people experiencing the intersection of DFV and ABI.

It is also important to recognise that the dynamics of power and control inherent in DFV may make it difficult for a person experiencing violence to access services that will assess for and assist with brain injury. For example, a perpetrator may not allow the person experiencing violence to access medical supports, or to follow recommended treatment plans. The person experiencing violence may also face other pressing issues that require prioritisation over their health such as immediate safety, homelessness, and concerns for their child's wellbeing.[21]

[20] Corrigan et al., 2003, p. 72.
[21] New York State Office for the Prevention of Domestic Violence, Report: Traumatic Brain Injury and Domestic Violence, no date, p. 3.

General lack of screening for TBI and Strangulation

Some of the research indicated that it is important for emergency responders, such as police and hospitals, to have definitive screening tools in place to ensure that domestic violence victims are screened for TBI and strangulation after an assault.[22] It is unclear if policies and procedures exist around this for police, general practitioners, emergency departments and other key responders in NSW. Evidence suggests that early screening and referral was shown to be a key factor for recovery outcomes.[23] Concussion care and rest after a head injury are important factors that affect the prevalence and impact of concussion/mild-TBI long-term.[24] These findings present a unique challenge for a person experiencing DFV, as they may not always be able to follow through with referral and care recommendations. Further research is needed to establish how screening for an ABI takes place at hospitals, amongst police, and in frontline services that engage with people who experience DFV assaults.

Complications and concerns regarding diagnosis

ABIs can manifest with similar symptoms to certain mental health diagnoses such as PTSD, Bipolar Disorder, Substance Use Disorder, and Schizophrenia, and there is an evidenced correlation between experiences of ABI and receiving these diagnoses.[25] People who experience DFV are also at heightened risk of receiving diagnoses related to mental health and substance abuse.

An ABI may be difficult to see in such cases where other diagnoses may also explain a person's presentation and symptoms. Some of the research studies excluded women who had co-morbid disorders involving mental health or Alcohol and Other Drugs (AOD).[26] This is an indication of the difficulties in identifying and treating ABI where other complex health concerns are also present. People who experience AOD problems are at higher risk of having a history of TBI and of experiencing further TBIs.[27]

Another key issue is the potential for discourses and responses about ABI to cause stigma by focusing on a person's 'symptomology' and the 'effects' of violence rather than on the injustice of violence. Any practitioner or service providing support to people who experience violence should be cautious about language and discourses that focus only on 'effects' and shut down opportunities to explore the resistance and responses of people who always respond to and resist acts of violence. If services were to implement screening for ABI or strangulation it is important that these conversation not be directed at assessing impacts and symptoms alone, but that these dialogues are also used as opportunities to discover and uphold a person's resistance, responses and dignity. [28]

[22] Corrigan et al., 2003; Brain Injury Association of Tasmania, *Understanding the Relationship between Family Violence and Brain Injury,* BIAT, 2016, p. 2; Douglas & Fitzgerald, 2014, p.235; Joshi et al., 2012, p.810.
[23] Corrigan et al., 2003, p.75; Murray et al., 2015, p. 5.
[24] Bunnage, M. *Suggestions for improving outcomes in the NHS following "mild" traumatic brain injury in adults, a bio-psycho-social approach*, Social Care and Neurodisability, 2013, p. 74; Murray et al., 2015, p. 6.
[25] Valera & Berenbaum, 2003, p.801; Kwako et al., 2011, p. 119; Murray et al., 2015, p.4; Holloway, 2014, p. 206. See also: American Psychiatric Association. *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing, 2013.
[26] For example: Corrigan et al., 2003; Valera et al. 2003.
[27] Corrigan et al, 2003, p.25; D.J Unsworth & J. L Mathias, *Traumatic brain injury and alcohol/substance abuse: A Bayesian meta-analysis comparing the outcomes of people with and without a history of abuse*, Journal of Clinical and Experimental Neuropsychology, 39:6, p.556.
[28] For further information on the role of services in upholding the dignity of people who experience violence see: L. Coates & A. Wade, '*We're in the 21st Century After All': Analysis of Social Responses in Individual Support and Institutional Reform.* In: Hydén M., Gadd D., Wade A. (eds), 'Response Based Approaches to the Study of Interpersonal Violence.' Palgrave Macmillan, London, 2016; A. Wade, *Small Acts of Living: Everyday Resistance to Violence and Other Forms of Oppression,* Contemporary Family Therapy, Human Sciences Press, Inc., 19 (1), 1997, p. 25.

Questions and Critical Analysis

The role of DFV services

The information and research studies reviewed focused primarily on case-studies and justice processes associated with the health and legal sectors. Two studies presented information on DFV services that used ABI screening tools in their work. [29] They presented a positive case for screening and referral for ABI amongst DFV services that engage people who experience violence. One study examined the various screening tools available to screen for ABI and found that the majority of tools did not screen for types of injuries that were specific to DFV such as strangulation.[30] As previously highlighted, the research also presented clear evidence for the need for screening to be used by services that are likely to engage with victims immediately after an assault, such as hospitals and police. Services that engage with people who experience violence, further down the track may be better equipped in their work by being able to recognise the signs of ABI and having awareness of the available pathways for support.

Information and awareness about screening and treatment

There was a lack of research that examined whether women who experience head injuries are more likely to seek screening and referral when provided with information about DFV and ABI. It was shown that many women and children may experience ABIs that go untreated due to not making police reports or seeking medical support after a DFV assault.[31] Further research is needed to determine if raising awareness about DFV and ABI could increase the number of women (who experience DFV) that access treatment in the weeks and months after an assault. ABI screening tools that can be used in refuges and women's services do currently exist, as do resources on good practice when working with people identified as having an ABI.[32]

If DVSM were to begin using screening tools, time, training and the development of stakeholder partnerships would be needed. It would also be important to understand appropriate referral pathways and treatment options available to people who may have an ABI, or to advocate for the creation of such pathways if none currently exist.

How do we mitigate the unintended consequences of 'stigmatisation' and 'stereotyping' that could result from raising awareness about the intersection of DFV and ABI?

Some of the resources examined in this report indicated that an ABI diagnosis and treatment could be either stigmatising or empowering depending on how the a person is informed and if they are able to successfully access treatment; little mention was made about the impact of social stigmas and responses to people with an ABI that is caused by DFV.[33] As it is well-established that stigmatisation and stereotyping is a common experience both for people who experience disability and for people that experience DFV, it is logical to surmise that a person experiencing the intersection of these issues could face greater stigmatisation and stereotyping. This is a particular concern where perpetrators might use a negative stigma of ABI to further control or harm a person who is experiencing violence.

Another issue worth considering, is that when the impacts of domestic violence are seen only through the medical lens it can draw attention away from the indignity of violence and suggest that the people that experience violence are now the locus of the problem, needing 'treatment' in order to recover. This diminishes the need for justice or broader socio-cultural responses. Any discourse around physical

[29] Valera et al., 2003; G. Zieman et al., *Traumatic brain injury in domestic violence victims: a retrospective study at the Barrow Neurological Institute*. Journal of Neurotrauma. 34, (4) 2016.
[30] Y. Goldin et al., *'Screening for history of traumatic brain injury among women exposed to intimate partner violence.'* PM&R, 8 (11), 2016, p. 1106.
[31] Murray et al., 2015, p. 3; Zeiman et al., 2016, p. 4.
[32] See: New York State Office for the Prevention of Domestic Violence, *Traumatic Brain Injury and Domestic Violence*, New York, n.d.; ARBIAS, 2011; Pennsylvania Coalition Against Domestic Violence*, Traumatic Brain Injury as a result of domestic violence: information, screening and model practices*. PCADV, Harisburg, 2011.
[33] Murray et al., 2015, p. 6; Hunnicut et al., 2016, p. 476.

assault, experiences of violence and a person's wellbeing, is not dignity-focused if the issues of resistance, responses and social context are not also explored. "The perpetrator's history is the history of violence. The victim's history is the history of resistance (not trauma – that's different)."[34]

These concerns should not stop DVSM from offering clients the opportunity to access the services they need based on their individual circumstances. A critical part of the work moving forwards will be that staff members need to be trained in methods of working with people who experience violence and may have a possible ABI. This includes being aware of the risks of increasing stigma, giving people false starts and/or hopes if treatment options are not available, and the importance of prioritising human dignity and advocating for justice.

With DVSM's limited resources, how will we respond to ABI in ways that are both achievable and impactful?

The information reviewed indicated that ABI can be a factor in the cognitive, emotional and physical difficulties that a person may experience as part of the indignity and injustice of violence. A person experiencing the intersection of DFV and ABI, needs to be understood in context, and responded to in a person centred way using a whole of person approach. As DVSM is only one organisation with limited resources, certain questions should be asked, such as: How ready are we to respond to this issue? What are the barriers to responding? How can we have the conversation about possible Acquired Brain Injury in ways that uphold other important issues for the people we support, such as dignity, justice and wellbeing?

The social context and systemic context for awareness, identification and response needs to be better understood in order to make meaningful progress locally and at scale.

In 2017-2018, a DFV/ABI Project was undertaken in order to explore these questions around barriers, access and system responses for people experiencing the intersection of DFV/ABI. The project resulted in the development of a DFV/ABI Project Report with the inclusion of related resources that aim to highlight barriers, build pathways and strengthen responses to this intersection.

In July 2018 DVSM with the support of seven other organisations launched the release of the DFV/ABI Project report to support the distribution and development of progress across contexts.

[34] Alan Wade, in the video: "*Creating Conversations event, Dr Coates, Dr Wade: Responses - Our Social Responses*," Nov 2017. See also: A. Wade, *A.,* 1997.

Conclusion

In summary, there is a growing evidence base around the intersection between DFV and ABI, which could inform more effective approaches to working with people experiencing or escaping DFV who have a possible ABI. DFV services (including DVSM) and Health services could strengthen work with people at risk of an ABI by carefully considering and selecting specific ways of responding to this intersection.

However, as identified in this report there are many barriers to take into account whilst cautiously moving forward, including: difficulty in identifying ABI; lack of clear referral pathways; potential for misdiagnosis; factors that complicate treatment such as the presence of other diagnoses; stigma; and a risk of keeping the focus of client interactions on symptoms and effects rather than being response-focused in our work.

People who have an ABI and who are experiencing DFV should rightfully hope that the individuals, organisations and systems with which they engage will be able to respond in an informed manner - one that supports a person experiencing the intersection of DFV and ABI while being cognisant of the dynamics of power and control that they navigate on a daily basis. Only by cautiously holding both areas of knowledge will DFV services, health services and other key responders be able to support people experiencing this intersection to increase their safety and wellbeing.

In October 2017, a project was designed in response to the Reflections Paper 1.0 that focuses on mapping and strengthening responses to the intersection of DFV and ABI. The final project report and associated resources were made available in July 2018 at the following link:

www.dvnswsm.org.au/our-work/resources/projects-and-initiatives/dfvabi

T: 02 9251 2405 | W: http://www.dvnswsm.org.au

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References

Alcohol Related Brain Injury Assessment Accommodation Support, Report: Looking Forward (4th Edition), *ARBIAS,* 2011: Brunswick, Victoria.

Ashworth, J. "How can children with ABI achieve their potential?" *Social Care and Neurodisability*, Vol. 4 Issue: 2, 2013: 58-63.

American Psychiatric Association. *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing, 2013.

Berry, J & Jamieson, L & Harrison, J., *Head and traumatic brain injuries among Australian children, July 2000-June 2006*. B M J Publishing Group, 2010: 1-5.

Bowden, T., 'Family violence: Three women hospitalised per week with traumatic brain injuries, advocate says', *ABC News,* 12 August 2015, retrieved from: http://www.abc.net.au/news/2015-08-12/family-violence-sees-women-hospitalised-with-brain-injuries/6692682

Brain Injury Association of Tasmania, *Understanding the Relationship between Family Violence and Brain Injury,* BIAT Inc., August 2016.

Brain Injury Australia, 'Fact Sheet 6: Acquired Brain Injury & Family Violence', (no date) *Retrieved From:* http://www.braininjuryaustralia.org.au/resources/fact-sheets-brain-injury-australia/acquired-brain-injury-family-violence/

Brain Injury Australia, 'Frequently Asked Questions About Inflicted Traumatic Brain Injury', (no date), *Retrieved From:* http://www.braininjuryaustralia.org.au/resources/fact-sheets-brain-injury-australia/frequently-asked-questions-about-inflicted-brain-injury/

Brownridge, D. A., Taillieu, T. L., Tyler, K. A., Tiwari, A., Ko Ling, C., & Santos, S. C., 'Pregnancy and intimate partner violence: risk factors, severity, and health effects.' [Comparative Study]. Violence Against Women, 17: 2011, 858-881.

Bunnage, M., 'Suggestions for improving outcomes in the NHS following "mild" traumatic brain injury in adults, a bio-psycho-social approach', *Social Care and Neurodisability*, Vol. 4 (2): 2013, 70-76. https://doi.org/10.1108/SCN-03-2013-0010

Coates L. & Wade A., 'We're in the 21st Century After All': Analysis of Social Responses in Individual Support and Institutional Reform. In: Hydén M., Gadd D., Wade A. (eds) Response Based Approaches to the Study of Interpersonal Violence. Palgrave Macmillan, London, 2016.

Commonwealth of Australia, *Overcoming Indigenous Disadvantage Key Indicators Report 2014*, Productivity Commission, 2014.

Corrigan, J. D., Wolfe, M., Mysiw, W. J., Jackson, R. D., & Bogner, J. A., 'Early identification of mild traumatic brain injury in female victims of domestic violence.' *American journal of obstetrics and gynecology*, 188 (5), 2003: 71-76.

Davis, N., 'Childhood concussion linked to lifelong health and social problems', *The Guardian,* 24 August, 2016. Retrieved from: https://www.theguardian.com/science/2016/aug/23/childhood-concussion-linked-to-lifelong-health-and-social-problems

Di Paolo M, Guidi B, Bruschini L, Vessio G, Domenici R, Ambrosino N., 'Unexpected delayed death after manual strangulation: need for careful examination in the emergency room.' *Monaldi Archives Chest Dis*. 71: 2009, 132-134.

Douglas, H., & Fitzgerald, R., Strangulation, domestic violence and the legal response. *Sydney L. Rev.*, *36*: 2014, 231-254.

Goldin Y, Haag HL, Trott CT. 'Screening for history of traumatic brain injury among women exposed to intimate partner violence.' *PM&R*, 8 (11): 2016, 1104-1110.

Holloway M., 'How is ABI assessed and responded to in non-specialist settings? Is specialist education required for all social care professionals?' *Social Care and Neurodisability*, 54: 2014, 201–13.

Jamieson, L. M., Harrison, J. E., & Berry, J. G. Hospitalisation for head injury due to assault among Indigenous and non-Indigenous Australians, July 1999-June 2005. *Medical journal of Australia*, *188* (10): 2008, 576-579.

Joshi, M., Thomas, K., & Sorenson, S.B., "I Didn't Know I Could Turn Colors": Health Problems and Health Care Experiences of Women Strangled by an Intimate Partner, *Social Work in Health Care*, 51 (9): 2012, 798-814.

Kwako, L. E., Glass, N., Campbell, J., Melvin, K. C., Barr, T., & Gill, J. M., 'Traumatic brain injury in intimate partner violence: A critical review of outcomes and measures.' *Trauma, Violence, & Abuse*, 12: 2011, 115–126. doi:10.1177/1524838011404251

McKinlay, A., 'Long-term outcomes of traumatic brain injury in early childhood.' *Australian Psychologist, 49* (6): 2014, 323-327. doi: 10.1111/ap.12084

Murray, C. E., Lundgren, K., Olson, L. N., & Hunnicutt, G., 'Practice Update: What Professionals Who Are Not Brain Injury Specialists Need to Know About Intimate Partner Violence–Related Traumatic Brain Injury.' *Trauma, Violence, & Abuse*, 17 (3): 2015, 298-305.

New York State Office for the Prevention of Domestic Violence, Report: Traumatic Brain Injury and Domestic Violence, no date, *retrieved from:* http://www.opdv.state.ny.us/professionals/tbi/index.html

NSW Domestic Violence Death Review Team, *Report 2015-2017,* NSW Government, Camperdown NSW, 2017.

Pennsylvania Coalition Against Domestic Violence, 'Traumatic Brain Injury as a result of domestic violence: information, screening and model practices.' PCADV, Harisburg, 2011.

Snyder, R. 'No Visible Bruises: Domestic Violence & Traumatic Brain Injury', *The New Yorker,* Dec 30, 2015, Retrieved From: http://www.newyorker.com/news/news-desk/the-unseen-victims-of-traumatic-brain-injury-from-domestic-violence

Sorenson, S. B., Joshi, M., & Sivitz, E. A systematic review of the epidemiology of nonfatal strangulation, a human rights and health concern. *American Journal of Public Health*, 104: 2014, pp. 54–61.

The Chronicle, 'Brain injuries in domestic violence cases can go undetected, causing ripple effect', *Chronicle-Telegram*, August 23, 2016, Retrieved from: http://www.chroniclet.com/national-news/2016/08/23/Brain-injuries-in-domestic-violence-cases-can-go-undetected-causing-ripple-effect.html

Unsworth, D. J & Mathias, J.L, 'Traumatic brain injury and alcohol/substance abuse: A Bayesian meta-analysis comparing the outcomes of people with and without a history of abuse', *Journal of Clinical and Experimental Neuropsychology*, 39, 6: 2017, 547-562

Valera, E. M., & Berenbaum, H. Brain injury in battered women. *Journal of consulting and clinical psychology*, *71* (4): 2003, 797-804.

Wade, A. Small Acts of Living: Everyday Resistance to Violence and Other Forms of Oppression*, Contemporary Family Therapy, Human Sciences Press, Inc*., 19 (1): 1997, 23-39.

Wade, A. *Creating Conversations event, Dr Coates, Dr Wade: Responses - Our Social Responses*," Nov 2017, Available at: http://www.insightexchange.net/our-social-response/

Yuh EL, Mukherjee P, Lingsma HF, et al. Magnetic resonance imaging improves 3-month outcome prediction in mild traumatic brain injury. *Ann Neurol*. 2013; 73: 224-235.

Zieman G, Bridwell A, Cárdenas JF. Traumatic brain injury in domestic violence victims: a retrospective study at the Barrow Neurological Institute. *Journal of Neurotrauma*, 34 (4): 2017, 876-80.

Zilkens, R. R., Phillips, M. A., Kelly, M. C., Mukhtar, S. A., Semmens, J. B., & Smith, D. A. Non-fatal strangulation in sexual assault: A study of clinical and assault characteristics highlighting the role of intimate partner violence. *Journal of forensic and legal medicine*, *43*: 2016, 1-7.

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