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To cite this article: Michelle Fitts, Jennifer Cullen & Jody Barney (2023) Barriers Preventing Indigenous Women with Violence-related Head Injuries from Accessing Services in Australia, Australian Social Work, 76:3, 406-419, DOI: [10.1080/0312407X.2023.2210115](https://doi.org/10.1080/0312407X.2023.2210115)

To link to this article: <https://doi.org/10.1080/0312407X.2023.2210115>



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Published online: 08 Jun 2023.



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Barriers Preventing Indigenous Women with Violence-related Head Injuries from Accessing Services in Australia

Michelle Fitts^{a,b,c}, Jennifer Cullen^{d,e}, and Jody Barney^f

^aInstitute for Culture and Society, Western Sydney University, Parramatta, New South Wales, Australia; ^bMenzies School of Health Research, Charles Darwin University, Alice Springs, Northern Territory, Australia; ^cAustralian Institute of Tropical Health and Medicine, James Cook University, Cairns, Queensland, Australia; ^dSynapse Australia, Brisbane, Queensland, Australia; ^eCollege of Healthcare Sciences, James Cook University, Cairns, Queensland, Australia; ^fDeaf Indigenous Community Consultancy, Shepparton, Victoria, Australia

ABSTRACT

Traumatic brain injury (TBI) is a serious yet commonly under-recognised injury sustained by women as a direct outcome of family violence. Although healthcare and support services are critical, many women do not access support services following this injury. At present, there are few relevant qualitative studies that have elevated the voices of Aboriginal and Torres Strait Islander women. This article describes the barriers that prevent Aboriginal and Torres Strait Islander women from accessing hospital and support services after experiencing a TBI from family violence in one regional (Queensland) and one remote location (Northern Territory). Interviews and focus-group discussions were conducted with 28 community members and 90 service professionals. Thematic analysis identified four key factors influencing women's access to health care: all women fear child removal; fear of escalating violence; prioritisation of other competing demands; and insufficient awareness of the signs of brain injury. Given child protection systems perpetuate cycles of discrimination based on poverty and structural inequalities that have generated fear and contributed to the reluctance of women to engage with services, child protection processes and practices need to be transformed to consider the impact of head injury on the everyday lives of women. Pathways need to be implemented to assist women to access healthcare and support services as well as strengthen families to maintain the care of their children.

Content warning: This article includes distressing information and may trigger trauma, especially for Aboriginal and Torres Strait Islander women.

IMPLICATIONS

- Aboriginal and Torres Strait Islander women living with a head injury experience severe trauma, coercive control, disadvantage, and poverty, which prevents them from accessing healthcare and support services.

ARTICLE HISTORY

Received 19 December 2022
Accepted 30 April 2023

KEYWORDS

Aboriginal and Torres Strait Islanders; Women; Traumatic Brain Injury; Head Injury; Family Violence; Remote; Australia

CONTACT Michelle Fitts  m.fitts@westernsydney.edu.au

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

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- Communities should be resourced to design, implement, and evaluate TBI prevention and intervention solutions as increased awareness and insight into the long-term consequences for the brain that can result from violence, including education for school-aged children, community campaigns, and targeted education for community members.
- TBI should be incorporated into child protection frameworks, workforce training, and assessment tools, along with training and education for community members.

Creating accessible health service pathways for women who have experienced violence is critical for women to obtain appropriate treatment for injuries such as traumatic brain injury (TBI). Although awareness is increasing, TBI is a serious, yet generally under-recognised injury sustained by women who experience family violence that can create changes in the brain (Costello & Greenwald, 2022; Fitz-Gibbons et al., 2022; Menon et al., 2010). Repetitive head injuries can cause diminished cognitive abilities such as attention and concentration difficulties (Campbell et al., 2018). Headaches, dizzy spells, vision and hearing problems, general distress, and worry are debilitating challenges that women with brain injury from violence have reported living with and managing in their everyday lives (Valera & Berenbaum, 2003). For women who care for children, these symptoms may affect their ability to appraise and respond to a child's behaviour and may mean they require support with caring responsibilities, as well as maintaining care routines (Pituch et al., 2022). While violence-related TBI occurs across broader society in Australia, Aboriginal and Torres Strait Islander women, like their Indigenous counterparts in other settler colonial countries such as the United States, have experienced higher rates of TBI from violence (Costello & Greenwald, 2022; Jamieson et al., 2008).

Although Aboriginal and Torres Strait Islander women experience high rates of head injuries and are diagnosed with TBI from violence, the barriers they experience in their healthcare and support service journey are not well understood. Family violence research has demonstrated the strength and resilience of women in their help-seeking journey to access culturally safe healthcare and support services (Langton et al., 2020). This journey is not straightforward, with accessibility to services affected by multiple complex factors of disadvantage linked to the history and ongoing legacy of colonisation, including overcrowding, housing insecurity, financial worries, and homelessness (Filev et al., 2022). Women may be at high risk of experiencing further violence should they seek hospital and support services for treatment for their injuries (Langton et al., 2020). Inadequate funding across multiple service sectors, including family violence and crisis accommodation services also means that these services cannot accommodate the needs of all women across the region they service, further adding to the vulnerability of women. Mainstream family violence responses, which are typically focused on policing, prosecution, and punishment, can intensify a woman's reluctance to access healthcare and support services (Cripps & Davis, 2012; Filev et al., 2022).

Aboriginal and Torres Strait Islander women also hold legitimate distrust of state institutions—such as child protection systems and the police—that have been historically harmful to Aboriginal and Torres Strait families and communities (Atkinson, 2002; Bennett, 2013; Langton et al., 2020). Family violence is a common reason for children

to be removed, despite the importance of keeping families together safely while addressing the violence (Chamberlain et al., 2022). The overrepresentation of Aboriginal children in child protection systems is considered one of the most pressing human rights challenges facing Australia today, with more Aboriginal and Torres Strait Islander children being taken from their families and communities than ever before. Compared with non-Indigenous children, Aboriginal and Torres Strait Islander children are 11 times more likely to be in out-of-home care (Australian Institute of Health and Welfare [AIHW], 2022). More recently, experts have raised concerns over systemic racism, discrimination, and coercive practices used by child protection systems that fail to address the complex needs of Aboriginal and Torres Strait Islander women who experience violence (Chamberlain et al., 2022; Filev et al., 2022). A landmark report on the out-of-home-care system in New South Wales identified a number of weaknesses in the delivery of appropriate services to Aboriginal families, including an increasing propensity to remove a child at birth and a lack of meaningful collaboration between the child protection and service systems (Davis, 2019).

This article reports on a component (hereafter referred to in this article as the study) of a three-year Australian Research Council project (Fitts, Cullen, Kingston, Johnson, et al., 2023). The aim of this study was to examine and understand what factors can prevent women from accessing hospital and support services following a TBI from family violence. The study involved interviews and focus groups with Aboriginal and Torres Strait Islander women as well as service providers in a remote town in the Northern Territory and a regional town in Queensland. The research question guiding this study was: What are the barriers that prevent women from accessing healthcare and support services following a head injury from family violence? The results of this study have implications for social workers given their integral role in the delivery of supports for women who have experienced family violence. The terminology used in this article and the whole project is “family violence”. This term aligns with the preferred terminology for violence in Aboriginal and Torres Strait Islander communities and encapsulates a range of survivor-perpetrator relationships, including forms of intimate partner violence; violence against children; and the extended nature of Aboriginal and Torres Strait Islander communities, families, and the kinship relationship within which a range of forms of violence occur (Carlson et al., 2021; Langton et al., 2020).

Method

Research Design

A decolonising theoretical framework was used to disrupt the usual power dynamics between the researchers and the study participants by centralising the voices of Aboriginal and Torres Strait Islander women and their family members who were living with the consequences of violence (Smith, 2021). This framework also directly focuses on the issues of power, privilege, and racism, while placing the inquiry within a cultural and historical context. Four specific methodological decisions were made to achieve this approach: (a) guidance from a project reference group and individual advisors who consisted of primarily Aboriginal and Torres Strait Islander women with lived experience, as well as women working in advocacy and service provision (including authors JC and JB);

(b) transformation of the project design to respond to the realities of community concerns and priorities, cultural considerations, and complex safety factors (Fitts, Cullen, Kingston, Wills, et al., 2023); (c) emphasis on two-way learning with the delivery of the TBI education workshops developed and run by Aboriginal and Torres Strait Islander educators prior to data collection (Martin, 2008); and (d) discussions of the preliminary findings with a selection of Aboriginal and Torres Strait Islander participants across the two project locations to assess, contest, amend, and authorise the findings. Within this approach, non-Indigenous researchers are repositioned as contributors to the process, while ensuring Aboriginal and Torres Strait Islander voices and perspectives are at the forefront of all aspects of the research (Moreton-Robinson & Walter, 2009; Rigney, 1999).

Positionality Statement

According to Creswell (2014), analysis of the researchers' own position within the study is vital as they are a "key instrument" within the research process. The first author identifies as an Anglo-Celtic woman who was raised on the lands of the Bunurong people of the Kulin Nation. For almost a decade she has committed her research energy to elevating the voices of Aboriginal and Torres Strait Islander peoples living with a disability, with a focus on TBI. This is demonstrated by her research focus of listening to Aboriginal and Torres Strait Islander peoples with TBI and their experiences of violence, in order to transform service responses. The second co-author is a Bidjara and Wakka woman, who holds a national and international professional profile in disability advocacy. She has worked in disability and aged care services for over three decades, is a member of the National Disability Insurance Agency's Independent Advisory Council, and is involved in a suite of research projects on complex neurocognitive disabilities, including fetal alcohol spectrum disorders (FASD). The third co-author is a proud Birri-Gubba/Urangan and South Sea Islander woman, who provides leadership to local Aboriginal people with disabilities and is also an advocate for the rights of Aboriginal people with disabilities within community, government, and community service sectors. She is dedicated to raising the voices of women with disabilities through various boards and organisations, including the Global First Nations Women's Disability Alliance.

Recruitment and Participants

This study draws upon interviews and discussion groups completed with community-based groups (e.g., women's groups, Elders' groups, and advocacy groups) and frontline workers. In order to generate a comprehensive understanding of women's experiences across a range of services, the research team contacted frontline workers in both medical (e.g., nurses, general practitioners, and specialists) and non-medical professions (e.g., housing and crisis accommodation, and social, welfare, disability, family violence, and community legal services). Using a combination of purposive, convenience, and snowball sampling, the research team mapped and approached a variety of different stakeholder groups regarded as highly knowledgeable and working closely with Aboriginal and Torres Strait Islander women who had or were experiencing family violence

(Palinkas et al., 2015). Service providers also contributed and strengthened the voices of Aboriginal and Torres Strait Islander women, as a large proportion of staff who participated in the interviews and discussion groups were Aboriginal and Torres Strait Islander women. On some occasions, Aboriginal and Torres Strait Islander staff shared information about their lived experiences of head injuries from family violence.

Procedure

A semi-structured interview schedule was developed for each of the two participant groups across two regions (referred to as region 1 and region 2). The interview schedules were developed through a multi-phase process involving: aligning the interview questions with research questions; receiving feedback on the interview schedules from individual project advisors; and piloting of the interview schedules (Castillo-Montoya, 2016). Interviews and focus groups were conducted to understand the experiences of women who have acquired a TBI from family violence, including their needs and priorities, what services and supports women access, and how and why they access them. Recommendations were sought regarding areas that could be improved to ensure women receive appropriate and adequate support during their rehabilitation and recovery. Probes concerning successes, challenges and barriers, and relevant issues stimulated discussion. Interviews and focus groups with women and community groups were conducted in private spaces at the local library and service providers, outdoor areas, or the primary meeting place for the group. Other than one interview and one participant group, interviews and focus groups with frontline staff were primarily conducted in person at participants' places of employment. A small number of interviews were completed at locations nominated by the participant (e.g., the participant's home or local café). Aboriginal and Torres Strait Islander women who participated as service providers also shared their own stories as women with lived experience of violence-related TBI or as family members of women with this experience.

Data collection took place between January and November 2022. As described in further detail elsewhere (Fitts, Cullen, Kingston, Johnson, et al., 2023), community groups and community-based service providers completed education workshops on TBI prior to data collection. The majority of the data collection in each of the two locations was co-conducted by an Aboriginal researcher and non-Aboriginal researcher. Written consent was obtained for interviews and discussion groups. Focus groups and interviews were digitally recorded and transcribed verbatim by a professional transcriber. Each transcript was reviewed for accuracy by one of the research team members (MF) against the original recording and was assigned a unique identifier. All written notes were transcribed. Transcripts, fieldnotes, and observations were managed with NVivo 12 (QSR International).

Data Analysis

Embedding the principles of Aboriginal and Torres Strait Islander data sovereignty, community members localised knowledge generation, and informed the construction of the narrative through the data analysis phase. The transcripts were analysed using inductive thematic analysis, rather than a pre-existing framework. This approach allowed for the emergence of thematic patterns of meaning and unexpected perceptions. Themes

conceptualised as “strong” or “dense” were those expressed by numerous people independently across the data or by an individual focus-group participant who elicited strong agreement from others (Braun & Clarke, 2022). In the first phase of analysis, the transcripts were read and re-read by the first author to increase familiarity of the data. Once familiar with the aspects of the data, the second phase involved the first author making handwritten notes on the transcripts in order to generate an initial list of ideas and early concepts. The third phase involved the production of the initial codes. These initial codes were discussed between members of the research team (including authors JC and JB) and, where agreement was reached, and codes were organised into groups and initial themes. The next phase involved reviewing the data coded under each theme to determine if there was a formed and logical pattern. This process was completed multiple times, where each theme was renamed, defined, and summarised. A selection of community members from the two regions were consulted by the research team to provide cultural data analysis to ensure the cultural accuracy of the quotes and naming of the themes. The knowledge from the data analysis meetings was incorporated into the coding and final naming of the themes.

Ethics

Ethics approval for the project was received from the Central Australian Human Research Ethics Committee (CA-21-4160), Townsville Hospital and Health Service Human Research Ethics Committee (HREC/QTHS/85271 and HREC/QTHS/88044), and Western Sydney University Human Research Ethics Committee (H14646). The study also received approval from Aboriginal community-controlled, legal and family violence research committees and boards and complies with national guidelines for research with Aboriginal and Torres Strait Islander peoples (NHMRC, 2018).

Findings

The data revealed four primary barriers preventing women from accessing healthcare and support services following family violence: all women fear child removal; fear of escalating violence; prioritisation of other competing demands; and insufficient awareness of the signs of brain injury.

All Women Fear Child Removal

A frequently mentioned explanation for women being reluctant to engage with emergency services (e.g., paramedics) as well as the hospital (e.g., healthcare professionals in the emergency department) is fear of child removal by child protection agencies should they report that their head injury resulted from family violence. Women avoided disclosure of violence to minimise the risk of surveillance and contact with child protection authorities: “[We] won’t report when there is domestic violence. If there is any words that come from the woman that [her] children were there, children are considered at risk and so they are taken” (Region 1, Community Group 1). Some women reported that their children had been removed following reporting violence. Further, some women had prior poor experiences with child protection systems, where inaccurate information was entered by child

protection workers and contributed to the decision-making process to remove children: “Negative information stays on record even when proven to be wrong. Then children are removed wrongly” (Region 2, Service Provider Focus Group 6).

It was common for women to avoid accessing hospital services following a head injury until they had determined that it was critical and symptoms were too difficult to manage alone. To navigate these systems without reporting violence, women implemented a range of strategies to minimise either the risk of being reported to child protection agencies or further surveillance by these systems, including providing limited detail to healthcare professionals, reporting another cause (e.g., falls) as responsible for their head injury (or diagnosed TBI), or selecting when it was safest to engage with healthcare professionals:

I’m also aware of clients that don’t access services or are very careful when they access services with the questions that they’re asked and the answers that they give, because they’ve [...] had children removed already for a range of reasons, including violence. But they’re also trying to protect and keep perhaps the new baby or the little ones that are with them, and trying extremely hard in exceptionally trying circumstances to keep their little families together. (Region 1, Service Provider 26)

Women’s fears regarding child protection systems were linked to the complex and connected effects of assimilation policies:

But the reality is that they’re, you know, the Stolen Generation issues in [this region] and the broader community, are very much ... the effects are still being felt. So, people do still worry that children will be removed. (Region 1, Service Provider 25)

The reality for many women was that most families have experienced trauma, which is often intergenerational (Atkinson, 2002). In one study region, child protection systems continued to maintain the intersecting cycles of intergenerational trauma, family violence, and child removal within the lives of women with head injury. According to service providers, child protection systems in this region flagged women removed as children from their families as being “high risk” for caring for their own children: “Systems flag [the] history of women who have been in child safety” (Region 2, Service Provider Focus Group 5). Participants with knowledge of this were troubled by the punitive nature of the response by the system to women who had experienced intergenerational trauma and were escaping violence. Service providers were also aware of instances where infants were removed shortly after birth during afterhours and on weekends, leaving women and families without effective methods to seek advice and support:

We have seen women who have been flagged by child safety. Child Safety will wait to get a court order on Friday afternoon, or afternoon special, where then the child is removed from the hospital afterhours or on the weekend. That mother cannot access any supports over the weekend. She is stressed and traumatised from that experience. (Region 2, Service Provider Focus Group 6)

Fear of Escalating Violence

Although the fear of child protection authorities had the greatest influence on women’s decision-making processes, other factors also contributed to their reluctance to access services following a potential head injury. Community group members described the secrecy of violence within families as remaining “hidden” (Region 1, Community

Group 1), partly because women experienced repercussions if reported the violence. Reporting of family violence to authorities or to healthcare and support services for many women in violent situations in both the major regional towns and outlying remote communities placed them at high levels of risk for further family violence. In some circumstances, women relocated to another community or town to ensure their safety when they reported violence to authorities.

While women risked retaliation by partners if they exposed violence through seeking medical treatment, they were also at times actively prevented from doing so by coercive means. Aboriginal and Torres Strait Islander participants drew on personal and professional experiences of family violence to explain how perpetrators of violence could prevent women from seeking medical care. Examples regularly mentioned included women being isolated from family members by the person using family violence as well as the prevention of women from using a phone or transport to access healthcare services. One service provider commented:

I think family violence in and of itself; a lot of users of violence I guess employ such a level of control and coercion that sometimes women are prevented from seeking medical treatment, or attempts to seek medical treatment, or disclose violence, including assaults to the head. It might actually make the situation worse. It might result in more violence or there might be an active effort of the perpetrator of violence to prevent people seeking any medical treatment, prevent women reporting incidents. (Region 1, Service Provider 1)

A high priority for women after violence was to secure their immediate safety, not only from their partner but also from family members. As one participant stated, “Women will not tell police—husband gets locked up and causes further harm [for her] when he gets out, from both sides of family” (Region 1, Community Group 1). Another commented, “Women are fearful of pressing charges on [their] partner because of him and his family” (Region 1, Community Group 2). This participant further explained that family violence did not necessarily begin and end with a partner who uses violence: “It’s not necessarily just partners, because if partners are incarcerated, the family members ... then there’s family violence, so women are still under coercive control of family, and especially once you’ve had that baby, that baby belongs to everyone” (Region 1, Service Provider Focus Group 4).

A frequently mentioned sentiment in the two regions, and supported by literature (Blagg et al., 2018; Cripps, 2023), was that some women preferred not to pursue charges against their partner through the criminal justice system because the system responses often did not address the underlying causes of violence and separated families. Women and service provider professionals stated that women often did not want to send their partner to prison; some women wanted instead to find a way to maintain their relationship with their partner, but for the violence to stop: “They may not want to see that partner, their man in jail. They just want the violence to end” (Region 2, Service Provider 1). Another participant from a community group similarly commented: “Don’t want to get husband locked up” (Region 1, Community Group 1).

Prioritisation of Other Competing Demands

Within the narratives, women were described as strong and resilient in continuing to maintain and meet the roles and responsibilities they have within their family and

community. This usually related to the needs of their children and other family members as a primary carer. As the following quote illustrates, women who had experienced head injuries from violence usually tended to the needs and priorities of others first:

That can be a huge barrier to them seeking medical support for themselves, going up to the hospital or following up with the GP [general practitioner] because their priority is not with their own health. It might be for the care of others, either children or someone else that they're caring for that then, their own health and wellbeing gets put on the backburner. (Region 2, Service Provider Focus Group 4)

Women were managing a range of issues that affected their ability to connect with health-care services. Participants told us that the priority for women was “keeping alive” and “survival”, while managing poverty as well as inadequate and insecure housing:

When a woman arrives here, the most important thing is rest, food, and finding that space to just sit with what's happened, and then medical attention. I don't always hear women prioritising medical attention in the first instance. I think that rest definitely, and even hunger, on a real, basic survival level. (Region 1, Service Provider 10)

Delivery of outreach services and programs to women and their families outside the major town footprint was valued by community members and service providers as it supported women who would otherwise have struggled to access services in larger service centres. In both locations, participants reported that the majority of funding was allocated to services in the major towns, with women living in outlying areas and remote communities having access to limited services.

Insufficient Awareness of the Signs of Brain Injury

Low levels of awareness and knowledge about the long-term consequences to the brain from violence were consistently received comments from community leaders and members: “We didn't know about this brain injury” (Region 1, Community Group 1). Another participant commented:

I didn't go to the hospital. I had a bit of [a] headache, didn't think it was serious enough to [go] and get checked, it [headache] went away. It happened many times. One time I black out, wasn't aware of the lasting harm that can cause. (Region 2, Community Member 22)

Participants compared the lack of awareness of TBI with an increased understanding of other forms of acquired brain injury that have occurred over time due to strong consistent work by service providers and investment by government. FASD was a frequently mentioned example, with community knowledge and awareness of FASD thought to have increased following workshops and community-wide education campaigns about the effects of alcohol during pregnancy. To increase knowledge access, TBI education workshops were held with community organisations and service providers to respond to the recommendation from community leaders about wider delivery of the education: “Important for community to know—have awareness about it—brain damage and DV” (Region 1, Community Group 2). To develop and build awareness of TBI, participants provided a range of recommendations to prevent TBI and improve understanding of women's lived experience with head injury acquired through violence. One suggested

the need for “more information and training for our women about DV and TBI” (Region 2, Service Provider Focus Group 3). Another service provider commented:

We need to be looking at schools doing forums. Every 6 months or every year get people in there, specialists in there, whatever you want to call them, DV workers in there, and talk to the schools and educate our kids. (Region 2, Service Provider 46)

Community members also recommended wider dissemination of the association between head injury and violence, as well as pathways women can access to seek help:

Put a strong message out there about head injury from violence. Put a strong message out there about—put the ad out there. It has to be strong, but it doesn’t have to be sensitive. People are desensitised from the violence. Tell them that there is some help out there—see us at the clinic about this. (Region 1, Community Member 24)

Discussion

This study has identified that women experience multiple barriers that affect their access to health care when they have experienced a TBI from family violence, including fears of child removal, poverty, housing uncertainty, ongoing experiences with family violence, pressure to remain silent, and coercive control. The themes identified in this study resonate with barriers identified in the broader family violence literature by Aboriginal and Torres Strait Islander scholars (Chamberlain et al., 2022; Cripps, 2012; Davis, 2019; Langton et al., 2020). There is a range of opportunities to address several of these barriers. Progression of any recommendations must include local partnerships with Aboriginal and Torres Strait Islander peoples and the centring of the voices of Aboriginal and Torres Strait Islander women with lived experience to ensure these practical measures are community-led, are culturally safe, and overall have beneficial impact, without doing further harm.

The fear and, in some cases, the removal of children from women who have experienced violence and TBI, which was one identified theme, suggests the need for purpose-built legislation that is more specifically tailored to TBI. It was common for Aboriginal and Torres Strait Islander women to experience structural bias within the child protection system, including systematically “red flagging” children for removal from parents who were in care themselves as children. Such bias must be removed to protect the rights of Aboriginal and Torres Strait Islander women and their children, while also breaking the cycle of state surveillance and punishment they experience in their lives (Chamberlain et al., 2022). Appropriate service policies are required within service systems to ensure the treatment women receive is compassionate and that they are provided with referrals and linking to support services in a meaningful, timely, and appropriate way. There are also strong calls for the transformation of child protection systems in Australia, including a dedicated Commission for independent oversight, bans on the adoption of Aboriginal children, and the transfer of authority of child protection services to Aboriginal community-controlled organisations (Davis, 2019; Filev et al., 2022; Secretariat National Aboriginal and Islander Child Care [SNAICC], 2022). Evidence has shown that Aboriginal and Torres Strait Islander organisations who can exercise authority within the child protection system have higher success rates of keeping families safe and reuniting children with their families (SNAICC, 2022).

Resourcing communities to enable them to design, implement, and evaluate TBI prevention and intervention solutions is an essential next step. There are multiple examples of effective community-led prevention strategies and programs to reduce violence in Aboriginal and Torres Strait Islander communities (Cripps & Davis, 2012; Filev et al., 2022). Community members in this study provided suggestions to increase awareness and insight into the long-term consequences for the brain that result from violence, including education for school-aged children, community campaigns, and targeted education for community members. It is critically important that women and families are equipped with appropriate skills and tools to recognise the signs of TBI and how best to support women with the long-term impact of TBI (Campbell et al., 2018; Pituch et al., 2022; Valera & Berenbaum, 2003). Sustainable investment to support regional and remote communities to implement what they know works, instead of funding additional, inflexible, punitive systems that continue to disempower women from accessing health care is critical to ensuring women have accessible and timely health care.

Other strategies to improve healthcare service access are reimagining the placement of social workers as well as professional training for frontline staff. Study participants reported women being at risk of further violence if they were identified as seeking health care as well as the competing needs and sometimes “survival” needs that take priority over attendance at a health service as significant barriers for accessing health care. Although further work is needed to inform the development of service provision spaces and delivery models that are more aligned with the needs of women with TBI, placement of frontline staff such as social workers outside of traditional settings, including emergency departments, could address the spatial disparity between social workers and women. Situating social workers in non-traditional settings (e.g., locally-run organisations, including art centres), where they can be accessible on weekends and after hours could provide a response that is more trauma responsive and that minimises stigma often experienced when accessing support (Haag et al., 2022).

Finally, developing the knowledge and skills of frontline staff including social workers is essential (McLindon et al., 2021; Menzies & Grace, 2022). More nuanced responses to disability, particularly TBI, in service provision have been recognised within violence and child protection policy frameworks in Australia (Australian Government, 2022; Department of Social Services, 2021). High-level quality training could be incorporated into undergraduate social work course curricula and ongoing professional development and education for frontline staff offered through professional bodies (Australian Association of Social Workers, 2018; 2022). Training package content could introduce concepts, knowledge, and skills on the interplay between violence and TBI and how TBI presents within parental behaviour as well as how to incorporate TBI in case management and referrals pathways (Haag et al., 2022; Pituch et al., 2022).

Limitations

These findings need to be considered within the context of the study limitations. While the study included two diverse regions, the findings may not reflect experiences in other locations. The sample size of community members was small and included mostly women over 30 years of age. In order to fully understand the barriers for women

connecting with service providers, more extensive research is required. To protect confidentiality, neither participant age nor service provider type have been provided.

Conclusion

The findings of this study provide insight into the barriers potentially preventing Aboriginal and Torres Strait Islander women from accessing health care and local services when they have experienced a head injury from family violence. Women with TBI from family violence should be viewed as survivors, requiring safe, accessible pathways to culturally safe and appropriate health, social, and disability supports. However, the extent of women's fears is indicative of multiple factors related to fears of child removal, risks of persecution of violence for accessing health care, and reporting violence, coercive control, and poverty. Although there are major challenges requiring attention that are beyond the scope of this article, there is an opportunity for workforce practices and policies within frontline service systems to better respond to TBI so that women can receive the care and support they require to recover.

Acknowledgements

We recognise and are thankful for the ongoing support the project has received from community members, advocates, women's groups, as well as family violence, health, and legal services who have helped to inform the design and implementation of this project. Further to this, we thank project team members, Professor Karen Soldatic, Elaine Wills and Yasmin Johnson, from Western Sydney University as well as Dr Gail Kingston from Townsville Hospital and Health Service. The views reflected in this article are those of the authors only and do not reflect the funder, the Australian Research Council.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Australian Research Council [grant number DE210100639].

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