Centre for Care

SCYPHeR
South Yorkshire Children and Young People's Health Research 2024

# Recognising and responding to vulnerability after childhood traumatic brain injury


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UKRI Economic and Social Research Council

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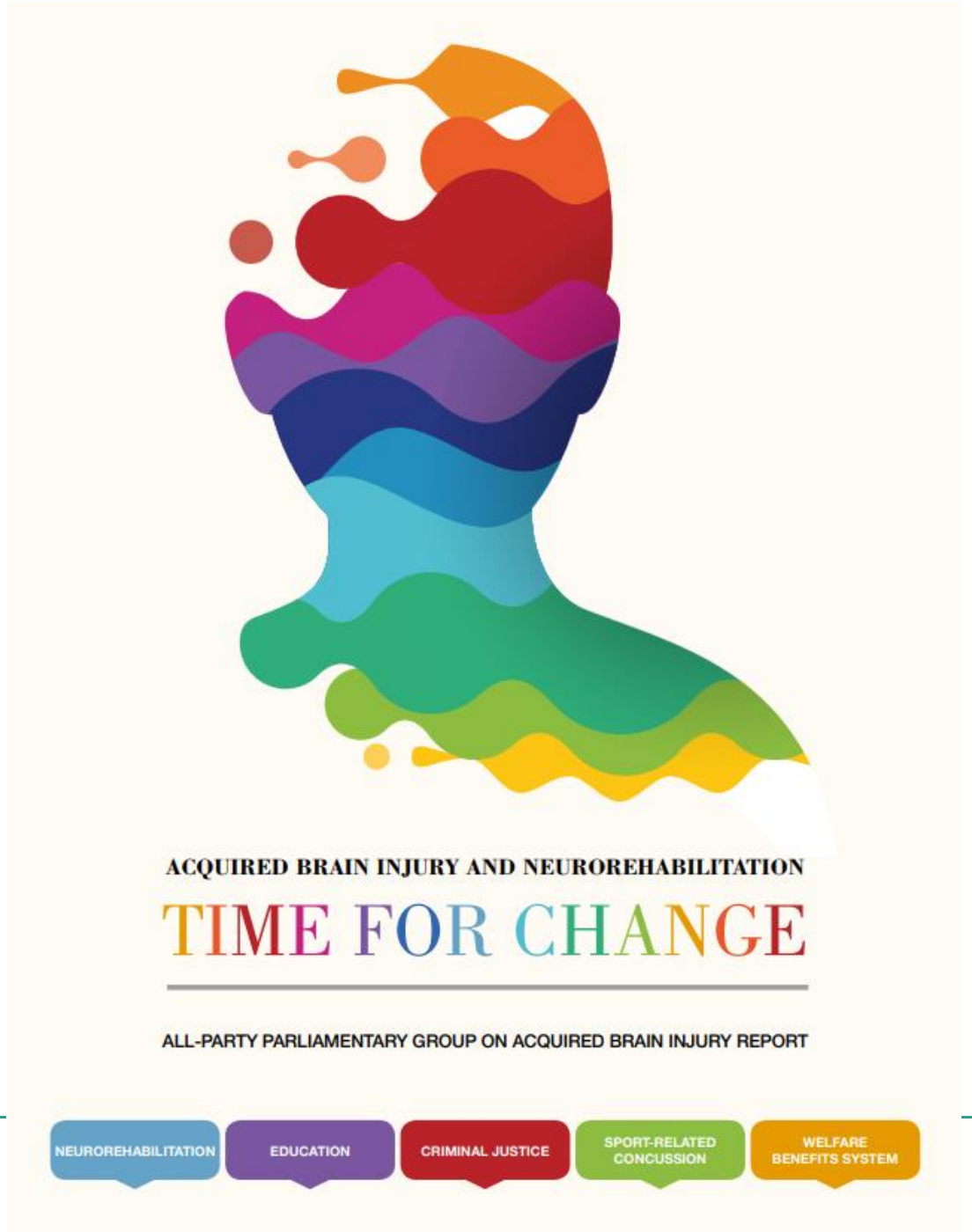
# Today's argument in a nutshell:

Young people with a traumatic brain injury are made vulnerable, discriminated against, and ultimately disabled by daily experiences, which combine to heighten risk of educational disengagement, school exclusion, and criminalisation.



# The social model of disability

‘Impairment is the functional limitation within the individual caused by physical, mental or sensory impairment. Disability is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers.’

(Barnes, 1991, p.2)

**My question and challenge to you:**

How can our hospital and health services help to prevent these potential negative outcomes for children after a TBI?

What can we do locally to make South Yorkshire an example of good practice?

**A lack of effective recognition and support following acquired brain injury increases risk of educational difficulties and disengagement**

# Endemic problems in transitions from hospital-to-school

Educators and clinicians report experiencing:

- lack of communication between medical and school professionals
- lack of preparation for the transition back to school
- lack of support and ongoing information for school professionals
- lack of teacher training and knowledge
- lack of clear policies and practices

(Hartman et al, 2015)

# Long-term consequences for learning

Children with a TBI can experience a bespoke combination of:

- Difficulties processing information
- Reduced concentration and attention
- Difficulties with organisation and planning
- Impaired working and longer-term memory
- Difficulties understanding and using language
- Fatigue

These heterogenous needs may not always fit with established criteria for special educational needs support

# Identifying and attributing needs in schools: cumulative and delayed impact of TBI

- Short term physical recovery may mask ongoing ‘hidden’ difficulties
- Unmet needs can have a cumulative impact: children experiencing TBI remain ‘behind the curve’ as they progress through education
- ‘Neurocognitive stall’ may occur: a slowing in later stages of cognition, social, or communication development
- Childhood TBI may cause difficulties in adolescence when affected brain regions are utilized for higher order functions. Secondary schools might not attribute this appropriately without awareness of the TBI.

# The misunderstanding of behavioural problems

Difficulties can emerge as behavioural problems, such as:

- Overactivity
- Disinhibition and impulsivity
- Irritability / reduced anger control
- Verbal and physical aggression
- Depression, anxiety, increased emotionality, social withdrawal

If not recognized as related to TBI, such behaviour can be perceived as attitudinal, including as an unwillingness to learn, oppositional behaviour, etc.

Children with a TBI appear prone to falling under the ‘catch-all label’ of behavioural, emotional and social difficulties, potentially leading to inappropriate support

# Implications

- ✓ Information sharing between health services and schools following childhood TBI should be mandated
- ✓ ‘Return to school’ pathways should be developed and routinely monitored, including at key points in educational trajectories
- ✓ (Failing that, parents need to understand the potential longer-term impacts...)
- ✓ All teachers need sufficient awareness to recognise and understand the influence of TBI and to challenge assumptions of misbehaviour
- ✓ TBI should be reflected in the Special Educational Needs and Disability Code of Practice, and specific interventions developed and evaluated

# N-ABLES: The National ABI Learning and Education Syndicate

- Established in 2018 on the back of recommendations made in the 'Time for Change' report of the All-Party Parliamentary Group for Acquired Brain Injury

- Strategic aims:

1) Raise the political profile of ABI in education.

2) Identify and share good practice in support of the education of children and young people with an ABI.

3) Increase awareness and understanding of ABI within the education system.

4) Create opportunities and collaborations for research focused on ABI and the education system.

**N-ABLES**

**The National Acquired Brain Injury in Learning and Education Syndicate**

**Follow / join us on Twitter #NABLES10**
**or by email NABLES@UKABIF.org.uk**

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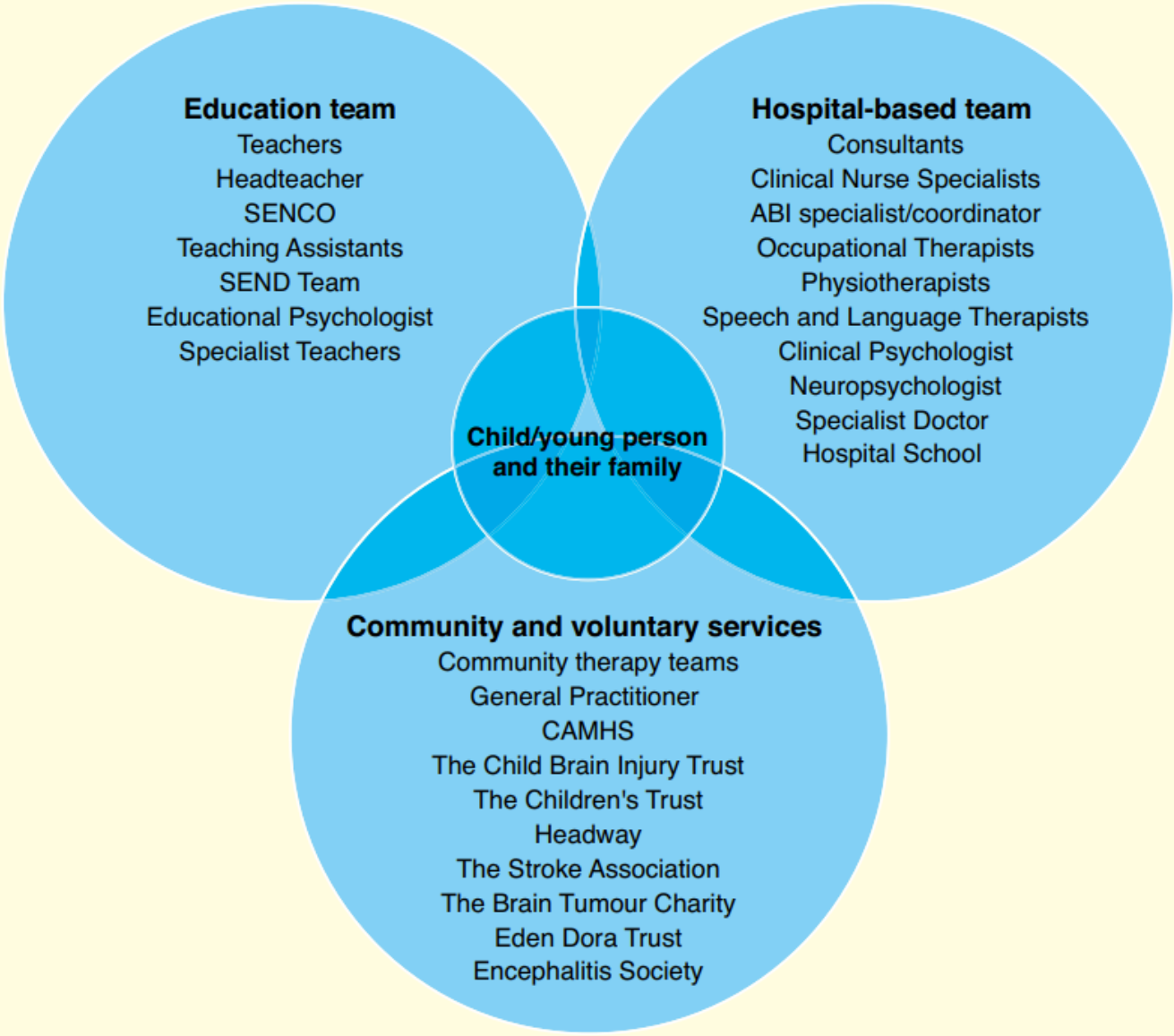
# ABI RETURN

## CHILDREN AND YOUNG PEOPLE WITH ACQUIRED BRAIN INJURY – GUIDING THEIR RETURN TO EDUCATION


# The 'RtE' team around the child and family



ABI RETURN

CHILDREN AND YOUNG PEOPLE WITH ACQUIRED BRAIN INJURY – GUIDING THEIR RETURN TO EDUCATION

# SENCO/keyworker return to education checklist

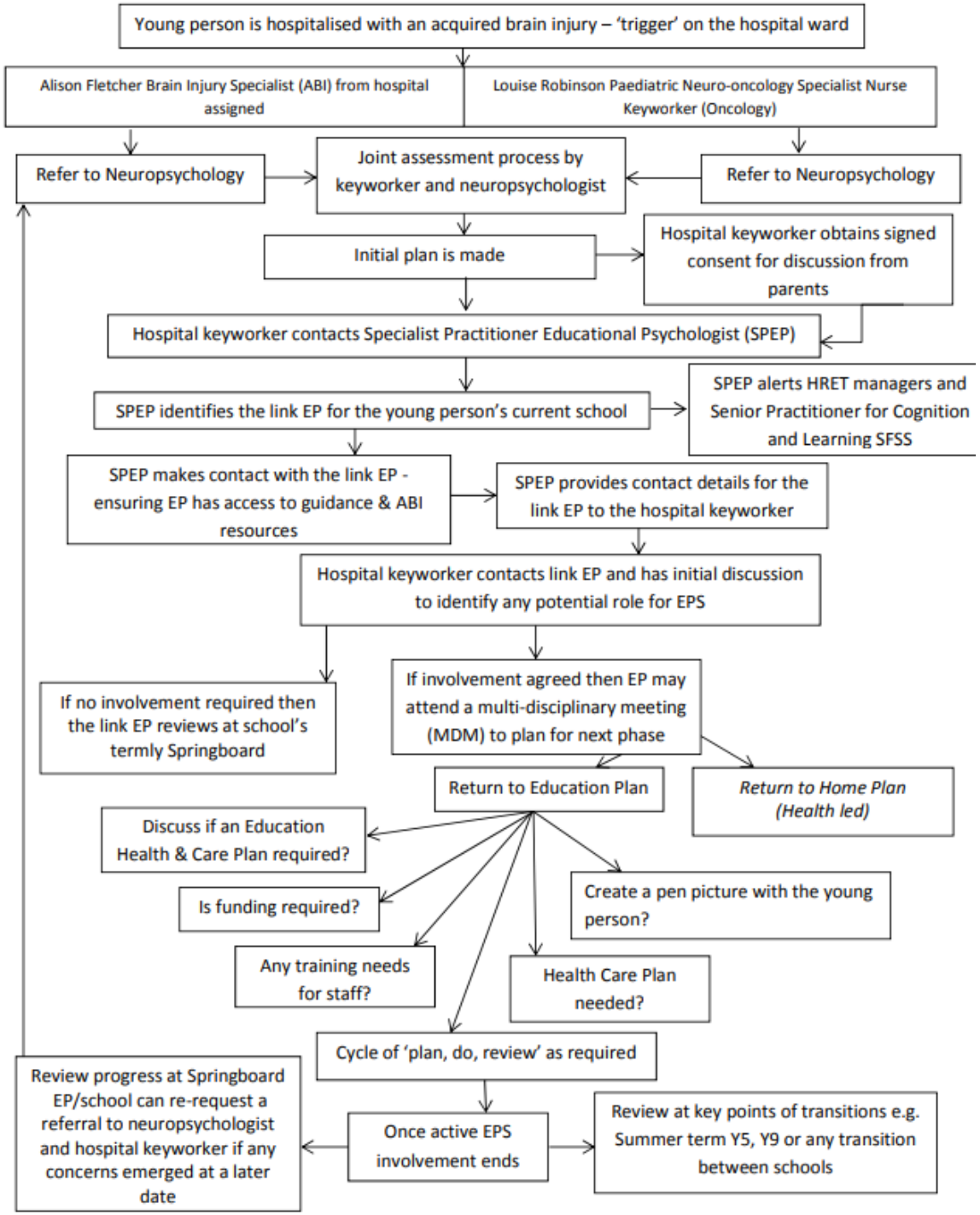
| Action | Person responsible | Completed by | Actioned |
|---|---|---|---|
| Identify a keyworker e.g. SENCO/staff member who knows the young person well | | | |
| Establish regular communication with parents/ carers and child or young person | | | |
| Engage with the hospital team e.g. attend MDT meetings and discharge planning meetings, link with the hospital school and provide pre-injury information on child/young person's strengths and needs. | | | |
| Liaise with health professionals involved e.g. neuropsychologist, speech and language therapist, occupational therapist, physiotherapist, consultants and specialist doctor | | | |
| Refer to educational support services e.g. educational psychologist, specialist teachers, home tuition services if required | | | |
| Explore access arrangements to support the return to school e.g. environment adaptation, timetable, phased return | | | |
| Consult with professionals when developing individual support plans e.g. access reports and training | | | |
| Consider application for interim funding based on health needs | | | |
| Continue with regular team around the child meetings in order to monitor progress and adapt the intervention plan according to need | | | |
| Establish if there is a need for a health care plan e.g. administering medication or personal care needs and training for staff | | | |
| Discuss early application for Education Health and Care Plan with parents/carers and supporting professionals | | | |
| Access free training for staff and peer group on Acquired Brain Injury | | | |
| Ensure that information about the child/young person's needs are communicated to all staff | | | |

ABI RETURN

CHILDREN AND YOUNG PEOPLE WITH ACQUIRED BRAIN INJURY – GUIDING THEIR RETURN TO EDUCATION

# Supporting information sharing within school

| Areas of need | Information to be shared |
|---|---|
| Basic information about the nature of the injury | |
| CYP's understanding of their needs/what do they want people to know? | |
| Child/young person's strengths, skills and interests prior to their injury | |
| Impact of the ABI e.g. cognition and learning, social, emotional, communication, sensory and physical | |
| What do peers/friends know? | |
| What works in the classroom? | |
| Things that don't help at school | |




Nottinghamshire County Council

**Educational Psychology Service**

# Making a Successful Return to Education: Supporting Children and Young People with Acquired Brain Injuries (ABI)

SAM WHITE LEGACY

# Experiences of disability and discrimination can criminalise young people with a TBI

*J Head Trauma Rehabil*
Vol. 30, No. 2, pp. 94–105


OPEN ACCESS

# The Prevalence of Traumatic Brain Injury Among Young Offenders in Custody: A Systematic Review

*Nathan Hughes, PhD; W. H. Williams, PhD; Prathiba Chitsabesan, MRCPsych; Rebecca C. Walesby, PhD; Luke T. A. Mounce, PhD; Betony Clasby*

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# Prevalence of traumatic brain injury (Hughes et al, 2015)

| Nature of TBI | Prevalence among young people in general population | Prevalence among young people in custody |
|---|---|---|
| **Any head injury** | 24 – 42% | 49 – 72% |
| **Head injury resulting in loss of consciousness** | 5 - 24% | 32 - 49.7% |
| **Head injury resulting in loss of consciousness for 20 minutes or more** | 5% | 18.3% |
| **More than one head injury** | 9.2 – 12% | 45 – 55% |

# Risk of criminalisation is increased after TBI

- Swedish population registers from 1973 to 2009 show that those who have experienced a TBI are **at twice the risk** of committing a violent crime than their unaffected siblings (95% CI 1.8–2.3) (Fazel et al, 2011)
- In a study of 30,000 people in Western Australia, males hospitalised by TBI **are 1.7 times more likely** to offend than same-sex full-sibling controls (95% CI 1·3–2·3) and **1.9 times more likely** to commit violent crimes (95% CI 1.2-3.0) (Schofield et al, 2015)
- In a study of 1.4m people in Ontario, Canada, experiencing a TBI is associated with a **2.5 times increased risk** of subsequent incarceration (95% CI 2·2–2·8) (McIsaac et al, 2016)

# Impairments associated with antisocial behaviour

- **Executive functioning**: decreased inhibition; inability to anticipate consequences of actions; poor sensitivity to punishment and reward; socially inappropriate behaviour in challenging contexts
- **Social communication**: affects interaction with peers and susceptibility to peer pressure; use of challenging behaviour as a means to communicate emotions
- **Emotional regulation:** impulsivity and impatience; difficulties in restraining emotional reactions; inadequate consideration to consequences of action; difficulties empathizing with feelings of others

# Restricted access to justice

- A failure of criminal justice agencies to identify and therefore appropriately support young people with TBI, before entering custody
- Terminology and conceptual language can be particularly difficult for young people with a neurodisability to understand (Sanger et al, 2001; Wszalek and Turkstra, 2015)
- Forensic interviewing techniques pose barriers to those with difficulties in narrative language skills (Wszalek and Turkstra, 2015)
- Communication difficulties can lead to ‘monosyllabic, poorly elaborated and non-specific responses’, ‘poor eye-contact and occasional shrugs of the shoulders’, which may be misinterpreted as ‘deliberate rudeness’ and ‘willful non-compliance’ (Snow and Powell, 2012)

# Inappropriate criminal justice interventions

- A lack of awareness of TBI leads to a lack of understanding of the causes and contexts of offending behaviour
- There is typically limited specialist services or responsive provision, despite evidence for the effectiveness of particular approaches (Clasby et al, 2018)
- Specific learning support needs can affect an ability to engage with criminal justice interventions, e.g. receptive language skills, learning difficulties, memory.
- Typical interventions are often highly verbal or seek to utilise metacognitive skills to reflect on behaviour (‘thinking about one’s own thinking’), which pose considerable barriers for young people with impairment

# Criminalising TBI?

This is inherently tautological: the failings of the system to effectively support these young people so as to prevent re-offending reinforce their involvement with the system and its continued failure to do so, resulting in a higher subsequent risk of eventual custodial intervention.

Hughes, N. and Chitsabesan, P. (2015) **Justice Matters: Support for young people with neurodevelopmental impairments**, Centre for Crime and Justice Studies Working Paper, CCJS: London.

# Damaging experiences of custody

- The transition between community and custody can effect continuity of care and support, and cause stress that can exacerbate certain difficulties
- Young people with TBI are at greater risk of being subject to restraint techniques, due to a lack of understanding of the influence of functional deficits on compliance (e.g. Talbot, 2008)
- Educational and rehabilitative interventions rarely take account of specific learning needs and styles
- Young people with neurodisability are at greater risk of bullying (Gooch and Treadwell, 2015), and self-harm or suicidal thoughts (Chitsabesan et al, 2015)

# Implications

- ✓ Record sharing should allow criminal justice agencies to know whem a child has experienced a TBI
- ✓ Routine screening should be undertaken in court and community justice, as well as custodial settings, and inform practice of all staff working with a young person
- ✓ Generic policing and youth justice procedures, practices and interventions should not assume cognitive and communicative competence or understanding
- ✓ Interventions must be adapted to take account of specific learning needs, and evidence-based specialist interventions should be used in criminal justice settings
- ✓ Children with disabilities should be diverted from our criminal justice systems

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