Second Action Plan Consultation Submission

Addressing Traumatic Brain Injuries in Australia's Response to Domestic, Family and Sexual Violence

About the Submitters

This submission has been prepared by Dr Breanne Hobden from the University of Newcastle on behalf of the MRFF-funded Hope in Healing project team.

Project title: Hope in Healing: Developing a Model of Care Approach for those Impacted by Traumatic Brain Injury through Domestic Family Violence
Project team: Dr Bree Hobden, Dr Anousha Victoire, Ms Shannon Richardson, Prof Deb Loxton, Prof Mariko Carey, Dr Zoi Triandafilidis, Ms Susan Pollock, Dr Jemma Keeves, Dr Christopher Oldmeadow, Ms Hannah Wetzler
Lived experience advisory group members[1]: Ms Shenane Hogg and Ms Phoebe Nagorcka-Smith.

The project brings together researchers, clinicians, service managers and consumers across multiple organisations. The project is led by the University of Newcastle and includes partnership from the Hunter New England and Central Coast Primary Health Network (HNECC PHN), the Hunter New England Local Health District (HNELHD), the Hunter Medical Research Institute (HMRI) and Port Stephen Family and Neighbourhood Services (PSFANS). It is overseen by a lived experience advisory group.

The following submission relates to the need for this project and preliminary findings, as well as recommendations for ongoing investment in the area of mild traumatic brain injury (mTBI) in the context of Domestic, Family and Sexual Violence (DFSV).

Contact Dr Breanne Hobden, bree.hobden@newcastle.edu.au for further information.

Overview

Traumatic brain injury (TBI), including mild traumatic brain injury (mTBI) and hypoxic brain injury from non-fatal strangulation, is a common but largely unrecognised consequence of domestic, family and sexual violence (DFSV). Evidence suggests a substantial proportion of victim-survivors experience brain injury, yet few dedicated screening, assessment, referral or treatment pathways exist. The Hope in Healing project has developed and is testing a trauma-informed model of care that integrates DFSV services, primary care and rehabilitation support.

This submission has five key recommendations for the Second Action Plan:

- **Recommendation 1**: Formally recognise TBI and non-fatal strangulation as significant and often hidden health consequences of DFSV within national policy, planning and service responses.
- **Recommendation 2**: Invest in accessible, culturally appropriate, trauma-informed care pathways that address the complex health, cognitive and social needs of victim-survivors experiencing TBI and non-fatal strangulation.
- **Recommendation 3**: Support workforce training, screening capability and referral pathways.
- **Recommendation 4**: Support the development of standardised screening and assessment tools.
- **Recommendation 5**: Scale and evaluate integrated models of care nationally.

[1] Only lived experience advisory group members who provided permission to be named are listed here.

A Case for Action

- A TBI is a brain injury caused by an outside force, such as a forceful bump, blow, or jolt to the head or body[1]. Non-fatal strangulation can also result in hypoxic brain injury[2].
- In a review of 15 studies, estimates of brain injury among those who have experienced DFSV ranged from 28-100%[3].
- A major Australian study that examined 10 years of data from Victorian hospitals found, among 16,296 DFSV victims, 40% (n=6,409) had experienced a brain injury[4]. This report notes that these figures are likely the *'tip of the iceberg'* given there were only 1,800 hospital admissions for DFSV annually, while ~ 63,000 of DFSV cases are referred to Victorian family violence services or the courts each year.
- Many victim-survivors of DFSV experience multiple TBIs, placing them at increased risk of persistent post-concussion symptoms that can significantly affect day-to-day functioning.
- Together, these findings indicate that brain injury is a common consequence of DFSV and is likely substantially under-recognised within existing health and support systems.

Story of Impact — Raymond Terrace Screening Trial

The Hope in Healing project was informed by a screening trial led by Port Stephens Family and Neighbourhood Services. The trial screened 85 victim-survivors accessing a local DFSV service and identified a substantial burden of previously unrecognised head, face and neck injuries. Of those screened, 42.4% identified as Aboriginal and Torres Strait Islander and 82.4% had not sought medical assistance following their injuries.

Among the women screened, 68% reported experiencing non-fatal strangulation in addition to assaults involving the head, face or neck. None of the children or young people screened had received medical care despite experiencing serious physical violence.

These findings demonstrate that traumatic brain injury among victim-survivors of violence remains widespread, under-recognised and largely untreated within existing health systems.

The overrepresentation of Aboriginal and Torres Strait Islander victim-survivors within the screening cohort highlights the importance of culturally safe pathways and partnership with Aboriginal Community Controlled Organisations in future implementation and scale-up activities.

This project demonstrates that injury caused by violence should be treated with the same clinical seriousness as injury sustained in any other context. A victim-survivor who experiences concussion as a result of violence should have access to timely assessment, treatment and recovery support, regardless of how that injury occurred.

Key Statistics

85
victim-survivors screened
screening trial over 3 months

82.4%
had not sought medical care
following head, face or neck injuries

68%
reported non-fatal strangulation
alongside head, face or neck assaults

0%
of young people had received medical attention
following head, face or neck injuries

These findings demonstrate an opportunity for intervention that may reduce long-term health, social and economic impacts for victim-survivors and their families. Despite growing evidence of prevalence and impact, TBI remains largely absent from national DFSV policy and service responses.

Recommendation 1: Formally recognise TBI and non-fatal strangulation as significant and often hidden health consequences of DFSV within national policy, planning and service responses.

Priority Area 1: Victim-survivors

What individual barriers exist for getting support among victim-survivors?

While severe TBIs require an emergency response, mTBI are likely to go unaddressed for this group due to low rates of medical care seeking among DFV populations. Many complex factors impede an individual's ability to access healthcare. The following provides a non-extensive list of possible contributing factors:

- Dynamics of abusive relationships (e.g., perpetrator preventing healthcare access or fear of further harm)[5,6].
- Difficulties managing and navigating the healthcare system while experiencing significant trauma[5,7]
- Fear of mandatory reporting resulting in children being removed when help is sought[5,7].
- When women leave domestically violent relationships, they often experience homelessness and significant financial disadvantage, which further impede their ability to prioritise healthcare[6,8].
- For women who experience TBI these barriers are compounded due to the impact on cognitive functioning[5,9].

These findings demonstrate that victim-survivors experiencing mTBI face unique and compounding barriers to accessing healthcare and rehabilitation services.

Recommendation 2: Invest in accessible, culturally appropriate, trauma-informed care pathways that address the complex health, cognitive and social needs of victim-survivors experiencing TBI and non-fatal strangulation.

Priority Area 5: System Integration and Workforce

What systems barriers exist to getting support among victim-survivors?

The healthcare system is currently not accessible for mTBI care for victim-survivors for a variety of reasons, not limited to:

- Costs of care - Medicare rebates are not always available for imaging reducing access to initial assessments, and the number of practices that bulk bill for consultations is declining.
- When victim-survivors do access primary health care, healthcare professionals often do not have the knowledge to support the complexity of care required for someone experiencing DFSV[7,10].
- Brain injuries related to DFSV often go unreported or undetected due to a lack of specific screening tools and challenges in classifying and diagnosing mTBIs.
- Notably, mTBIs are often invisible on scans and require detailed cognitive testing, symptom evaluation, and an understanding of the trauma history for identification.
- Stakeholder consultations conducted through the Hope in Healing project suggest existing concussion referral pathways may not be consistently accessible or appropriate for victim-survivors experiencing DFSV-related mTBI.

The healthcare system currently presents significant barriers to accessing mTBI care for victim-survivors.

Recommendation 3: Support workforce training, screening capability and referral pathways.

Recommendation 4: Support the development of standardised screening and assessment tools.

Response: Hope in Healing

A dedicated primary care response to mTBI and non-fatal strangulation in DFSV

While Australia has established pathways for concussions sustained through sport, workplace injury or road trauma, few accessible pathways exist for victim-survivors who sustain concussions through violence for sub-acute injuries.

The Hope in Healing project seeks to ensure these injuries are treated with the same clinical seriousness as sports-related or workplace concussions.

Through a Delphi study, the project has established expert consensus on best practice care for DFSV-related mTBI and non-fatal strangulation, with a localised co-design process currently underway. The clinic is intended to be piloted in 2027.

Expert Consensus on best practice for mTBI in the DFSV context

A Delphi study is a structured process used to reach expert consensus through multiple rounds of consultation.

Key findings:

- *72 items across over 7 components of a care pathway were endorsed.*
- *Components of care explored included:*
  - *Training & Workforce Capacity*
  - *Screening & Identification*
  - *Information & Education Following Screening*
  - *Triage & Referral Processes*
  - *Clinical Assessment*
  - *Specialist & Allied Health Referral and Care Pathway (Post Primary Care)*
  - *Support Strategies*

- *Sample recommendations that received 100% endorsement across experts included:*

Interagency collaboration protocols should be developed to support screening and referral
A toolkit should be developed for GPs and allied health professionals to support those reporting DFSV with mTBI
Frontline community service workers (e.g., refuge staff, crisis support workers, caseworkers) should receive training in Referral processes for mTBI
It is important to offer education/information with clear and plain language information that is specifically designed for those who may have experienced mTBI through DFSV
It is important to offer mTBI education/information with client-led safety planning for provided resources to reduce the risk of the perpetrator accessing shared resources
Clinical assessment should include a lethality and risk assessment (including re-injury) and/or referral to DFSV specialist service if not already connected
Funding should be available to cover gap fees and reduce financial barriers to accessing care for those reporting DFSV
Transport support should be considered for those reporting DFSV needing assistance to attend appointments

From 2027, HNECC PHN will commission a two-stage model: frontline DFSV practitioners trained to screen and refer, connected to a dedicated community-based concussion clinic where a GP, allied health practitioner and specialist DFSV social worker provide integrated assessment, treatment and care navigation. The feasibility and acceptability of this pilot model of care will be examined by the project team.

The Hope in Healing project will provide a practical example of how healthcare, rehabilitation and DFSV services can be integrated to improve identification, assessment and recovery outcomes for victim-survivors experiencing mTBI and non-fatal strangulation. Evaluation of this model will provide critical evidence regarding its acceptability, feasibility and potential for broader implementation.

Recommendation 5: Scale and evaluate integrated models of care nationally.

Conclusion and Recommendations

There are pertinent gaps across all areas of care relating to mTBI care for victim-survivors of DFSV. These gaps include a lack of: support for individuals; training for healthcare professionals; standardised screening tools for mTBI in the DFSV context; educational resources for victim-survivors; and referral pathways for further assessment and ongoing support.

Injury caused by violence should be treated with the same clinical seriousness as injury sustained in any other context. However, the absence of clear health systems procedures for mTBI in the context of DFSV creates almost insurmountable barriers for victim-survivors to seek care and healing.

The Second Action Plan presents an opportunity to ensure that TBI and non-fatal strangulation are no longer overlooked within DFSV responses. The Commonwealth has already invested in developing and piloting solutions through the MRFF-funded Hope in Healing project. Future opportunities should involve building on this existing investment rather than creating new systems from scratch.

PRIORITY INVESTMENT ACTIONS

① Develop a national workforce capability program.

Fund training, clinical guidance and resources for GPs, nurses, allied health practitioners and frontline DFSV workers to identify, respond to and refer people experiencing mTBI and non-fatal strangulation.

② Scale PHN-led DFSV mTBI service models nationally.

Continue and expand primary care pilot programs addressing DFSV-related mTBI and non-fatal strangulation across all PHN regions.

③ Establish nationally consistent screening and referral pathways.

Invest in development, validation and implementation of standardised screening tools, referral protocols and integrated care pathways for DFSV-related mTBI and non-fatal strangulation.

References

1. Obasa AA, Olopade FE, Juliano SL, Olopade JO. Traumatic brain injury or traumatic brain disease: A scientific commentary. *Brain Multiphysics* 2024; **6**: 100092.
2. Victoire A, De Boos J, Lynch J. "I thought I was about to die": "Management of non-fatal strangulation in general practice". *Australian Journal of General Practice* 2022; **51**(11): 871-6.
3. Campbell JK, Joseph A-LC, Rothman EF, Valera EM. The prevalence of brain injury among survivors and perpetrators of intimate partner violence and the prevalence of violence victimization and perpetration among people with brain injury: a scoping review. *Curr Epidemiol Rep* 2022; **9**(4): 290-315.
4. Gabbe B, Ayton D, Pritchard EK, et al. The prevalence of acquired brain injury among victims and perpetrators of family violence. 2018.
5. Wills E, Fitts M. Listening to the voices of Aboriginal and Torres Strait Islander women in regional and remote Australia about traumatic brain injury from family violence: a qualitative study. *Health Expect* 2024; **27**(4): e14125.
6. Ivany AS, Kools S, Sharps P, Bullock L. Extreme control and instability: Insight into head injury from intimate partner violence. *JFN* 2018; **14**(4): 198-205.
7. Hollingdrake O, Saadi N, Alban Cruz A, Currie J. Qualitative study of the perspectives of women with lived experience of domestic and family violence on accessing healthcare. *J Adv Nurs* 2023; **79**(4): 1353-66.
8. Chan CS, Sarvet AL, Basu A, Koenen K, Keyes KM. Associations of intimate partner violence and financial adversity with familial homelessness in pregnant and postpartum women: A 7-year prospective study of the ALSPAC cohort. *PLoS One* 2021; **16**(1): e0245507.
9. Oyesanya TO, Ward EC. Mental Health in Women With Traumatic Brain Injury: A Systematic Review on Depression and Hope. *Health Care Women Int* 2016; **37**(1): 45-74.
10. Aljomaie HAH, Hollingdrake O, Cruz AA, Currie J. A scoping review of the healthcare provided by nurses to people experiencing domestic violence in primary health care settings. *IJNS Advances* 2022; **4**: 100068.