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Acquired Brain Injury: Prevalence, societal perceptions, demographic intersections, and the case for systemic reform in criminal justice and therapeutic practice

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Abstract

Acquired brain injury is one of the most prevalent yet persistently under-recognised causes of cognitive and behavioural disability worldwide. This review synthesises current literature on ABI, with particular emphasis on distinguishing it from traumatic brain injury, epidemiological patterns, and the impact of societal and media representations on public understanding. The review examines demographic intersections that increase risk, especially among younger males and individuals experiencing domestic violence, poverty, and homelessness. It also analyses the overrepresentation of ABI within criminal justice systems, the financial and social consequences of inadequate identification and support, and the current landscape of psychological and rehabilitative interventions. Significant deficiencies are identified in screening practices, access to therapy, and practitioner training. The review concludes by recommending structural reforms across the healthcare, justice, and social policy sectors and outlining research priorities to address these critical gaps.

Keywords: Acquired Brain Injury; Traumatic Brain Injury; Criminal Justice; Stigma; Review

1. Introduction

Acquired brain injury (ABI) encompasses all forms of brain damage occurring after birth, arising from a wide range of causes, including traumatic events, neurological illness, and systemic medical emergencies. Despite its broad scope and significant clinical relevance, ABI remains poorly understood in both public and professional contexts. It is often conflated with narrower diagnostic categories or misattributed to behavioural or psychological causes when its neurological origins are unrecognised (Williams et al., 2018). The consequences of this lack of recognition extend beyond academic concerns, manifesting as diagnostic neglect and therapeutic exclusion, and, for those in custodial settings, as inappropriate institutional responses.

This review synthesises research across several interconnected domains. It first delineates the definitional boundaries between ABI and traumatic brain injury (TBI), then reviews the prevalence literature, drawing on both statistical and anecdotal evidence. The analysis then examines representations of ABI in social discourse and the media, explores theoretical frameworks of stigma, and considers the impact of dominant narratives that pathologise behaviour without acknowledging its neurological origins. Demographic data are analysed in detail, with particular emphasis on the increased risk among younger males and the intersecting vulnerabilities associated with domestic violence, poverty, homelessness, and social marginalisation. The review further investigates the consequences of these risk factors within the criminal justice system, evaluating the human and economic costs of confining cognitively impaired individuals in punitive rather than supportive environments.

The review also assesses the current state of psychological and rehabilitative interventions for individuals with ABI, including cognitive rehabilitation (CR), cognitive behavioural therapy (CBT), and emerging models such as link worker

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schemes. Significant gaps are identified in practitioner training, service availability, and the financial structures governing access to specialist care. The review concludes by advocating a systemic reorientation of ABI practice and policy, aiming to normalise help-seeking, reduce stigma associated with neurological disability, and ensure that affected individuals receive supportive rather than punitive responses.

2. Defining Acquired Brain Injury and Traumatic Brain Injury

The terms acquired brain injury and traumatic brain injury are often used interchangeably in both lay and clinical discourse. However, they denote conceptually distinct categories with different aetiological, epidemiological, and therapeutic implications. Understanding the distinction between them is fundamental for accurate diagnosis, appropriate service allocation, and meaningful research synthesis (Fleminger & Ponsford, 2005).

Acquired brain injury is the broader of the two constructs. It refers to any brain injury occurring after birth, regardless of the mechanism of injury. This includes not only physical trauma but also damage arising from hypoxia, stroke, encephalitis, brain tumours, toxic exposure, and metabolic disorders such as hypoglycaemia. The defining features of ABI are postnatal onset and the resulting alteration in neurological functioning, which may affect cognition, emotion, behaviour, communication, and physical capacity to varying degrees, depending on the location and severity of the injury (Headway, 2023). ABI therefore encompasses a heterogeneous population whose presentations may differ substantially and whose needs may span multiple domains of healthcare and social support.

Traumatic brain injury (TBI), by contrast, is a specific subtype of ABI characterised by injury caused by external physical force. TBI may result from road traffic accidents, falls, assaults, sports injuries, or blast exposure in military environments (Menon et al., 2010). The Glasgow Coma Scale is commonly used to classify TBI severity into mild, moderate, and severe categories, based on the duration of loss of consciousness, post-traumatic amnesia, and neuroimaging findings. Whilst mild TBI (colloquially referred to as concussion) may resolve without lasting impairment in many cases, repeated or severe TBI is associated with persistent cognitive, emotional, and behavioural sequelae that can fundamentally alter an individual's functioning and identity (Carroll et al., 2004).

The functional consequences of both ABI and TBI frequently overlap and may include deficits in attention, memory, executive functioning, impulse control, and emotional regulation. These difficulties can be subtle and inconsistent, making identification challenging even in clinical settings equipped for assessment. When these symptoms occur without a known diagnosis, they are often misinterpreted as a personality disorder, substance misuse, or deliberate non-compliance. Such misattributions have significant consequences for the individual's access to appropriate support (Williams et al., 2010). The present review uses ABI as the primary term of reference, while acknowledging TBI as its most extensively studied subtype, and draws on both literatures where evidence is available.

3. Prevalence: Synthesising Statistical and Anecdotal Evidence

Establishing accurate prevalence figures for ABI poses considerable methodological challenges. Surveillance systems vary across jurisdictions, and definitional criteria are applied inconsistently. A substantial proportion of injuries, particularly mild TBI, go unreported or undiagnosed at the time of occurrence (Cassidy et al., 2004). Despite these limitations, the available epidemiological data indicate that ABI is far more prevalent than commonly recognised, and cumulative lifetime exposure likely exceeds published incidence rates substantially.

Global estimates suggest that approximately 69 million people sustain a TBI each year, with road traffic accidents, falls, and interpersonal violence the primary mechanisms of injury (Dewan et al., 2018). In the United Kingdom, the Headway charity estimates that more than 1.4 million people attend emergency departments each year after a head injury; however, many are discharged without a formal diagnosis or follow-up (Headway, 2023). These figures do not include the broader population of individuals who sustain brain injuries through non-traumatic mechanisms such as stroke, hypoxia, or neurological infection, conditions that collectively impose a substantial additional burden on the ABI population.

ABI prevalence statistics are rapidly becoming obsolete. The frequency with which individuals sustain brain injuries through everyday activities, sport, workplace accidents, and domestic violence means that population-level estimates require continual updating to remain accurate. Furthermore, advances in neuroimaging and diagnostic technologies are improving the detection of previously unrecognised injuries, particularly in the mild-to-moderate range, suggesting that earlier prevalence figures may significantly underestimate the true prevalence (McAllister, 2011). The incidence of ABI

is therefore best viewed as a dynamic figure that reflects not only the true injury rate but also the changing sensitivity of diagnostic practice.

Anecdotal and journalistic evidence offer a complementary lens for understanding the human scale of ABI prevalence, particularly where institutional data are absent or inaccessible. A Guardian investigation published in 2025 reported that nearly half of male prisoners in Victoria, Australia, had sustained a brain injury, with diagnosis often marking a pivotal moment when individuals could begin to reinterpret past behaviour and engage productively with rehabilitation (Henriques-Gomes, 2025). Whilst journalistic accounts lack the methodological rigour of clinical research, they play an important role in raising awareness of populations whose neurological vulnerabilities have been obscured by institutional and societal narratives of moral failure. The convergence of statistical and anecdotal evidence across custodial, community, and clinical settings suggests that ABI is not a rare or exceptional condition but a widespread and largely unmet public health challenge.

The gap between clinical prevalence and recognition is particularly pronounced in non-healthcare settings, such as prisons, homeless shelters, and social care settings. Studies consistently show that most individuals with ABI in these settings have never received a formal diagnosis (Shiroma et al., 2012). This diagnostic invisibility has far-reaching consequences for access to services, legal proceedings, educational attainment, and vocational rehabilitation, underscoring the systemic nature of the problem and the inadequacy of individual-level interventions alone.

4. Societal Perceptions, Stigma, and the Role of Media Representation

How ABI is understood and represented in society profoundly shapes the experiences of those living with the condition. Despite the neurological basis of its symptoms, ABI frequently elicits social responses more typically associated with moral deviance or psychological disorder, reflecting a broader cultural tendency to hold individuals accountable for behaviours that may, in fact, be neurologically mediated (Ayden et al., 2025). Shifting these perceptions requires engagement with both conceptual models of stigma and the specific representational practices that render ABI visible or invisible in public discourse.

Goffman's (1963) foundational account of stigma describes a process in which individuals are reduced from whole persons to discredited identities based on characteristics perceived as deeply discrediting. Applied to ABI, this framework illuminates how cognitive and behavioural sequelae, namely impulsivity, emotional dysregulation, social disinhibition, and memory impairment, are attributed to character rather than to neurology. The individual is seen not as someone who has experienced injury but as inherently difficult, dangerous, or irresponsible. This attribution error is not merely a matter of individual perception; it is institutionally reinforced through disciplinary frameworks that punish symptoms and through clinical encounters that diagnose without contextualising.

Link and Phelan's (2001) elaboration of stigma as a social process involving labelling, stereotyping, separation, status loss, and discrimination offers a further conceptual framework for understanding how ABI-related stigma operates across institutional contexts. Individuals exhibiting behavioural consequences of ABI are frequently labelled as non-compliant, aggressive, or treatment-resistant before any neurological assessment. Once applied, these labels become self-reinforcing: they shape clinicians' expectations, influence institutional responses, and limit access to services that might address the underlying impairment. The stigma of ABI is thus not only a psychological burden borne by the individual but also a structural mechanism that actively forecloses rehabilitation pathways.

Media representations of brain injury have historically oscillated between two poles: the miraculous survivor narrative, in which injury catalyses personal transformation and extraordinary achievement, and the menacing other, in which neurological damage is invoked to explain violent or antisocial behaviour. Both representations distort the everyday reality of ABI, which is characterised not by drama but by invisible, fluctuating difficulties that intersect with existing social disadvantage (Ralph et al., 2013). The "what is wrong with you" framing, which pervades both popular media and institutional encounters, positions ABI-related behaviour as a personal failing rather than a consequence of structural injury. This framing must be actively countered if individuals are to receive appropriate support.

A more constructive representational approach begins by asking not "what is wrong with you?" but "what happened to you?" This shift in orientation places behaviour within biographical and neurological contexts rather than moral evaluation (Sweeney et al., 2018). This reframing has begun to gain traction within trauma-informed care frameworks, which emphasise the role of adverse life experiences in shaping behaviour and advocate assessment practices that consider neurological history alongside psychological and social factors. Translating this orientation from clinical philosophy into everyday institutional practice remains, however, a significant challenge, particularly in environments

such as prisons and emergency services, where rapid judgements about behaviour are routine and the capacity for nuanced assessment is limited.

The lived experiences of people with ABI provide further evidence of the pervasive social exclusion stigma produces. Qualitative research consistently documents social withdrawal, damaged relationships, loss of occupational role, and diminished sense of identity following ABI (Nochi, 1998). These experiences are intensified for those whose injury occurs in the context of social disadvantage, for whom the neurological sequelae of ABI compound pre-existing barriers to social participation. Efforts to normalise social inclusion for people with ABI must therefore address both attitudinal change and structural inequality, recognising that stigma reduction without material support yields limited real-world gains.

5. Demographic Intersections: Who is Most at Risk?

Epidemiological data consistently identify younger males as the demographic group most susceptible to ABI, particularly injuries sustained through traumatic mechanisms. Males aged 15 to 35 account for a disproportionate share of TBI incidence globally, with elevated rates attributable to engagement in contact sports, higher-risk occupations, road traffic accidents, and interpersonal violence (Faul et al., 2010). This age-sex concentration of risk is not simply a biological phenomenon; it reflects gendered patterns of socialisation, risk-taking behaviour, and occupational exposure that are amenable to social and policy interventions.

Domestic violence is a significant yet often overlooked pathway to ABI, particularly among women and girls. Repeated head injuries, strangulation, and physical assaults are common features of domestic abuse and carry substantial neurological consequences that are frequently misattributed to psychological trauma alone (Valera & Berenbaum, 2003). Studies of ABI prevalence among women in domestic violence services report rates substantially higher than those in the general population, with many individuals sustaining multiple unreported injuries over prolonged periods (Haag et al., 2022). The co-occurrence of ABI and domestic violence creates a compounding vulnerability, in which cognitive impairment may reduce an individual's capacity to access support, navigate legal processes, or make safety-planning decisions. These consequences demand ABI-aware practice across all services working with survivors of domestic abuse.

Poverty and socioeconomic disadvantage are independently associated with elevated ABI risk through multiple pathways, including greater exposure to environmental hazards, reduced access to protective equipment in occupational settings, limited access to post-injury medical care, and residence in higher-crime neighbourhoods where assault is more prevalent (Faul et al., 2010). The relationship between ABI and economic disadvantage is bidirectional: whilst poverty elevates the risk of injury, ABI in turn undermines employability, earning capacity, and social functioning, potentially deepening and entrenching economic hardship. This matters for intervention design: addressing neurological needs in isolation, without attending to the social and economic context, is unlikely to produce sustainable improvement.

Homelessness is another demographic intersection associated with markedly elevated rates of ABI. Research in the United Kingdom and North America consistently finds that between 50 and 80 per cent of individuals experiencing homelessness have a history of head injury, often sustained before becoming homeless (Hwang et al., 2008). The relationship between ABI and homelessness involves multiple causal processes: pre-existing injury may contribute to the social and occupational difficulties that culminate in housing loss, whilst the experience of homelessness itself, which is associated with assaults, falls, and substance use, increases the risk of further injury. Individuals experiencing homelessness with ABI are unlikely to access specialist neurological support, and the temporary, crisis-focused nature of homeless service provision rarely accommodates the sustained, adapted engagement that effective ABI rehabilitation requires.

Educational disadvantage and lower educational attainment are further correlates of ABI vulnerability, both as precursors to injury risk and as consequences of early-onset neurological impairment. Children who sustain ABI during critical developmental periods may experience lasting difficulties with attention, memory, and executive function, which can impair academic progress and social development, even without ever receiving a neurological diagnosis (Max et al., 2012). These unrecognised childhood injuries may set the stage for later contact with mental health services, substance misuse services, and the criminal justice system, making early identification and support a critical preventive investment.

6. Acquired Brain Injury and the Criminal Justice System

The overrepresentation of individuals with ABI in criminal justice systems is among the most robust findings in the neurodisability literature and among the most consequential in terms of human suffering, economic cost, and social policy. Across jurisdictions, studies consistently report that between 40 and 60 per cent of incarcerated individuals have a history of head injury, with many of these injuries occurring before first offending and never formally recognised or treated (Williams et al., 2018). The factors linking ABI to criminal justice contact are multiple and complex, encompassing neurological impairments in impulse control and risk appraisal, the social consequences of injury, including unemployment and relationship breakdown, and the accumulated disadvantage of living with an unrecognised disability in systems designed for those without one.

In custodial settings, the cognitive and behavioural consequences of ABI are often misinterpreted as deliberate non-compliance, personality disorder, or motivational deficit. Impulsivity, difficulty understanding and following instructions, emotional dysregulation, and difficulty retaining verbally delivered information are potential sequelae of frontal lobe or diffuse axonal injury. Yet custodial staff may interpret these signs as insolence, disruptiveness, or unwillingness to engage with rehabilitation programmes. The result is a pattern of institutional response that punishes rather than accommodates neurological impairment, leading to disciplinary sanctions, restricted access to programmes, and, in some cases, segregation, outcomes that intensify psychological distress without addressing the underlying need (Williams et al., 2010).

The financial costs of housing individuals with unrecognised ABI in prison systems are substantial. Repeated disciplinary incidents, healthcare contacts, and programme failures place an additional burden on resources. Failure to identify neurological impairment may contribute to poorer engagement with rehabilitation and may be associated with increased risk of reoffending, with downstream economic costs in policing, prosecution, and re-incarceration (Parsonage, 2016). Economic analyses of neurodisability in criminal justice contexts suggest that investment in screening and targeted support yields considerable long-term savings and improved individual outcomes. The case for fundamental change is therefore not only ethical and humanitarian but also economically rational.

The personal costs borne by incarcerated individuals deserve equal attention. Living with undiagnosed ABI in prison means navigating a complex institutional landscape with impaired cognitive resources and without an explanatory framework for one's difficulties. Research on the experiences of prisoners who receive a late ABI diagnosis identifies consistent themes of relief, retrospective anger, and profound identity disruption. Recognising that behaviours previously attributed to moral failure have neurological origins provokes both grief and the re-authoring of the self (Henriques-Gomes, 2025). These psychological processes have direct implications for rehabilitation engagement and desistance, suggesting that diagnosis itself, when properly supported, can be a key therapeutic intervention.

Routine ABI screening at the point of entry into custody has been proposed and piloted in several jurisdictions to enable early identification and needs-led service allocation. The Brain Injury Screening Index (BISI) and the Brief Traumatic Brain Injury Screen (BTBIS) are validated tools that are sufficiently brief for custodial use. Studies evaluating their implementation have found high rates of previously undetected injury (Ferguson et al., 2012). However, specialist follow-up assessment and support for those identified through screening remain inconsistent. Without investment in post-screening pathways, screening programmes risk raising awareness of need without building the capacity to meet it.

Staff training is a complementary imperative. Custodial officers and programme facilitators who understand the cognitive and behavioural manifestations of ABI are better placed to adapt their communication, modify programme delivery, and interpret behavioural incidents within a neurological rather than a purely disciplinary frame (Williams et al., 2010). Equity, Diversity, and Inclusion (EDI) frameworks increasingly recognise neurodiversity as a dimension of diversity that requires reasonable adjustments in institutional practice, including within the criminal justice system. However, translating EDI principles into ABI-specific operational guidance remains a domain in need of considerable development, and training programmes for custodial staff with this focus are not yet systematically available across the sector.

7. Current Interventions for Acquired Brain Injury

7.1. Cognitive Rehabilitation

Cognitive rehabilitation (CR) encompasses a range of structured therapeutic approaches designed to address cognitive deficits arising from ABI, including difficulties with attention, memory, executive function, and processing speed. Drawing on principles from neuropsychology and learning theory, CR programmes use a combination of restorative techniques, which aim to strengthen impaired functions through systematic practice, and compensatory strategies, which help individuals develop alternative approaches to tasks that have become difficult (Cicerone et al., 2011). Meta-analytic reviews have established a moderate evidence base for CR across several cognitive domains, with the strongest evidence for attention training and functional communication, and emerging evidence for executive function and memory strategy training (Rohling et al., 2009).

However, delivering CR in applied settings faces significant structural barriers. Access to neuropsychological services is inequitable, with considerable regional variation and an overall scarcity of specialist provision relative to need (Turner-Stokes et al., 2015). Community-based CR programmes, where they exist, are often time-limited and may lack the individualised, adaptive delivery that effective rehabilitation requires. In custodial settings, the availability of CR is particularly constrained, and the organisational culture of many prisons does not readily accommodate the patient-centred, low-stimulation, and cognitively adapted environments in which rehabilitation is most effective.

7.2. Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) has been applied in modified forms to individuals with ABI, with a particular focus on emotional difficulties, including depression, anxiety, and post-traumatic stress, that frequently accompany neurological injury. Standard CBT protocols require adaptation for this population, including shorter sessions, more frequent repetition and review, written summaries to support memory, and concrete, contextualised examples rather than abstract cognitive formulations (Gracey et al., 2010). When appropriately adapted, CBT has demonstrated effectiveness in reducing psychological distress and improving functional outcomes for individuals with mild to moderate ABI. However, evidence for its effectiveness in more severe presentations remains limited.

The relationship between psychological and neurological difficulties in ABI is complex and bidirectional. Psychological interventions that address catastrophising, avoidance, and negative self-evaluation may support neurological recovery by reducing the cognitive and emotional load associated with distress, whilst neurologically-based difficulties, including metacognitive impairment and reduced insight, may limit an individual's capacity to engage with the cognitive components of CBT. Trauma-informed adaptations of CBT are increasingly recognised as important for ABI populations, many of whom have sustained injuries in the context of violence, abuse, or accidents that carry psychological as well as neurological sequelae (Soo & Tate, 2007).

7.3. Link Workers and Community-Based Support

Link worker schemes are an emerging model of community-based support for individuals with ABI, designed to bridge the gap between clinical services and everyday social functioning. Link workers, variously described as community navigators, care co-ordinators, or social prescribers, provide practical, relational support to help individuals access services, manage daily tasks, and navigate complex institutional environments. Whilst not uniformly available across the United Kingdom, pilot programmes in several regions have demonstrated promising outcomes in service engagement, social inclusion, and fewer crisis presentations (Coetzer et al., 2017).

The therapeutic value of the link worker relationship extends beyond practical navigation. For individuals with ABI who have experienced repeated institutional failures and a pervasive sense of not being understood, the consistent, non-judgemental presence of a designated worker with knowledge of the neurological context can, in itself, be powerfully reparative. Link workers trained in ABI can adapt their communication style and pace interactions appropriately, and advocate within systems that may not be structured to accommodate cognitive differences. The absence of such provision in criminal justice contexts, where equivalent functions might be performed by case managers or key workers with ABI-specific training, represents a significant gap in the rehabilitation infrastructure.

7.4. Gaps in the Applied Field and Barriers to Therapeutic Practice

Despite the availability of established and emerging interventions for ABI, access to qualified and specialist support remains deeply inequitable and structurally constrained. The gap between need and provision is particularly stark in community and custodial settings, where the concentration of individuals with unrecognised or under-supported ABI is highest and therapeutic infrastructure is most limited. Several interconnected barriers account for this disparity and addressing them requires reform at the levels of professional training, service commissioning, and policy.

Access to talking therapies, including both CR and CBT, for individuals with ABI is constrained by cost, disproportionately disadvantaging those with the greatest need. Effective ABI rehabilitation typically requires extended, intensive engagement and significant adaptation of standard therapeutic protocols, all of which translate into higher per-episode costs relative to standard psychological treatment (Turner-Stokes et al., 2015). Publicly funded services operating under financial pressure may prioritise shorter, higher-volume interventions that do not align well with ABI-specific needs. In private markets, the cost of specialist neuropsychological assessment and therapy places evidence-based support beyond the reach of many individuals affected by ABI, particularly those in social groups with the highest ABI prevalence, including those with histories of homelessness, substance misuse, or custodial experience.

The scarcity of qualified practitioners with specific competence in ABI is a further structural constraint. Whilst clinical psychology training programmes include neuropsychological content, the level of specialisation required to work effectively with complex ABI presentations typically necessitates post-qualification training and supervised practice that are not uniformly available or supported. Many therapists working in community and criminal justice contexts report limited confidence in identifying or responding to ABI-related cognitive difficulties. They may inadvertently pathologise symptoms, modify treatment too little or too much, or experience therapeutic ruptures arising from misunderstood cognitive behaviour (Gracey et al., 2010). The result is a workforce with significant unmet training needs in one of the most prevalent and consequential areas of acquired neurological disability.

Working therapeutically with individuals with ABI also poses specific clinical challenges that generalist training does not adequately address. Fluctuating capacity, reduced insight into deficits (anosognosia), difficulty retaining therapeutic content between sessions, and the emotional complexity of adjusting to acquired disability all require therapeutic flexibility and tolerance for non-linear progress, which may challenge therapists trained in time-limited, protocol-driven models (Ylvisaker & Feeney, 2000). The therapeutic relationship itself assumes heightened significance in ABI work, where relational consistency and a genuine understanding of the neurological context may be prerequisites for meaningful engagement. These clinical demands have implications not only for practitioner competence but also for supervision, caseload management, and the organisational cultures in which ABI work is conducted.

Social stressors and environmental factors further complicate the provision of therapy. Individuals with ABI often live in social environments characterised by poverty, trauma, social isolation, and institutional distrust, conditions that are directly relevant to therapeutic engagement and outcomes yet lie beyond the scope of conventional clinical intervention. Effective practice with this population, therefore, requires an ecological awareness that situates individual cognitive and emotional difficulties within a structural context and advocates environmental modification as part of a comprehensive rehabilitation plan. The lack of frameworks that formally integrate social and environmental factors into ABI care pathways remains a significant gap in the field of application.

8. Conclusions and Future Directions

This review has demonstrated that acquired brain injury is a major and substantially unmet public health challenge, with consequences that extend across healthcare, social welfare, and criminal justice systems. The evidence reviewed consistently points to a large, heterogeneous population disproportionately concentrated in social disadvantage, which both increases the risk of injury and reduces the likelihood of recognition, diagnosis, and appropriate support. The case for systemic reform is unambiguous, and the present paper concludes by identifying key priorities for action across professional, institutional, and policy domains.

The most pressing priority is to embed ABI awareness as a lens for understanding behaviour and social functioning across professional contexts. Health, social care, education, criminal justice, and housing professionals all encounter individuals whose presentation may reflect neurological impairment, in addition to or instead of psychological or social difficulties. Embedding ABI awareness into professional training across these sectors, moving from the specialist to the generalist and from the clinical to the institutional, is an essential precondition for early identification and appropriate support to interrupt the cascade of disadvantage that unrecognised ABI so frequently produces.

Alongside structural reform, reducing the stigma experienced by individuals with ABI requires sustained cultural change. Public understanding of brain injury remains limited and is distorted by sensationalist media representations that emphasise the exceptional whilst rendering the everyday invisible. Awareness campaigns that centre the lived experience of ABI, including late diagnosis, identity disruption, and institutional misrecognition, can contribute to a cultural shift in which acquired neurological disability is understood as a dimension of human experience that demands accommodation rather than condemnation. Reducing stigma is not only a matter of individual dignity; it is a prerequisite for the help-seeking behaviour on which early intervention depends.

Specialist psychological and rehabilitative support for individuals with ABI will not improve without sustained investment in practitioner training and service development. The current scarcity of qualified ABI specialists, inadequate funding for long-term rehabilitation, and the absence of nationally available community support models, such as link worker schemes, collectively constitute a structural failure in provision that cannot be addressed by clinical innovation alone. Commissioning frameworks must recognise the cost-effectiveness of early and sustained investment in ABI support relative to the long-term costs of unmet need, which are borne not only by public budgets but also by individuals, families, and communities.

Finally, the research base on which practice and policy depend requires substantial expansion. Whilst epidemiological data on ABI prevalence are increasingly robust, there remains a significant deficit in research examining the subjective experience of ABI from the perspectives of those most affected, including those with histories of criminalisation, homelessness, or domestic abuse, as well as from the perspectives of therapists, support workers, and institutional staff who encounter this population in practice. Longitudinal, qualitative, and participatory methodologies play a particularly important role in generating knowledge grounded in lived experience, sensitive to social context, and capable of informing the systemic change urgently called for by the evidence reviewed here.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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