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Abstract
Purpose
The purpose of this paper is to examine the research into prevalence of acquired brain injury in non-ABI specialist services, the impact of the invisible aspects of executive impairment and loss of insight upon functioning and to question how this is assessed and managed by generalist services.

Design/methodology/approach
A literature search was undertaken to identify where people with an ABI may come in to contact with services that are not specifically designed to meet their needs.

Findings
ABI is prevalent amongst users of a variety of community, inpatient and criminal justice services. The common albeit invisible consequences of ABI complicate assessment, service use and or treatment particularly in the context of a lack of underpinning knowledge and experience amongst the staff in non-specialist ABI services. As a consequence risks to children and adults are increased, opportunities for rehabilitation and growth are lost and human potential squandered. Addressing the first stage in this process, developing knowledge of the consequences of ABI and how to assess need, is a pre-requisite for change.

Practical implications
An absence of basic underlying knowledge of the consequences of ABI impacts upon assessment and so limits the effectiveness of services. A consequence of this is manifest in the over-representation of people with an ABI to be found in non-specialist settings.

Originality/value
Little research is undertaken from a social and community perspective into the impact of ABI over the longer term for those who have no contact with specialist services and yet, quite clearly by their use of other services, have unidentified, unrecognised and un-responded to needs.

Introduction
As those working in the field of social care our assessments and the knowledge that underpins and informs those assessments are key to our roles. My professional practice as a social work qualified brain injury case manager leads me to question how we develop that knowledge when it sits outside of what we (or our employers) may expect? If our knowledge excludes factors that have a major impact upon what we are assessing can we Safeguard children for example?
In this paper I outline the prevalence and impact of acquired brain injury and the likelihood that such injuries are a daily feature of social work and social care practice, whatever our chosen field of endeavour. I argue that the impact of acquired brain injury is a fact of our professional lives, one which many individuals and services seem structurally ill-equipped to deal with, starting with a very basic absence of knowledge of the impact of acquired brain injury.

It is necessary to start by asking the question where do people with an acquired brain injury intersect with social care services?

**Prevalence of head injury admissions to hospital**

Numbers of people who have a head injury, either via trauma or medical condition, each year within the UK are unclear and would appear to vary depending upon location (Tennant, 2005) and suffer from under-recording via NHS coding (Thornhill et al., 2000). In all, 20 per cent of the Thornhill cohort of 769 people with an acquired brain injury that they followed up did not have a coding that reflected their injury and hence they would have been missed if recruitment to the research had been based solely on NHS coding to identify them.

McKinlay et al.’s prospective cohort study followed, for 25 years, 97 per cent of all children born in Christchurch New Zealand in mid 1977. Over 30 per cent of this cohort researched sustained a traumatic brain injury by the time they reached 25 years old (McKinlay et al., 2008).

**Residual disability**

A prospective cohort study (Thornhill et al., 2000), identified that 154 people per 100,000 of the population were left as “disabled” as measured by the Glasgow Outcome Scale Extended, (GOSE) one-year post-brain injury (Wilson et al., 1998). The rate of disability amongst those who had been assessed as having a “mild” brain injury, as measured by Glasgow Coma Scale upon admission was unexpectedly high. Totally, 47 per cent of this population were classified as severely or moderately disabled one-year post-injury.

Only 28 per cent of those defined as moderately or severely disabled one-year post-injury had received any form of rehabilitation. Only 15 per cent had contact with social services, replicating precisely Murphy et al.’s (1990) findings from ten years earlier. In the 15 years since the Thornhill study was undertaken, eligibility criteria for services has risen further (Roulstone and Morgan, 2009). Potentially even fewer people with a severe brain injury have contact with social services presently. The GOSE identified, for the cohort that were defined as having had a severe brain injury, 76 per cent had cognitive difficulties and 76 per cent reported difficulties with mood.

Experience shows that if brain injured people do come to the attention of social services knowingly, this is often via the physical disability team, despite the fact that physical impairment post-acquired brain injury is the exception not the norm. Professor Barnes, quoted in Higham and Phelps, notes that 90 per cent of people with a severe head
injury make a reasonably good physical recovery (Higham and Phelps, 1998).

The impact of acquired brain injury: executive impairment
Some of the more common complaints post-acquired brain injury are that of fatigue, headache, reduced speed of processing, difficulties with attention (sustained, selective and divided), with memory (often as a consequence of attentional deficits), with “executive” functions such as reduced idea generation, difficulties planning and organising, reduced problem solving and reasoning capability, reduced ability to initiate planned activity, etc. and with what may be described as “neuro-behavioural” difficulties such as irritability, disinhibition, impulsivity, loss of empathy, egocentricity, blunted emotional responses, emotional lability, aggression and perseveration (Powell, 1997; Oddy et al., 1985; Wood and Williams, 2007).

Such functions and behaviours are clearly complex to assess and therefore formulate a planned response to, as they are complex to even conceptualise (Barkley, 2012). There is evidence, in the non-brain injured population, that the capacity to predict one’s ability to exercise executive control is poor (Nęcka et al., 2012). When compared to loss of limb or spinal cord injury, brain injury has the potential to be more complex in both the assessment of need and the formulation of what plans can be put in place to rehabilitate, compensate or ameliorate for the condition owing to the range of domains that may have been affected by the injury and the interrelationships between them. Quality of life post-acquired brain injury would appear correlated to return to a healthy and productive lifestyle, valued by the individual (Corrigan et al., 2001). As post-traumatic growth and recovery is possible (Hawley and Joseph, 2008; Powell et al., 2007) then knowing what will support and promote such positive change is required.

Executive impairments are difficult to assess in formal settings being is best undertaken over time, in real-life settings and with evidence from third parties. There is no straightforward tabletop testing that replicates executive impairment in real life functional settings, such tests are considered to have low ecological validity. This is recognised in the literature (Manchester et al., 2004; Barkley, 2012) and the in the English and Welsh Courts (Verlander v Rahman, 2012).

The failings of Neuropsychological testing alone as a method for identifying executive impairment was identified within what many would describe as the seminal work in this field (Lezak, 1976) as well as in much earlier work, albeit the language to describe executive impairment used today is absent (BMJ, 1945) (No author name available as BMJ articles were published anonymously in 1945).

Difficulties with problem solving, for example, can have, as their root, difficulties with idea generation. When this is the case, problem-solving strategies cannot simply be applied by the brain-injured party, as the options to weigh up and decide between cannot be generated in the first place. In this instance a difficulty with idea generation can become a significant handicap to an individual, particularly when dealing with novel situations and this has an impact upon functional independence and employability. Experience shows that difficulties with idea generation and initiation are often misattributed to issues of motivation (Notwithstanding the fact that difficulties with poor
idea generation and the associated task failure experienced may be demotivating *per se*. A lack of insight into this difficulty may compound the problems faced by the injured party as all “blame” for failure and difficulty is externalised and so learning opportunities are limited. A neuro-behavioural response simply to reject ideas provided by others (egocentricity) is further disabling for those who cannot idea generate. How such difficulties are understood and assessed is key to planning and implementing services required to Safeguard, to meet need and prevent social exclusion.

As difficulties with executive functioning in performance are an interplay of other variables of potentially complex aetiology but include cognition, mood, emotion and fatigue, then variability of performance is an expected and natural part of the condition (*Stuss et al.*, 2003). It is difficult to gauge how it would be possible to take account of this variability in a one off assessment meeting and how such an approach affects the formulation of plans for intervention in light of this variability.

**Loss of insight**

A further complexity, not unique to acquired brain injury, is that loss of insight into the condition by the injured party is common. Whilst loss of insight into physical impairment is relatively rare, poor self-awareness of cognitive and, in particular, executive impairment is not (*Prigatano, 2005*). To a degree this is logical and understandable as the injured party is more likely to have had a pre-accident knowledge and understanding of what physical impairment is and feedback gained from failure to be able to carry out a physical task, such as standing, is very direct and even painful (It is worth recalling at this juncture that 90 per cent of people with an acquired brain injury are noted to make a good physical recovery (*Higham and Phelps, 1998*). Opportunities to learn and therefore adapt to changes in function are more direct and easily understood (*Hart et al.*, 2009).

One’s capacity to develop self-awareness into cognitive or executive difficulties is, experience shows, more difficult. Feedback from which to learn is less direct and requires greater levels of abstract reasoning to process. Abstract reasoning itself is an executive functioning that may be impaired by brain injury. The skills and abilities required to develop and maintain insight are the ones affected by the injury. Mantell describes this clearly thus:

> Where there are clear physical disabilities, these can easily become the focus of attention, neglecting the impact of the damage to the brain. Often the person may have no physical impairment, but lack insight into their needs. Consequently, they do not look like they need any help and do not think that they need any help, so not surprisingly they often do not get any help (*Mantell, 2010*).

Loss of insight/reduced self-awareness following acquired brain injury is the subject of intense investigation, most usually by Neuropsychologists. Poor self-awareness following brain injury is common, particularly in the earlier stages of recovery (*Prigatano, 2005*). This is often in the context of no discernible loss of IQ as well as no visible impairment making the process of assessment an iterative one of enquiry and not simply a
Difficulties with poor insight/reduced self-awareness are associated with poorer rehabilitation outcomes (O'Callaghan et al., 2012), increased carer burden (Ergh et al., 2002) and is a risk factor for behavioural disturbance (Bach and David, 2006).

In practice, difficulties with insight are associated with difficulties engaging the client with rehabilitation, support and vocational activities (Medley and Powell, 2010).

Crosson generated a hierarchical pyramidal model to describe three levels of awareness post-ABI. These levels are Intellectual, Emergent and Anticipatory awareness, with Anticipatory being the highest level of awareness (Crosson et al., 1989). In this model people with intellectual awareness of their difficulties are able to state what their problems are “Since my accident my memory is terrible” for instance, but not to put in place any strategies to compensate for this, to not recognise when they are experiencing a failure as a consequence of their memory difficulties and to not be able to adjust their behaviour accordingly. This knowledge is therefore solely “intellectual” in nature. This is a very confounding factor for assessment, as the brain-injured party would appear fully cognisant about their difficulties, wholly aware of their impairment. In practice, as this knowledge is purely intellectual, this does not affect the behaviour of the injured party and therefore does not affect their functioning and or functional independence. Any assessment that takes place in the absence of corroborating evidence and/or observation (relying purely on self-report) is therefore very easily able to miss the needs of the brain-injured party.

The remediation of poor self-awareness is a rehabilitation goal, supporting individuals to develop insight in to their condition and what will support them to “rehabilitate” and/or “adapt” (Fleming et al., 2006). Such an approach is recognised to support both the injured party and their family/carers (Medley and Powell, 2010). Improved self-awareness is also associated with increased likelihood of independent living (Malec and Moessner, 2000).

**The impact of parental brain injury**

Parental brain injury is noted to have been a significant factor in a Serious Case Review (SCR) where significant injury occurred to children and to an adult:

*This Serious Case Review has highlighted the need for professionals who primarily work with children and families to understand the nature and possible consequences of traumatic brain injury and the need for professionals who work primarily with traumatic brain injury to understand the possible impact of traumatic brain injury on parenting (Summerfield, 2011, p. 7).*

And:

*The nature of the risk assessments on the part of the Specialist Centre and Children’s services were lacking. In the case of the Specialist Centre, they assessed father’s risk to others based on self-report, they did not seek*
information (Summerfield, 2011, p. 15).

Bearing in mind the skills and abilities required to successfully parent, it is perhaps unsurprising that parental brain injury is reported to have a negative impact for both child and parent (Uysal et al., 1998). High risk of emotional and behavioural difficulties amongst the children of people with a brain injury is reported (Butera-Prinzi and Perlesz, 2004).

As social workers have a key role in the assessment of parenting abilities, knowledge of acquired brain injury supports the possibility that such parents can be assisted to parent to a standard considered adequate and provide a suitable and safe environment for a child previously considered to be potentially at risk by the actions (or lack of action) of their parents (Azar and Read, 2009; Tomison, 1996).

Symptoms of post-traumatic stress disorder have been found in 48 per cent of children of parents with acquired brain injuries in one survey (Kieffer-Kristensen et al., 2011) and lack of parental warmth, nurturing and boundary setting has been identified (Uysal et al., 1998) in another.

Despite the recognition by rehabilitation professionals that children can be negatively impacted upon by parental brain injury, rates of inclusion of children with rehabilitation and the work carried out with their injured parents remains low (Webster and Daisley, 2007).

Whilst the prevalence of people with intellectual disabilities has been noted to be significantly higher in terms of child safeguarding procedures (and the outcome more likely to lead to permanent removal of the child) (Booth et al., 2005), I am not aware of any investigation in to the rates of parental acquired brain injury in such proceedings in the UK.

**Impact of childhood brain injury upon education and childhood development**

That reduced speed of processing, difficulties with attention, memory, behaviour, interpersonal relationships, etc. is a challenge within a school environment, for both staff and pupil, is unsurprising. Lack of knowledge, understanding and experience of teachers proves a limiting factor for academic success and reintegration (Linden et al., 2013).

There is a wealth of literature regarding the impact of childhood acquired brain injury and the negative impact this may have upon development and a young person's ability to learn social and functional skills required to become independent and self-managing (Anderson et al., 2012; Dooley et al., 2010; Rosema et al., 2012).

**Impact upon relationships**

Contact with friends and family has been identified as a key factor in the quality of recovery for individuals (Engberg and Teasdale, 2004) and difficulties maintaining friendships in particular has been noted to be extremely isolating for people with acquired brain injuries (Morton and Wehman, 1995). Evidence has been found to demonstrate that friendships can be negatively affected by acquired brain injury, both in
terms of the numbers of friends and the quality of the friendship (Prigatano and Gupta, 2006). Access to informal support, via friendships, would appear to be negatively affected.

An injury that causes personality and behavioural changes is one that is both common and experienced by the injured party and their relatives, most keenly felt perhaps by parents and partners/spouses. It is unsurprising therefore that relationship breakdown post-acquired brain injury is a feature reported upon. Wood and Yurdakul (1997) noted that, in their cohort, 49 per cent of relationships broke down within a five- to eight-year period post-injury.

Neurobehavioural sequelae of acquired brain injury are common with Deb et al. (1999) finding that 40 per cent of their follow up cohort exhibited three or more identifiable symptoms such as social disinhibition, irritability and lack of initiation. Such sequelae understandably impact upon relationships. Isolation following acquired brain injury and the loss of roles and friendships is common (Rowlands, 2000).

Conversely, violence in relationships is noted to cause acquired brain injury to women (Monahan and O’Leary, 1999).

**Impact upon family/carers**

A body of literature exists as to the specific burden felt and difficulties experienced by those who are the “carers” of people with an acquired brain injury, including the development of psychiatric and health difficulties by the carers (Moules and Chandler, 1999). This is a sudden onset condition, acquired without warning, and the longer-term impact takes time to ascertain. As the majority of the impact of the injury is not visible (in relation to changes to cognition, executive functioning, mood, personality and behaviour) the non-injured party is often left unsupported and lacking information (Powell, 1997; McPherson et al., 2000).

In a comparison study with the carers of people with dementia, carers of people with an acquired brain injury were shown to suffer greater carer burden, poorer mental health and reduced quality of life (Jackson et al., 2009).

The intensity and complexity of caring for brain-injured relatives, without adequate support, is such that parents have been reported to wish their own brain-injured children to be dead (Webb, 1998; Higham et al., 1996). Many writers have attempted to capture the very personal nature of acquired brain injury and the emotional impact upon family (Crimmins, 2001; Swanson, 1999). Resolution or emotional closure for relatives being hard to achieve because of what is described as “ambiguous loss”. The injured party is physically present but emotionally changed/absent and so grief is unresolved (Boss, 1999). Carer burden is noted to increase over time (Levor and Jansen, 2000).

Notwithstanding the position families are left in by brain injury, their incorporation and involvement in the process of rehabilitation is recognised as central to good recovery (Kreutzer et al., 2010).
Prevalence of acquired brain injury in UK prison populations
Research into prevalence of acquired brain injury rates in UK male prisoner populations shows similar and concerning levels of injury (Williams et al., 2010) at around 60 per cent and a meta-analysis of previous studies indicating a prevalence rate of 52 per cent (Shiroma et al., 2012). The largest UK study undertaken to date, by Pitman et al. (2013), indicated a prevalence rate of 47 per cent amongst a prisoner population and that of these brain injured prisoners, 73 per cent reported that the brain injury predated their first offence, 71 per cent had experienced more than one traumatic brain injury, 30 per cent had experienced five or more traumatic brain injuries, 43 per cent had been in prison five or more times, 80 per cent had a history of drug use and they were three times more likely than non-brain injured prisoners to have held only partly skilled, unskilled jobs or to have never been employed.

Prevalence of acquired brain injury in psychiatric settings/amongst people with a psychiatric diagnosis
Prevalence of acquired brain injury within UK psychiatric settings/users of psychiatric services appears to have not been interrogated. Within the limited US studies available prevalence of traumatic brain injury in psychiatric settings notes increased rates of injury, compared to controls, increased severity of injury compared to control groups and increased likelihood of the presence of more than a single incident of brain injury (Burg et al., 1996; McGuire et al., 1998).

A large study (n=1,440) by Fann et al. identified that the relationship between acquired brain injury and psychiatric conditions can and does operate in both directions:

The main finding of our study was that patients with any indicator of psychiatric illness experienced an increased risk of subsequent TBI (relative risk 1.6) compared with those who had no indicator of psychiatric illness. This increase was seen with three different indicators of psychiatric illness: ICD-9-CM diagnoses, psychiatric medication prescription, and psychiatric service utilisation (Fann et al., 2002, p. 618).

With specific reference to schizophrenia and traumatic brain injury Molloy et al. undertook a meta-analysis of research available and found that there was an increased risk of developing (or of being diagnosed with) schizophrenia post-traumatic brain injury of 60 per cent. They state:

This meta-analysis supports an increased risk of schizophrenia following TBI, with a larger effect in those with a genetic predisposition to psychosis (Molloy et al., 2011, p. 1104).

A review of the literature into suicide post-acquired brain injury indicated that this appears to run at approximately three times community controls (Fleminger et al., 2003). Simpson and Tate (2007) estimated this to be at three to four times greater than for the general population.

As rates of acquired brain injury amongst UK based psychiatric service users has not to
my knowledge ever been established, it is not possible to state how many people are 
missdiagnosed/misplaced as having mental health problems with no reference made to 
their brain injury. Experience would lead me to state that this is not unheard of at all, 
particularly in the case of brain injury in childhood/adolescence leading to an altered 
development by the young person concerned (Fleminger, 2008). UK social workers, 
specialising in mental health settings, would be expected to come across people with an 
acquired brain injury but who may not self-identify as such and therefore their 
assessments and interventions will not be informed by the underlying nature of the 
presenting condition.

**Acquired brain injury and substance use**
Work by Corrigan *et al.* into prevalence of traumatic brain injury amongst services users 
at a dual diagnosis (substance use and severe mental illness) US treatment centre 
identified that 72 per cent of their cohort were brain injured. Perhaps more importantly, 
it was noted that the participants with a brain injury had commenced drug use at a 
younger age, had worse functioning and had a more severe diagnosis of mental ill 
health (Corrigan and Deutschle, 2008). Further work by Corrigan notes: 

*Early childhood injuries were also associated with slower speed of information 
processing and more cognitive complaints; in addition, these clusters were also 
associated with more complicated substance use disorders (Corrigan et al., 
2012).*

**Acquired brain injury homelessness, unemployment and quality of life**
Acquired brain injury amongst homeless populations has been assessed at around 48 
per cent with 90 per cent reporting acquiring a brain injury prior to becoming homeless 
(Oddy *et al.*, 2012).

Return to work, post-acquired brain injury, has been noted to be complex and an early 
study, (Brooks *et al.*, 1987) demonstrated that employment rates dropped from 86 to 29 
per cent post-injury and that “the presence of cognitive, behavioural, and personality 
changes was significantly related to a failure to return to work”. Research into 
employers’ attitudes towards applicants with a declared acquired brain injury rated 
similarly to those applicants who declared a history of schizophrenia (Bricout and 
Bentley, 2000).

General quality of life post-injury is subjectively and objectively deleteriously affected 
(Jacobsson *et al.*, 2010) and is noted to be reported upon as lower even than for other 
groups with long-term and life-changing health conditions (Horneman *et al.*, 2005).

**Long-term outcome following acquired brain injury and deterioration of 
psycho-social functioning**
Long-term outcomes studies in relation to acquired brain injury demonstrate a mixed 
picture with examples of good recovery, poor recovery and deterioration over time 
(Fleminger, 2012). A long-term follow up study demonstrated that deterioration post-
discharge from hospital was a possibility and that this may be mediated by factors that 
are not medical in nature but were associated strongly with psycho-social factors
Further long-term follow up studies have identified psycho-social deterioration over time (Millar et al., 2003).

Olver et al. note that functional gains were made by the cohort they studied in a longer term follow up but that there were also losses of employment, student status and ongoing difficulties with cognitive, emotional and behavioural difficulties remained high at the five-year mark. The authors of this study link the idea of increased awareness of the impact of the injury upon the injured party over time with the need for longer term and proactive interventions to be established. Whilst this cohort had access to support, if requested, to maintain employment when this proved to be at risk, this was not initiated by the brain-injured. They note that increasing self-awareness over time can lead brain injured people to be more receptive to intervention at a later stage (Olver et al., 1996).

Impact on premature mortality
Prevalence of injured parties living in the community has increased as advances in para-medicine, neurosurgery and intensive care management have taken place (Higham and Phelps, 1998; Powell, 1997).

Once the initial acute phase of the condition has passed, the injury itself is not noted to foreshorten life expectancy. Life expectancy therefore had previously thought not to have been affected or at least not greatly affected. McMillan's work in Glasgow, however, a 13-year prospective study, would appear to raise doubts about the commonly held view that death rates, post-acute phase, are similar to those of non-brain injured people with an increased likelihood of mortality being assessed as 2.8 times community controls (McMillan et al., 2011). Cause of death was not noted to be directly related to the brain injury itself.

This significantly increased rate of mortality raises questions regarding why this should be the case when the explanation is not simply medical in nature, it would not appear to be the brain injury per se that is causing death but the impact of the brain injury upon day to day functioning. It is recognised that this cohort of injured people are potentially experiencing cognitive and executive difficulties and, as per the Thornhill cohort, may well be living without any formal or even informal support in the community. It is possible to question whether an absence of support or rehabilitation to compensate for cognitive, executive, behavioural and emotional difficulties foreshortens life. Most simple examples being a lack of ability to manage a balanced diet and/or note when medical treatment is required and be able to comply with it. These are the very issues we support our clients with on a daily basis, issues that some of our clients do not manage themselves without input.

Potential contact between social care service and people with an acquired brain injury: conclusion
Evidence exists in the literature of the impact of acquired brain injury in terms of increased rates of mortality (not directly related to the injury itself), reduced academic achievement/participation in education, increased rates of relationship breakdown, loss of informal support networks, very significant carer burden, increased (and serious) risks to children, reduced participation in work (with the concomitant reduced income and
loss of self-identity this creates) of poorer mental health and suicidality and of increased rates of homelessness and incarceration, often within the context of problematic alcohol and drug use and of significant recidivism.

As the nature of the injury, particularly those aspects relating to executive impairment and emotional and behavioural difficulties, take time to develop, are not readily apparent for simple assessment and, as noted, are not always aspects of difficulty that the brain injured person is aware of, there are implications for the long term nature of need for (and style of) service provided to such people to promote recovery and rehabilitation but, just as importantly, to prevent deterioration.

Acquired brain injury is therefore common and it is inconceivable that a UK social worker could work without coming across brain injury in some guise, irrespective of their speciality and chosen field of practice. That the brain injured party themselves may not self-identify as brain-injured and that their functioning and presenting difficulties may not be obvious is a complicating factor.

The impact of the injury, as noted above, is social exclusion from which the injured party is severely restricted from addressing themselves without external input as a consequence of the injury itself.

To return to the SCR noted previously, one may ask for example how a social worker could make an assessment of parenting skills and of risk to children without sufficient knowledge of the impact of acquired brain injury and the need for corroborative evidence to make an assessment? The underlying cause of parental aggression, poor boundary setting, neglect and lack of attachment to children and of childhood symptoms (Anderson et al., 2008) of PTSD is implicated in the risks to a child and the plans that may be made to Safeguard them. If, by way of a very simple example, perceived or actual neglect of a child is predicated on poor post-injury capacity for a parent to shop, cook and launder adequately as a consequence of reduced ability to plan, initiate and problem solve, then directly supporting such activities may well be indicated as the least intrusive and most effective way of supporting a family to safely stay together. Knowledge of what works is required (Webster and Daisley, 2005). If, however, parental aggression and violence is as a consequence of disinhibition and impulsivity, directly as a consequence of injury to the frontal and pre-frontal cortex, then the ability of unwelcome and dangerous behaviour to be controlled requires considerable expertise to assess.

**Implications for practice**

Our practice, our assessments and plans for interventions that Safeguard young and old, that provide vital services and that reduce social exclusion require underpinning by knowledge. An absence of this knowledge, especially in the context of complicated brain injured people who lack insight, means that the decisions and plans that follow our assessments have the potential to be dangerously flawed.

I would argue that spreading knowledge regarding the impact of acquired brain injury is required for all social workers, in practice and in training. Simply recognising the
prevalence and impact of such injuries and how they manifest is the starting point to a necessary revolution that has been happily caused by advances in medical treatment. The long-term consequences of acquired brain injury are most usually psycho-social in nature not medical. It is in to our professional domain that people find themselves thrust unwillingly. Survivors of acquired brain injury are here to stay, it is social care services that need to respond and respond positively. The starting point is an acceptance and acknowledgement of the condition and its impact followed by a greater understanding of how to respond effectively; understanding what works is key to what we need to do. The alternative is not working presently.

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