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BRAIN INJURY ASSOCIATION OF VIRGINIA

The Voice of Brain Injury: *Help, Hope & Healing*

Explaining the Intersectionality of TBI and Domestic Violence to New Audiences

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Executive Director

Learning Objectives:

Attendees will learn

1. How to build partnerships between domestic violence advocates, community agencies, law enforcement and other professionals who works with survivors of IPV.
2. Content appropriate for training a variety of audiences on the link between BI and DV.
3. Resources for survivors of IPV with TBI and those that work with them.
4. Policy options that can be pursued to improve outcomes for persons who experience TBI as a result of IPV.

BIAV Initial Entry

Initial work in the area began in our 2001 TBI Act grant

In consultation with domestic violence service providers, designed English and Spanish domestic violence/TBI tip cards.

Conducted ~30 presentations on the intersection of DV and BI:

- Local DV Task Forces
- CIT Continuing Education event
- Shelters
- 10 local SDVAs

Mailed:

- 1,025 tip cards to all 41 domestic violence programs in Virginia
- 600 to 6 DSS offices
- 5,700 to 114 local health departments

Partner Relationships

Partnership is a generally legal or contractual relationship where two or more parties have shared goals, rights and responsibilities. Partnerships are often limited to achieving a particular, targeted objective, and all parties share the risks and responsibilities inherent to the effort.

Collaboration is generally not a legally binding relationship, but is perhaps the most rigorous cross-organizational relationship, as it is one in which two or more people pool their common interests, needs, assets and skills to promote a shared vision or goal. Individuals share authority, risks, and responsibilities, and are often working toward a greater good for their communities.

Cooperation is the most informal type of relationship between two parties, and primarily involves assisting each other in some fashion or at least not opposing the other's efforts.

Partnership

BIAV was approached by the Partnership for People with Disabilities and the Virginia Commonwealth University School of Social Work to participate in multi-year I-CAN! Accessibility Project

The mission of the Project is to promote and facilitate awareness about the abuse of people with disabilities and to advocate for equal access to services and legal protections; it is supported by grant funding through the Virginia Sexual and Domestic Violence Victims Fund and the Department of Criminal Justice Services

BIAV's Phase 1 participation was advisory; will conduct training in Phase 2. Supported in part as subcontractors for Virginia's federal grant

2 phase project

- Abuse Awareness Training for Vulnerable Populations
- Brain Injury Awareness Training for Domestic Violence Service Professionals

Abuse Awareness Training for Vulnerable Populations

GOAL: provide targeted outreach to persons with brain injury and professionals who support them and education them about abuse and the community resources available for assistance.

Series of roundtable discussions held with persons with brain injury. Topics included knowing the warning signs and types of abuse; understanding the connection between violence, abuse and TBI; knowing what to do and what not to do; shared experiences; and community resources.

Contributed to the development of short film that featured the participant's saying what they learned https://www.youtube.com/watch?v=CAAsqwXxzco

BI Provider Training

Assessment surveys led the curriculum development of statewide training project for brain injury support staff

5 regional trainings

- Enabled facilitator to offer individualized support and adapt resources to meet the needs in their community
- One day; 7 hours
- 60 attendees

Most important aspects of training identified by respondents were information on the dynamics of domestic violence, skill based education on how to speak to clients about the issues and training on protective orders and mandated reporting

Year 1: Outcomes

Pre and post tests:

- Increase in all scores on all questions for all trainees.
- Predominant areas of improvements were in recognizing the connection between DV and BI; understanding roles in assessing violence; gaining strategies for talking with survivors about abuse; learning what to do and what not to do; knowledge of protective orders; and strategies, tools and resources.

Indicted they would use the training to educate others about healthy and unhealthy relationships; increase knowledge in the community regarding DV; screen for violence, harm and abuse with clients; and as information for grant proposals

Collateral Activity

Worked with VCU and PPD on collaborative project with the Office of the Executive Secretary of the Supreme Court of Virginia to ensure the online service module is accessible to people with disabilities. http://www.courts.state.va.us/courtadmin/aoc/judpln/programs/afapo/home.html

To make this process easier, I-CAN! staff assists users in completing the required forms for a protective order by matching them with volunteer scribes who will record the individual's responses as they move through each module.

Year 2: Training

Domestic violence services professionals staff at 3 YWCA facilities within a regional network will receive training to assist consumers who have experienced abuse and on appropriate referrals for community supports.

Will be held over 4 hours at a centralized location. Content and feedback gathered from the in person training will be used to create a webinar series in Year three for Domestic Violence Service professionals throughout Virginia

Webinar series will have certificates available contingent upon completion of posttest evaluation measures.

Awareness Training for Domestic Violence Service Professionals

GOAL: To provide advanced knowledge and skills training about the connection between disability and abuse, and the connection between traumatic brain injury to domestic violence and sexual assault to service providers throughout Virginia.

Activities:

- Expand capacity building activities so YWCA Advisory Board members can serve as resources about disability and abuse.
- Develop and administer a training curriculum for domestic violence/sexual assault service professionals.
- Provide live and webinar presentations to domestic violence/sexual assault providers for the YWCA about abuse and brain injuries.

Partnership Models

Partnership with health care providers can be structured in many different ways. There are advantages and challenges with all approaches, but each can represent a significant impact in reaching patients who are experiencing DSV.

Cross-sectoral partnerships with government and law enforcement agencies, private sector organizations, educational institutions and university researchers, medical facilities and state and national organizations to foster collaboration create dynamic impact.

Health centers and domestic violence and sexual assault (DV/SA) advocacy programs are natural partners given their shared mission to improve the health, wellness, and safety of their clients.

Some health insurance plans are now required to provide coverage of screening and brief counseling for DV. Not a screening requirement but if the service is provided, health insurance plans are required to reimburse which incentivizes screening

Informal Relationship Building

Informal connections to organizations can be even more powerful and sustainable than formal methods mandated by a grant or other source.

Encouraging informal connections across sectors ensures that the partnership will outlast funding periods and employee turnover.

Suggestions to begin building informal partnerships across sectors:

- Participate in training opportunities offered by other organizations
- Network at conferences or seminars
- Visit the organization
- Learn to “speak the language” of the organization or sector
- Connect with power holders in the organization and maintain those relationships

Collaboration

The first step in building an inter-organizational relationship is to determine: ***What is it we want to accomplish?***

Possible collaborators within the domestic violence sector include:

- Local domestic violence program s
- Statewide coalition of domestic or sexual violence agencies
- State office of violence prevention
- Legal Services
- Tribal or Collegiate domestic violence services

Cross training can provide education for both domestic violence advocates and those working in various capacities across the criminal legal continuum. Joint training sessions can be an effective way to increase collaboration across sectors.

Possible Collaborators Within the Criminal/Legal Sector

- Probation and parole officers
- Police/law enforcement (city, county or state level)
- Judges/courts (criminal and/or family)
- Prosecutor's office
- Public defender office
- Department of Corrections (state prison)
- Local sheriff or jail administrator (city or county level)
- Human Service programs under contract with corrections or the local jail to provide services to those on probation/parole.

"The initial barrier to success was getting officers to take a new approach to domestic violence, one that recognized domestic violence is an entry level to more violent acts."

Common Barriers to Collaboration

Many domestic violence staff lack sufficient training about the criminal legal system and the macro level barriers that women face as a result of having a criminal record.

Many correctional officers and other criminal legal staff lack sufficient understanding about the potentially long-ranging effects of intimate partner violence on both the mental health of women and on recidivism.

Both systems tend to work independently of each other, with little or no contact or understanding of the value of collaboration.

Staff turnover is rampant

Attitudinal bias, especially among law enforcement and court officers

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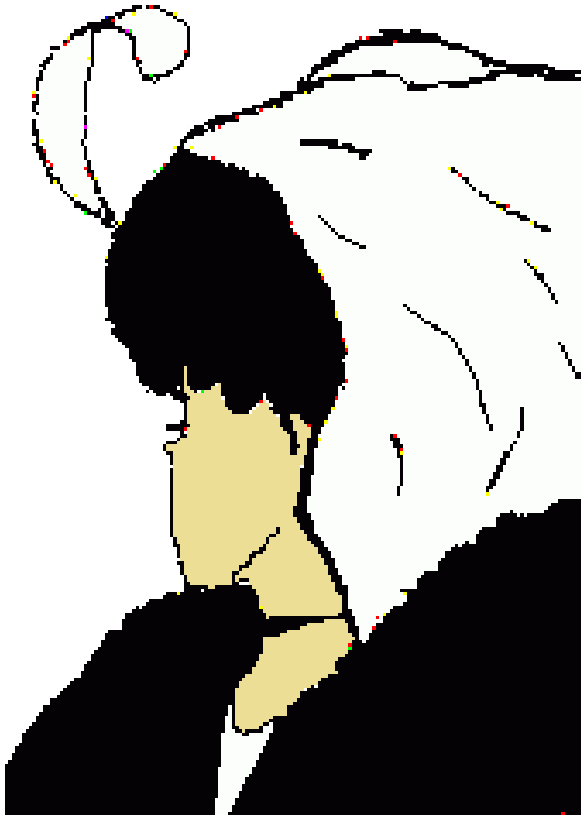


Other Recent Efforts

BIA of NYS: Collaborated on a 2 year training program for staff at shelters, and in law enforcement, the courts system and hospitals; education on link between BI and IPV, screening, resources to work effectively with clients:

BIA of Nebraska: Cooperated with 2 agencies/shelters to conduct rigorous screening. 67 staff were trained to use the HELPS. 66% of participants had lost consciousness as a result of assault, 60% screened positive for symptomatology consistent with BI

BIA of Iowa: Partnered with the Iowa Coalition Against Domestic Violence and 10 domestic violence programs to screen clients; utilized the HELPS brain injury screening tool. 162 individuals were offered the opportunity to complete the screening; 148 agreed to participate; 60% screened positive for a TBI.

Ok. I Have Their Attention…Now What?

Must connect the dots for them…

- the relationship between brain injury and IPV but with other populations that intersect with this audience
- the relationship between what we know to be the effects of brain injury and how they mirror those of IPV

Must provide to them…

- a cogent argument on the necessity of screening and brain injury informed care
- resources to effectively serve these individuals

Frequency and Extent of Brain Injury

TBI: 1.1 million - treated and released
290,000 are hospitalized and survive
51,000 people die every year

- Virginia Dept. of Health estimate: 28,000 TBI's occur annually in Virginia
- Nearly 170,000 Virginians 5.3 million Americans are living with a long term disability as a result of TBI
- It is the leading cause of injury related death and is responsible for more years of injury related disability than any other cause worldwide

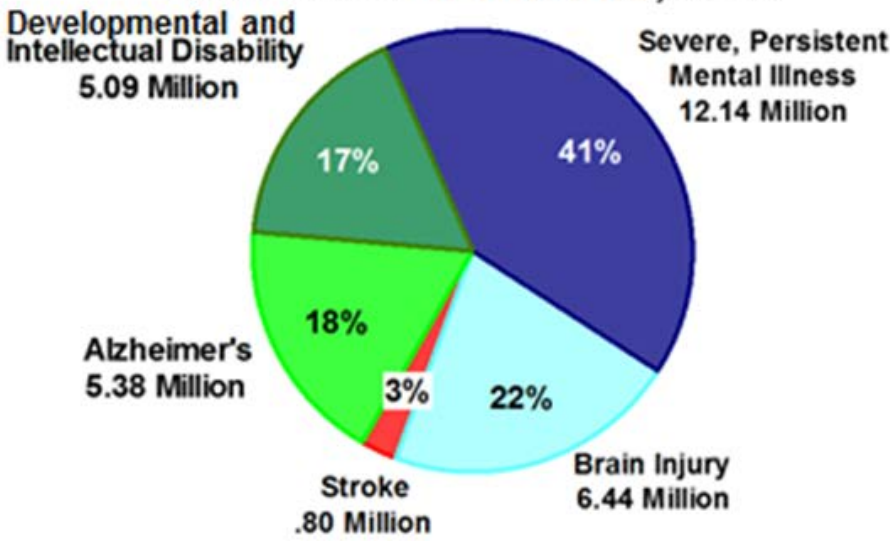
Falls are the leading cause, followed by motor vehicle accidents

After a TBI, the risk for a second injury is THREE times greater; after a second TBI, the risk for a third injury is EIGHT times greater

Stroke: 218,000 in Virginia last year

- Nearly 98,081 Virginians are disabled as a result, and are NOT institutionalized

PREVALENCE OF COGNITIVE DISABILITY IN THE U.S., 2015



Total: 29.86 Million Persons

Source: D. Braddock. (2015). Boulder, CO: University of Colorado, Coleman Institute for Cognitive Disabilities.

Coleman Institute for Cognitive Disabilities
UNIVERSITY OF COLORADO
Boulder | Colorado Springs | Denver | Anschutz Medical Campus

Mechanisms of Brain Injury

Primary:

- Non-Traumatic: cerebral vascular accidents, infections, brain tumors, oxygen deprivation
- Traumatic:
  - Biomechanical Injury: acceleration – deceleration, rotational, cavitation, diffuse axonal injury (DAI)
  - Cytotoxic Injury: axonal swelling, neurotransmitter excitotoxicity, and energy crisis created by metabolic disruption and diminished blood flow

Secondary:

- Bleeding: hematomas, vessel wall collapse
- Swelling: cerebral edema, hydrocephalus
- Increased Intracranial Pressure (ICP)
- Systemic Complications

Mechanisms of Brain Injury

Traumatic

- Falls
- Motor vehicles accidents
- Struck by or against
- Assault
- Blast

Non-Traumatic

- Stroke
- Infection
- Aneurysm
- Toxic exposure (including opioids)
- Surgical intervention
- Brain tumor

Brain Injury Can Begin a Disease Process

Impacts multiple organ systems

- Endocrine/Hormone
- Immune
- Vision
- Musculoskeletal

Is disease causative and disease accelerative

- 37 times more likely to die from seizures, and 7 times more likely to die from pneumonia and other respiratory conditions
- Risk factor for epilepsy, sleep disturbances, psychiatric disease, Alzheimer's disease, chronic traumatic encephalopathy

Shortens the life span

- Life expectancy reduction of seven years for those with moderate to severe TBIs
- Individuals with mild TBIs have been found to have a small but statistically significant reduction in long-term survival

Moderate to Severe TBI

15-25% of brain injuries

Usually sustain some alteration of consciousness

Typically hospitalized, appropriately diagnosed

Most receive follow-up care through the medical system

Most receive inadequate rehabilitation (if they get any at all) resulting in chronic disability and a lifetime of poverty

Mild TBI

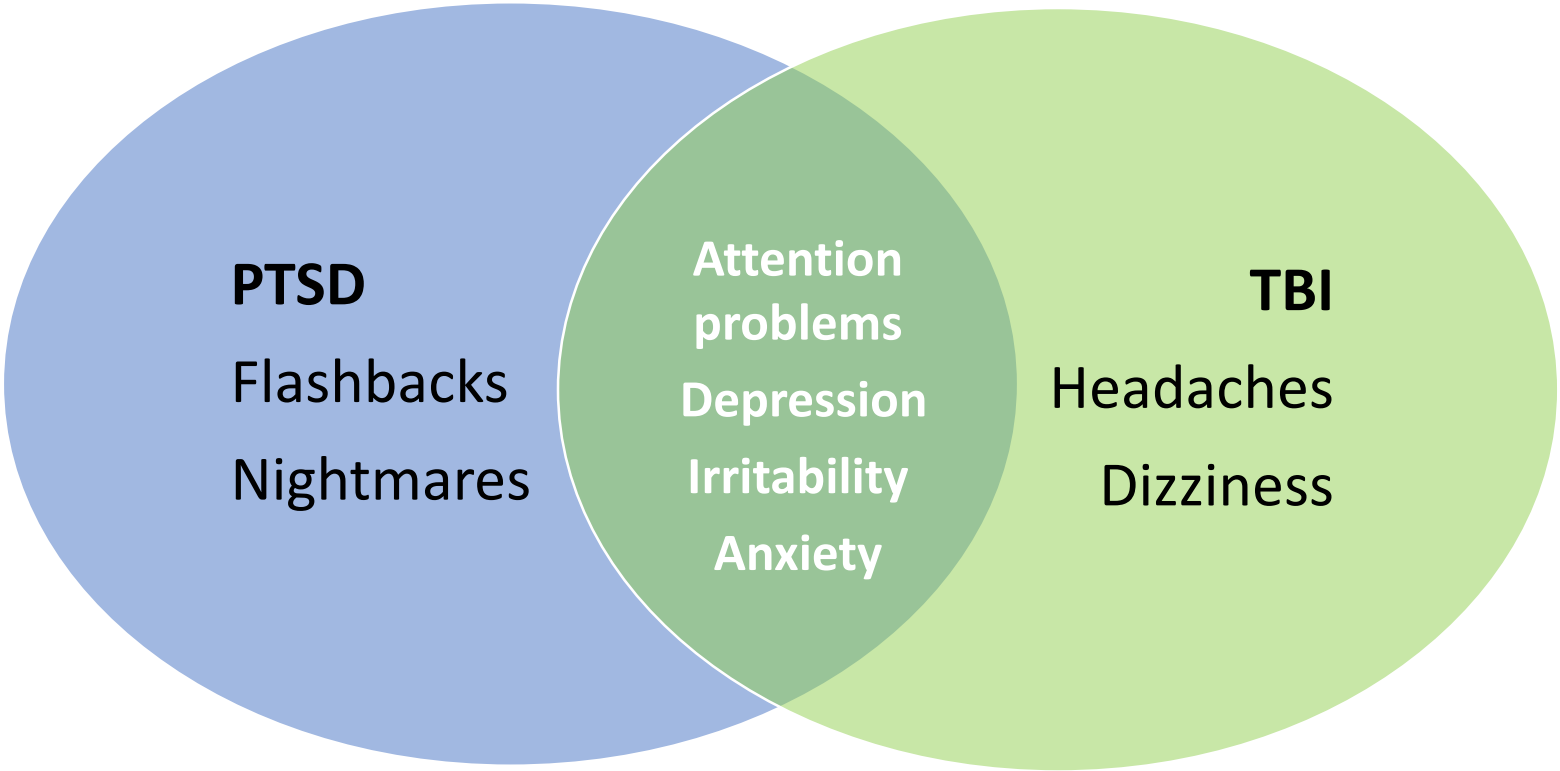
1.7 million brain injuries are diagnosed annually in the US; between 75%-85% (1.0 to 1.2 million) are estimated to fall into the mild range

May or may not experience loss of consciousness; not likely to be hospitalized for their injury

Although some may experience symptoms for several months before they clear, most people eventually recover completely

15% of them will experience chronic cognitive, emotional, behavioral and physical problems

Mild TBI and PTSD: Overlapping Symptoms



No cardiologist ignores a ‘mild’ heart attack. He or she doesn’t say to the patient, “Don’t worry about exercise or your diet unless the heart attack is severe.” Yet we don’t treat a concussion the same way as we do a heart attack. For some reason we tell people “You’re fine” when we know they aren’t.

Dr. Heechin Chae

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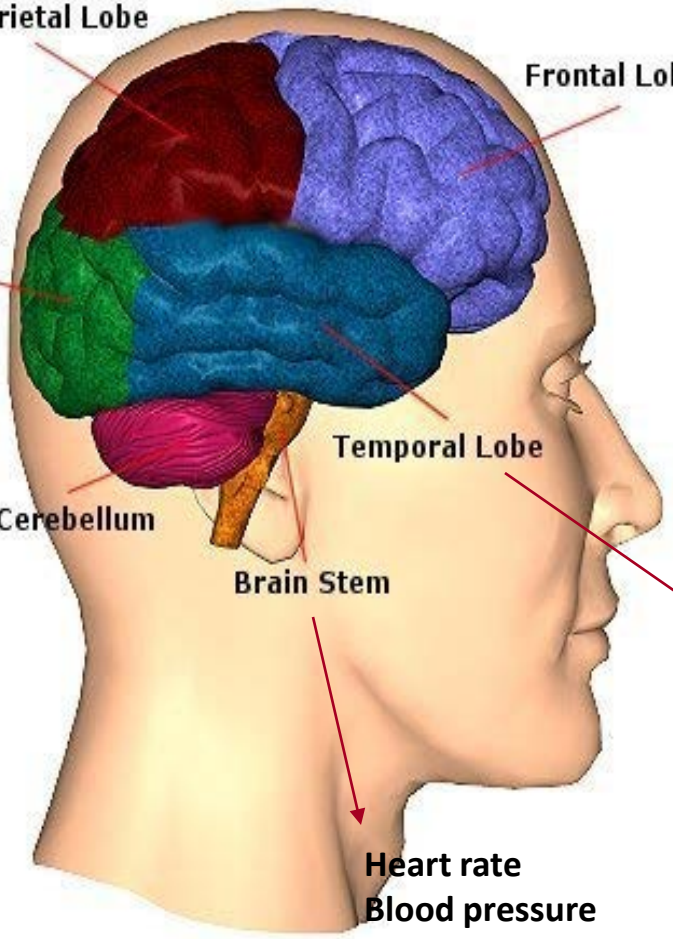


Body sensation (touch, temp, pain)
Spatial Relations
Academic skills (reading)

Executive Functions
Emotional Control
Impulse Control
Judgment
Motivation

Visual Perception

Muscle Tone
Posture
Balance
Coordination

Heart rate
Blood pressure
Respiration

Speech
Language
Hearing
Memory

Think About It….
TBI and Domestic Violence

CDC (2003): Intimate partner violence (IPV) results in ~2 million injuries every year; of those only 1%, or less than 10,000 victims, are appropriately identified by the health care system.

Holmes (2018): As many as 23,000,000 women in the US who have experienced IPV also live with brain injury.

Warren (2016): The rates of TBI in women who are seen in the emergency room or in a domestic violence shelter are between 30 and 74 %; most occur from a direct blow to the head or from strangulation, which can result in loss of oxygen to the brain.

Zieman et al (2017): 81% of 115 patients reported loss of consciousness at the time of a domestic assault; 21 % sought help.

TBI and Homelessness

Petrenchik (2006): Rate of head injury among the homeless is 24%, compared to 2% in the general population

Hwang et al. (2008): Of homeless individuals with TBI, 70 percent experienced their first brain injury before they became homeless.

Topolovec-Vranic (2012): 45% of 111 homeless men surveyed had suffered at least one TBI in their life, with 87% of those injuries occurring before they were homeless.

Oddy et al. (2012): 48% of the homeless participants reported a history of TBI compared to 21% in the control group; 90% indicated they sustained their first TBI before becoming homeless

TBI in Justice Involved Populations

Pickelsimer (2010): 65% of males and 73% of females reported having sustained TBIs at some point in their lives.

Williams (2010): 60% of adult male offenders within a prison self-reported a head injury; of the overall sample, 16% had experienced moderate-to-severe TBI and 48% mild TBI.

Kreutzer (2012): 53% of children remanded in the juvenile justice system in Virginia over an 18 mo. period screened positive for brain injury

McIssac et al (2016): Individuals with TBI are approximately 2.5 times more likely to be incarcerated in a federal correctional facility in Canada than people who have not

TBI and Behavioral Health

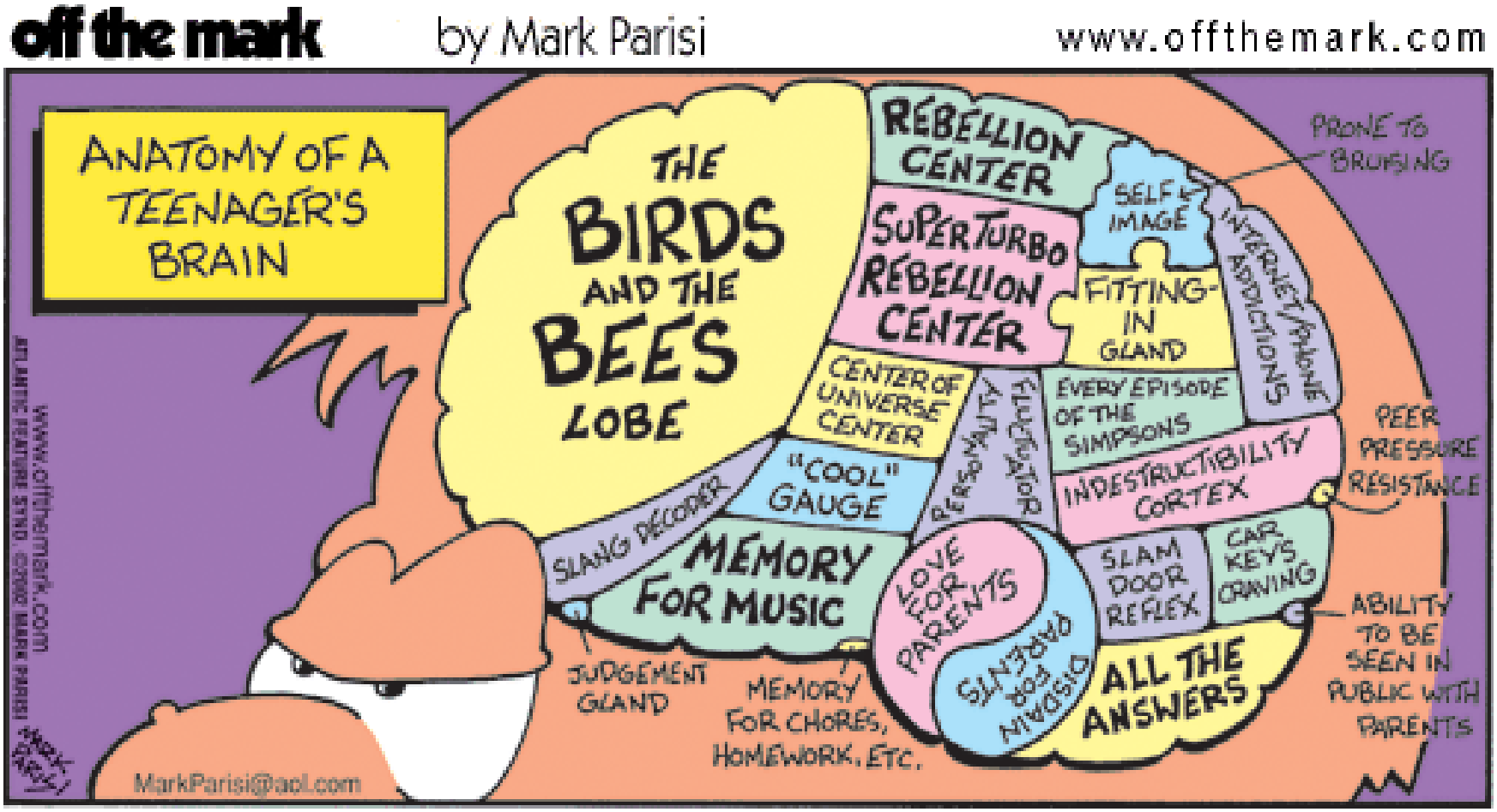
Kaponen (2002) of 60 individuals 30 years post injury: 50% developed a major mental disorder after their TBI, and 23% developed a personality disorder

Kim (2007): In chronic TBI, the incidence of psychosis is 20%; depression: 18-61%; mania: 1-22%; post TBI aggression is 20-40%.

Van Reekum (2000): Compelling evidence of TBI causation for depression, anxiety and Bipolar Affective Disorders

Fann (2002): Psychiatric illness and subsequent TBI: 450,000 members of HMO in Washington were reviewed, and TBI was found in 1,993; 90% of which (1,440) were mild

- Psychiatric illness indicators: diagnosis, medications, treatment
- Findings: Average risk was 24.2% in TBI population vs 14.3% in control group; 9.1% of TBI cases were attributable to psych diagnosis



Cognitive / Physical Changes

- Poor attention span
- Memory disturbance
- Language impairment
- Executive dysfunction
- Intellectual loss
- Inability to shift cognitive sets
- Sleep disturbance
- Headaches
- Visual problems
- Dizziness/Vertigo
- Seizures

Cognitive Impairments Can Lead to Behavioral Issues

Difficulty attending to what's important in their environment

Trouble initiating activity, or stopping it once they've started

Impulsivity and disinhibition

May lack insight into the impact of their behavior on others, and have limited ability to see another perspective

Failure to understand what is expected of them, or cannot remember long enough to carry out what is expected

Unable to do what's being asked of them and engaging in other maladapative behavior

Emotional / Behavioral Changes

- Irritability
- Rage
- Depression
- Anxiety
- Agitation
- Aggression
- Disinhibition
- Apathy
- Impulsivity
- Self-centeredness
- Poor self-awareness

Behavioral Issues Can Lead to Societal Challenges

Lack of insight and ability to self-monitor their behavior

Difficulty appreciating the effects of their behavior on others or making judgments as to the appropriateness of their behavior

Trouble modulating their behavior or responses to situations

Irritating or explosive social behaviors

Problems changing their behavior patterns in response to consequences that may be effective in managing the behavior of others

Assessment/Referral

You don't get better if you're not begin treated for the right thing.

Not every TBI is alike. Each injury is unique and can cause changes that affect a person for a short time, or perhaps permanently.

Sending someone to a neurologist on your provider list doesn't mean they're knowledgeable about brain injury. There are more than 600 neurological diseases and disorders.

BIAV has lists of professionals who are known to have expertise in brain injury; they include physiatrists, neurologists, psychiatrists, psychologists, optometrists, counselors and more

At a minimum, someone who may have a brain injury, regardless of the severity should be assessed by a neuropsychologist if their symptoms persist more than 28 days/4 weeks.

(As far as we know, picture is public domain)

Screening Questions

If someone has been involved in a domestic violence assault, the following questions may help determine if additional assistance is needed:

- Was your head hit?
- Was your head slammed into an object?
- Were you choked, suffocated, shaken or strangled?
- Did you lose consciousness?
- Did you feel dazed and/or confused?
- Are you having trouble concentrating, organizing or remembering things?
- Are you experiencing emotional changes such as irritability, sadness or lack of motivation?
- Are you experiencing headaches, vision and/or hearing problems or loss of balance?

Screening Tools

HELPS BI Screening Tool: Five question screening instrument -

- Medical evaluation
- Loss of consciousness
- Problems
- Injury history for each positive response
- Interpretation Scale

Ohio State University TBI Identification Method

- 5 screening questions
- Injury history for each positive response
- Interpretation Scale

Brief Screening for Possible Brain Injury

- History and symptomatology questions
- Interpretation Scale

Resources

Medicaid Expansion

Many programs requires most health plans to cover certain preventive services, including domestic and interpersonal violence screening and counseling

Concussion Clinics

- Popping up all over the place and already understand mTBI.
- Cultivate a relationship with providers you know; ensure availability to the provider and maintain the relationship
- Provide training and technical assistance that increases their understanding of the IPV/TBI link
- Establish a referral protocol so the provider knows how to contact IPV program services as needed

Federally Qualified Health Centers (FQHC)

Community-based health centers and clinics providing a wide range of comprehensive primary care and case management services to patients on a sliding fee scale.

Services provided can vary from center to center but many offer mental and behavioral health services in addition to medical and dental services. FQHCs have experience integrating a wide range of services into their model.

Primary Care Medical Homes (PCMHs)

Physician-led primary care arrangements offering team-based care. The medical team organizes the care across the “medical home neighborhood” and leverages nonmedical supports and services

Nonmedical supports can include community health workers, home visitation, and other services that take care to the patient and outside the primary care provider’s clinic walls.

Toolkits

TBI as a Result of Domestic Violence: Information, Screening and Model Practices

Pennsylvania Coalition Against Domestic Violence (PCADV): For trainers and advocates; provides key information, exercises and resources. The materials facilitate ways to better equip DV program staff to recognize, understand and respond more effectively to the specific needs of those living with TBI as a result of DV.

Working with Victims with Brain Injuries in Domestic Violence Shelters

New York State Office for the Prevention of Domestic Violence (OPDV): Domestic violence victims who have a TBI may need help coping with the high levels of stress and stimulation that can be part of communal living.. Screening for TBI during shelter intake will help advocates identify ways to make the shelter more accessible and user-friendly.

https://vawnet.org/sc/understanding-intersection-tbi-and-dv

Policy Implications

- Domestic Violence Courts in Idaho, New York and Texas offer Peer-to-Peer Support to improve responses to DV
- In Massachusetts, the Governor's Council to Address Sexual and Domestic Violence created policies to ensure collaborative response by shelters, law enforcement agencies, treatment service providers, and medical clinics.
- The Institute of Medicine (IOM) and the U.S. Preventive Services Task Force recently recommended for the first time that health care providers regularly screen and counsel for DV.
- In California, a new law will become effective in January 2018 directing all California law enforcement agencies to ask victims of domestic violence if they were strangled, and further to document any evidence of strangulation.
- Virginia (2014 HB 708) amended aggravated assault to include the attempt to strangle or suffocate

Violence Against Women Act

VAWA programs include:

- The Services, Training, Officers and Prosecutors (STOP) state formula grants supports coordinated community responses to domestic and sexual violence, as well as specialized services.
- The Civil Legal Assistance for Victims (LAV) program addresses the civil legal needs of victims. It provides practical solutions and long-term stability for victims and their children, and helps to lower incidents of domestic violence.
- The Services for Rural Victims grant enables communities to develop services to meet the unique needs of victims in rural areas.
- The Transitional Housing grant provides a continuum between emergency shelter and permanent safe housing for survivors.
- The Improving Criminal Justice Response program increases offender accountability and reduces homicide.
- The Sexual Assault Services Program state formula grant funds rape crisis centers and services.

Work Worth Doing

Providing training for police and emergency medical personnel around the risk factors for TBI in domestic violence situations, particularly for women, and systematically screening female emergency attendees for signs of domestic violence could increase the identification of TBI.

Understanding of symptoms of TBI in victims of domestic violence could help courts and police to more effectively and empathetically question victims of domestic violence who may have memory lapses due to their condition.

Identifying TBI in domestic violence victims could lead to more appropriate criminal sentencing of those who act violently in the home taking into account the full range of harm that they have inflicted on their partners.


Thank you!