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Temporalities of emergency: the experiences of Indigenous women with traumatic brain injury from violence waiting for healthcare and service support in Australia

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ABSTRACT

Globally, traumatic brain injury (TBI) has been recognised as a serious health issue not only because of the immediate impacts at the time the injury occurs but even more so due to the longstanding impacts. Even though TBI is a globally recognised condition, the research is disproportionately focused on its incidence in, and immediate and long-term effects on men. A growing body of research suggests that generally, women who experience family violence are at high risk of TBI and suffer its impacts in ways that reflect gendered differences in the patterns and frequency of violence. In Australia, the social and physical costs of TBI are multiplied for Indigenous women, whose experience of disability and access to healthcare lies at the intersection of gender and race in the historical context of settler colonialism. The present study addresses the need for research into the sociodemographic inequalities that affect access to culturally appropriate hospital care, timely response systems, and flexible, safe and engaged social services. This paper draws on data from interviews and focus groups with Indigenous women, hospital staff and community-based service providers and suggests potential pathways for further research in settler-colonial settings elsewhere in the world.

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Introduction

The emergency department (ED) is a time-critical space in which medical professionals order somatic symptoms and injuries into a hierarchy of urgency and make decisions about the speed of response and treatment regimes. In the hospital setting, time is primarily organised around signs and symptoms of severity. A fast response time is particularly critical for people admitted with trauma-related injuries caused by violence, for

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whom immediate intervention has been shown to be vital to their survival (Curtis et al., 2020). Hospital emergency care practices are underpinned by a temporal logic that seeks to ensure that in such situations, medical intervention can prevent death, further degeneration of the brain through secondary traumas, and disability (Dixon et al., 2020). The initial emergency response is fast, but changes pace to allow for careful and considered deliberation and observation of effects to determine courses of action and techniques of intervention. Violence, trauma and recovery thus have their own rhythms, flow and beat. The navigation of multiple temporal flows between the ED, healthcare respondents and the patient, and the cause and site of their traumatic injury, is a critical dance of clinical expertise, biopolitical temporalities and the potential subterfuge of biological matter.

Yet, as recognised in the extant literature, the critical temporalities of violence, trauma and recovery are often historically determined. The historical continuum of sociodemographic disparities – according to race, ethnicity, gender, ability and class – in emergency healthcare continues to prevail (Manuel, 2018). In emergency healthcare, vital care temporalities that sustain and rehabilitate life too often remain governed by broader social, institutional and historical inequities (Vohra-Gupta et al., 2023). As we demonstrate, this is particularly the case for Indigenous women with a violence-related traumatic brain injury (TBI) in settler-colonial Australia.

Baraitser and Brook (2021, p. 3) argue that the temporalities of hospital emergency care are governed by deeply embedded colonial logics, in which ‘the powerless tend to care for the powerful, and not the other way around’. These historical legacies persist in hospital EDs and primary healthcare in settler-colonial contexts and affect health outcomes for Indigenous women (Cullen et al., 2022). Across Australia, Canada, Aotearoa New Zealand and the United States, Indigenous women are the least likely to attend emergency services even when they experience high-intensity trauma-related violence. This is due to the combined factors of racism within the healthcare system, distrust of hospital staff based on prior experiences, geographic remoteness and affordability of transport (Australian Institute of Health and Welfare, 2023). The combined gendered and racialised impacts of the ongoing disparity in access to and use of emergency healthcare for Indigenous women and children who experience trauma, injury and harm from violence is a global problem (World Health Organization, 2021). The absence of culturally safe and appropriate care is but one aspect of this lack of access.

The temporalities that define emergency care for Indigenous women and children with violence-related TBI and trauma are a critical site of gendered and racialised inequality in Australian healthcare. This paper draws on the narratives of patients, frontline hospital staff, and community-based service providers to show how temporalities of care structure the hospital experience for Indigenous women with violence-related TBI. It argues that Indigenous women’s experience of time is enmeshed in the power dynamics of hospital settings, characterised by prolonged waiting periods for triage, doctors, scans, observation and assessment, and referrals, producing intense feelings of frustration, helplessness and alienation from the Western medical establishment. As a consequence of the perceived lack of immediate action by these systems, Indigenous women may elect to disengage, putting them at risk of health complications arising from incomplete treatment.

Even though TBI is a globally recognised condition, the research field is disproportionately focused on its incidence in, and immediate and long-term effects on men. This gender bias – from the biomedical focus on the brain to patient recovery post-injury and structures of familial, social and community supports – has precipitated a small and growing body of research into the gendered dynamics of TBI in immediate healthcare responses. The current study aims to address the need for TBI research that engages with broader sociological histories of racialised medicine and forms of gender bias in healthcare that are yet to be rendered visible to mainstream global health research, care and knowledge production. Importantly, in this paper, we draw upon the work of core intersectionality theorists working across Indigenous-disability (Gilroy & Donnelly, 2016) and Indigenous-gendered violence (Cullen et al., 2022) to understand the significant ways in which Indigenous women and girls who acquire a TBI through family violence are responded to in healthcare settings. In line with a growing number of Indigenous-disability scholars (Daniels-Mays, 2023), the paper demonstrates the importance of moving beyond theories of intersectionality alone. The research project that provided the basis of this paper sought to understand the reproduction of impairment and disability through drawing together theories of intersectionality with that of decolonisation. This is what Indigenous-disability scholars, such as Daniels-Mays (2023), have tried to capture in their work when referring to theories of BlakAbility, and Gilroy and Donnelly's (2016) Indigenous-disability standpoint theory.

Concurring with Gilroy and Donnelly's (2016) former work and more recent developments from Indigenous-disability scholars such as Daniels-Mays (2023) is necessary to fully situate the Indigenous-disability experience within settler-colonial, Australian healthcare structures of power in ways that fully comprehend, illuminate and distil the extensive issues, barriers and concerns faced by Indigenous women and girls with impairment onset, as they navigate emergency public healthcare. The aim of this paper is to move beyond healthcare studies that conceive Indigenous-disability-gendered impairment creation as a naturally occurring phenomenon across the life course. We recognise the critically significant ways in which longstanding, settler-colonial, racialised, ableist, misogynistic everyday structures, institutions and practices shape Indigenous women's and girls' experiences of public emergency healthcare systems at a critical juncture in the TBI experience, that is, the moment of acquiring a lifelong impairment. We also recognise the need for rapid, responsive healthcare. As this paper demonstrates, this rich sociological positioning of Indigenous-disability-gendered experiences of public health care systems is necessary if the research impacts can appropriately inform responses in ways that ensure life long recovery, safety and wellbeing for Indigenous women and girls with a recently acquired TBI.

Decolonising community collaborative research: the methodological frame

Disability scholarship within settler colonial contexts such as Australia, Canada and Aotearoa New Zealand has been at the forefront of thinking through the need to reorient the ways Indigenous-disability research and knowledge translation are collectively conducted in partnership with the community (Fitts et al., 2023a; Vargas et al., 2022). Interestingly, similar scholarly work suggests that across settler-colonial contexts there is a shared understanding of research praxis within Indigenous communities who live at the intersectionality of indigeneity, disability and gender in settler-colonial contexts. In reviewing the emerging body of research, the work suggests:

> approaches [that] include recognition of the time necessary to build sustainable and trusting partnerships between researchers and the community research partners from the outset; a focus on the co-creation and co-production of essential research components and processes, rather than merely labelling research activities for each stage; centring collaborative research orientations from the point of research conceptualisation as the core ethical value of practice to inform the overall design; and adapting and adjusting the research parameters. (see Fitts et al., 2023a, p. 97)

This includes enabling extensive time in the field and financial investment in educational resources, to ensure that local communities are fully briefed and therefore, making informed decisions about whether they should participate or not in the research project (Nguyen et al., 2020).

The field work undertaken in this project built upon the work of Indigenous disability scholars such as Gilroy and McEntyre and sought direction and advice from Indigenous community-controlled organisations, to incorporate decolonising methodological approaches to strengthen cultural sensitivity, legitimacy, and responsiveness (Gilroy et al., 2018; McEntyre et al., 2019). This involved greater flexibility in data collection, for example continuing data collection until all members of a community who wish to participate have been interviewed, rather than stopping at data saturation. The project also commissioned local artists to develop resources for the communities in which the research occurred. Artists were often intimately involved and understood the implications of the research through either their own personal experiences or being involved in the area more directly. Thus, this approach not only combined theoretical understandings of intersectionality and decoloniality, but actively adopted decolonial frameworks of relevance determined by community members who were guiding the project overall. The methodological foci of the project therefore, involved knowledge translation practices at the earliest stage, co-designed with Indigenous women as research partners actively adapting learnings into the research design from the outset of the fieldwork (see Fitts et al., 2023a).

Methods

The study discussed in this paper is part of a larger three-year, qualitative, multisite project funded by the Australian Research Council (DE210100639) on understanding the needs and priorities of Indigenous women living with TBI from family violence (Fitts et al., 2023b). By using a qualitative exploratory design in this study, the researchers were able to illuminate how a phenomenon that has received little research attention (Costello & Greenwald, 2022) is manifested, leading to the contribution of new knowledge in the area (Polik & Beck, 2012). During the initial stages of implementation of the larger project, womens groups, hospital staff and community-based service providers told the research team that a substantial proportion of Indigenous women with TBI from family violence who present to hospital leave without completed treatment and discharge (Fitts et al., 2023a). All three groups cited a primary reason for leaving was 'waiting'. With these local prompts, we decided to explore the temporality of waiting and its implications for violence-related TBI emergency care as a critical component of the larger project.

Participants

Interviews and discussion groups were completed between June and November 2022 in one regional town in Queensland, Australia. The location where the research was conducted is not disclosed to protect the identity of participants. In order to generate a comprehensive understanding of Indigenous women's experiences across a range of services, this study draws upon interviews and focus groups with Indigenous women with experience of TBI from family violence, hospital staff and community-based service providers. Participants from the hospital represented various occupations, including consultants, nurses, Indigenous Hospital Liaison Officers, Aboriginal Health Workers, social workers, occupational therapists and physiotherapists. Professionals represented acute and crisis services as well as long-term programs and services within disability, family violence, health, housing and accommodation, mental health, and justice and correctional sectors. Services also contributed and strengthened the voices of Indigenous women with lived experience of family violence, as a large proportion of participants from the hospital and community-based services were themselves Indigenous women.

Data collection

A combination of purposive, convenience and snowball sampling was used by the research team to map and approach a variety of different stakeholder groups (Palinkas et al., 2015). A multipronged approach was used to recruit hospital staff and community-based service providers. To begin, all hospital staff and community-based service providers were invited to participate in a face-to-face interview or discussion group with a member of the research team. Team leaders of community-based services and the hospital were emailed copies of the participant information sheet and consent form and a summary of the project and contact details of the lead researcher (author MF). Staff interested in participating in the study contacted a researcher via telephone or email. Once contact had been made, the researcher liaised with each potential participant to find a suitable time to meet in person, discuss the information disseminated in the project (hard copies of the participant information sheet and consent form were provided), and, if consent was given, conduct an interview or focus group. Recruitment from hospitals and services also involved attendance at staff meetings and clinical education sessions (face-to-face and online) to present information on the project and advise avenues of staff participation if interested. Snowball sampling was also used, with participants asked to recommend other relevant staff to participate (see Patton, 1990). Some staff were recommended to the research team and therefore contacted directly. Individual interviews, paired interviews and focus groups with community-based service provider staff usually took place at their service office. All hospital-staff interviews, paired interviews and focus groups took place in a location within the hospital (e.g. private room at the library, office of the health professional).

A total of 24 participants from the hospital took part in the study. Thirteen staff participated in an individual interview. A further 11 staff participated in paired interviews, consisting of two and three staff. Eleven participants identified as being of Aboriginal and/or Torres Strait Islander background. Of the 52 participants from services who took part, 14 participated in individual interviews and two participants completed a paired interview. Five focus groups were completed with 36 participants. Sixteen service participants identified as being of Aboriginal and/or Torres Strait Islander background.

Twelve Indigenous women with lived experience were recruited through both women's groups and community-based services. Community-based service staff approached Indigenous women who met the project criteria. At this initial conversation about the project, the staff member explained the project supported by a short video about the project and project flipchart. Indigenous women who were interested in hearing more about the project and possibly participating in the project met with one or two members of the research team. Initial meetings usually took place at the service office or the women's group's meeting space.

A flexible interview guide was used to focus the conversation on: the care, support and treatment Indigenous women presenting to the ED with head injuries from family violence; factors that enhanced their healthcare and interactions Indigenous women had at the hospital; perceptions of cultural, social and structural barriers to healthcare access; and policies and practices that could be implemented to enhance the healthcare Indigenous women receive in the hospital and post-discharge (see Denzin & Lincoln, 2011).

Data analysis

All audio recordings of the interviews and focus groups were transcribed and assigned a number and checked for accuracy against the original recordings. Written notes from all the interviews and focus groups that were not audio recorded were typed up as transcripts and also assigned a participant number. Transcripts were imported into NVivo 12 (QSR International) to assist with data management and analysis. The transcribed data were then selectively coded and categorised in relation to the principal research questions (Braun & Clarke, 2013) by the first author. To support validity of the themes, the resulting codebook and coded data, were then disseminated and discussed between the authors, other members of the research team and members of the advisory group consisting of mainly Indigenous women, and also presented to staff from the regional hospital for cross-checking and refinement of thematic analysis (Denzin & Lincoln, 2011). In this process, data were treated analytically and connected with existing literature to develop and deepen the exploration and interpretation of data beyond the primary case-study field site (Braun & Clarke, 2013).

Ethics

Ethics approval for the project was received from Townsville Hospital and Health Service Human Research Ethics Committee (HREC/QTHS/85271 and HREC/QTHS/88044).

Findings and discussion

The results of this study provide an overview of the challenges Indigenous women in settler-colonial Australia who have experienced head injuries from family violence face in seeking support for healthcare and to escape family violence. Waiting emerged as a focal experience which shaped and defined the accounts of Indigenous women engaging with the ED and community-based services. The findings of this study serve as a corrective to gendered and racialised bias in TBI health research globally, and especially in relation to settler-colonial contexts, where the implications are significant for Indigenous women with TBI from family violence. The discussion section provides an outline of women's experiences of waiting in the ED. Analysis of temporal patterns of waiting reveal relationships of disrespect and discrimination that often result in subtle forms of retraumatisation. Indigenous women's responses to this waiting are interpreted as practices of resistance to dependence on settler-colonial healthcare institutions, in which hospital temporality is experienced as indefinitely prolonging pain, rather than moving towards its resolution. The qualitative data suggest that hospital spaces and responses that specifically consider patients' psychological wellbeing, safety and security are essential components of healthcare for Indigenous women with TBI from family violence.

Waiting for triage, medical monitoring and social services

For the Indigenous women and those who supported them,including community-based service providers, the experience of 'waiting' usually related to periods of time (e.g. severalhours) in which there was limited progression through each phase of the acute healthcare journey: waiting in the ED reception after completion of the triage process; waiting for an ED bed and communication with health professionals; waiting for laboratory and radiology results from scans and assessments; and waiting for referrals. Waiting was described by Indigenous women and community-based service providers as 'unacceptable' and one of the most challenging aspects of accessing healthcare in the ED:

> If she's able and willing to present to the hospital, organise CT [computerized tomography] scans, sort that out and that can be a nightmare. I feel like that can be hours and hours and hours of waiting. So by the end of that, the woman is exhausted, or she's just done. I feel like the last time I went to wait for the CT scan that it was an … I was there for, like, 16 hours. That's just not good enough. (Theresa, women's service, community-based provider)

Participants held different perceptions, understandings and insights related to the timing of progression through the acute-care journey. Some participants stated that some Indigenous women with head injuries from family violence were fast-tracked through the acute-care phases to ensure that they remained invisible to other patients within the ED area. The relationship between a rapid ED response and personal safety is critical to Indigenous women who experience TBI violence, as it ensures that family perpetrators are unable to locate them in public waiting rooms within ED sections of public hospitals:

> In some cases, […] we try and create the fast-track. So, they are placed into a more secluded room where we can control access of any potential people who may be trying to gain access

> to them, if that makes sense. So, we try and create a safer environment for these women. These women are often prioritised to be seen above other people who may have been waiting longer as a higher clinical priority, often because they're experiencing large amounts of distress. Obviously, it depends on the clinical workload in the department. But trying to be sensitive to the traumatic events that these women have faced. (Elise, medical and nursing, hospital)

A comparative view was that Indigenous women were triaged by nursing staff at a lower acuity level than they ought to have been for their presenting injuries, and such scores were not always reflective of Indigenous women's injuries or pain levels based upon triaging scoring (Queensland Government, n.d.). Lower rating scores at triage added extended time for Indigenous women to progress to the next phase of the acute-care journey – namely, to have initial assessments by ED medical and nursing professionals. As illustrated by the following quote, some participants thought the lower acuity scoring was reflective of systemic racism and stereotyping:

> I think there's inherent bias in the system that Indigenous patients [are] often triaged lower. I don't have any stats to support that, that's just based on my observations and experience over time. If they're triaged lower, it means other people will be seen before them. The pathway – so, for example, they come into the ED, say that they're put into a bed, and their triage is a category four, that means the other three categories will be seen before them. (John, medical and nursing, hospital)

While physical injuries were considered in rating the severity of the injury, it was perceived that the triaging scoring structure did not consider other factors Indigenous women were required to navigate to present to the ED. Leaving children in the care of family or the person who used violence against them were features frequently reported by women who sought acute healthcare: 'I was stressed. My kids were with my family. I had my sister texting me. She was telling me the kids couldn't stay with her too long.' (Hayley, a woman with lived experience). Hospital staff and service providers alike recognised that women were often managing text messages and phone calls from their partner, their partner's family or their family while accessing healthcare in the ED.

Once inside the ED, observation was a critical first step in the treatment process. Observation is a standard practice used to identify the right forms of treatment for the injury and provide medical and nursing staff the opportunity to monitor neurological changes, including conscious state as well as other key symptoms following a period of loss of consciousness that could indicate a serious injury: 'The central rule is that if you've sustained a head injury with a loss of consciousness, you need to be observed for at least 4 h' (Laura, medical and nursing, hospital). Another participant commented:

> You would want to observe her longitudinally over time and see does she develop an altered level of consciousness? Does she start vomiting lots? Is there any other signs of severe head injury? But that requires the person to want to stay. (Steven, medical and nursing, hospital)

Characteristics of an Indigenous woman's presentation could also affect the time required to progress and complete the four-hour observation and related assessments. For example, hospital staff stated the involvement of alcohol and intoxication could add time required for medical professionals to clear Indigenous women for discharge from the hospital.

Aspects of the observation period were perceived to contribute to the heightened levels of agitation experienced by women. Being 'poked and prodded' and having little other communication with health professionals in a busy, fast-paced environment fuelled women's feelings of frustration. While medical and nursing staff stated that a CT scan was usually conducted to rule out serious, life-threatening injuries, some staff reported that on some occasions a CT scan would not be requested if a woman had presented frequently, with head injuries from multiple violent episodes, to minimise the radiation risk that is generated from these scans. A range of other tests and assessments were conducted by medical professionals to rule out other injuries and impacts of the injury, including blood loss and kidney failure.

Another reason Indigenous women were asked or encouraged to wait in the ED was to access social and cultural supports including Indigenous Health Liaison Officers, social workers and occupational therapists. While nights and weekends were the typical time women presented to the ED, these services were not funded for a permanent 24-hour presence at the hospital. If Indigenous women wanted to follow up on these referrals, they were required to wait until the commencement of the morning shift. The additional layer of waiting for this access could be challenging for women who had caring responsibilities.

When Indigenous women were waiting for social and allied health support, hospital staff stated that they attempted to create safe spaces for them, including moving them to the short-stay unit, which was considered to have a lower stimulation environment than the ED. Many participants referred to the work of an organisation external to the hospital that provided specialist domestic-violence crisis counselling, intervention, information, referrals, safety planning and pathways to safety (e.g., emergency transport and accommodation). It was frequently mentioned that the referral process to this organisation was lengthy and required women to wait several hours in the hospital. Due to hospital bed pressures, women who had finished their medical care were asked to wait in spaces that were not designed to promote safety, wellbeing and healing. On occasions, staff were able to relocate women to the short-stay unit, a space that was similar to the ED. Otherwise, women were required to return to the waiting room of the ED:

> [Name of the service provider] can take a long time to work a plan out, hours and hours. Then we've got bed pressures, so we need them to get out of their bed when we're just waiting for a plan for discharge to be made. So it will be a matter of putting them back out in the waiting room or in our family room to wait for that phone call to come back, and sometimes they just get sick of waiting. (Lynette, allied health, hospital)

Indigenous women's resistance to waiting

Waiting to move through the phases of acute care added to heightened levels of anxiety and agitation that women were often already experiencing following the family-violence incident that contributed to their injury. A patient who is likely to leave was described as one 'who comes in agitated, doesn't want to be there, feels unsure, gets put into a bed and then isn't seen for two to three hours in that bed' (Sheryl, medical and nursing, hospital). Women resisted the waiting times in the ED in various ways. One example was the use of verbal and physical aggression and outbursts, such as swearing and throwing items. As illustrated by the following quote, this could result in security codes being called by hospital staff for 'de-escalating' women for their own personal safety as well as the safety of staff and other patients:

> Usually what happens if that person's not seen in a relatively timely manner, that person's going to ark up. They're going to start swearing. They might start throwing things. They don't want to be in that environment. They feel judged. They feel like people are talking about them, which they are. Usually then there's a period of de-escalation. We have something called a Code Grey, which is when it'll be called out over the speaker. Security will attend, medical staff will attend and nursing staff will attend. (David, medical and nursing, hospital)

Requests for, and attendance of, security guards to the ED resulted in women leaving the hospital without completing their observation and treatment: 'Usually, that makes the situation worse, and usually those people storm out, sometimes without treatment' (Paul, medical and nursing, hospital). Another method of demonstrating resistance to waiting was leaving the ED:

> Went there at night-time. The nurse at the counter asked all these questions. Couldn't remember if I blacked out. I think I did. Waited and waited in the waiting room to be called. No one said anything to me. I just got up and left. (Chelsea, a woman with lived experience).

When Indigenous women demonstrated resistance to the system and environment by removing themselves from the ED waiting room or becoming angrily frustrated within the ED once assigned a bed, their actions were perceived, by both health professionals and service providers, to attract repercussions. Medical charts would include records of 'non-compliance', 'discharge against medical advice' and 'aggressive behaviour'. According to hospital staff and service providers, these medical notes affected how hospital staff interacted and responded to Indigenous women in future hospital presentations:

> Because then some, a lot of the times they're in the waiting room, and you know what the waiting room is like. Then they're classed as DAMA [discharge against medical advice] or because they go on, they might be confused or scared or whatever it might be, and then they leave the waiting room before they're even seen, and then that's also on their chart too. […] And now they've come back in, now they've got this on their chart, they're aggressive, they're aggressive. So straight away, as soon as the nurses see that, the doctors see that, oh, they're aggressive, [they] don't want to touch them. (Sylvie, medical and nursing, hospital)

With a high proportion of Indigenous women leaving the hospital prior to completing care, some participants reported following up Indigenous women. However, this was not part of regular practice and was outside the roles and responsibilities of their positions. A small number of hospital staff thought Indigenous women who discharged from the hospital, without complete care and against medical advice, were impatient and demanding: 'Some of them are just impatient, don't want to wait around for treatment' (Tracy, medical and nursing, hospital).

Another way Indigenous women displayed resistance towards the temporal patterns of the healthcare system was not returning to the ED in the future. These were Indigenous women who were reluctant to return after the healthcare system failed to provide the outcomes they had hoped for when first presenting to the ED. For example, presentation at the hospital did not always generate greater access to community services for Indigenous women's everyday priorities, such as childcare and safe housing. Avenues for increased safety, for Indigenous women and their children to escape environments where they were experiencing family violence, were desired outcomes of their presentation to the ED that were frequently discussed by Indigenous women. Another desired outcome was individualised support to help Indigenous women manage everyday impacts from long-term family violence, such as managing pain from repeated injuries to their face, head and neck sustained over years. Indigenous women and service professionals highlighted that this frustration with the experience of waiting to move through the acute-care journey was not an isolated experience. Rather, their frustration pointed to problematically longstanding and systemic prolonged waiting times in the broader hospital and service systems. Indigenous women were compelled to wait, often with limited meaningful communication, for an extended period of time. Their narratives expressed the view that many services were not able to provide timely care and resources because they were at capacity, leaving Indigenous women to return to where the family violence occurred. One service provider explained that long waiting periods to gain access to community-based services added to Indigenous women's feelings of worthlessness and futility:

> So they'll come in, and normally, if we – because we can't help them, then they'll just get really angry at us and 'No one's effing helped me, and you don't care about me, and you don't want me to get into a house', and then they'll normally leave. (Kelly, family violence, community-based service provider)

Another participant agreed, adding that Indigenous women 'will go back because there's nowhere else to go. Even if it's her place she has to go back there and he just comes and goes and it all starts all over again' (April, Indigenous Hospital Liaison Officers and Aboriginal Health Workers, hospital).

Conclusion

These experiences offer insight into the responses of healthcare and support services at a time when governments around the world are developing and implementing frameworks, service pathways and strategies to respond to the unacceptable rates of violence against women (Australian Government, 2022; Australian Government, 2023; Dale et al., 2021). The findings reported here suggest Indigenous women are encountering healthcare responses and spaces that are not designed for their needs, which, in turn, is leading to their exclusion from the system. Other ED studies identify gender and racial bias in triage screening, with women generally receiving a less acute triage score than men, and Indigenous peoples receiving lower acuity triage scores than those who are white settlers (Lopez et al., 2010; McLane et al., 2022). For Indigenous patients, their presentation may not be taken seriously, and treatment and care resources may be allocated in ways that disadvantage them compared to other patients (McLane et al., 2022). The failing of the public health system to provide Aboriginal woman, Ms Dhu, with timely critical care for her injuries is an example of the gendered, institutional, and structural racism Indigenous women experience within the Australian public healthcare system (Klippmark & Crawley, 2018). The literature demonstrates that if Indigenous peoples have poor experiences of healthcare, they are unlikely to access it. As Indigenous women experience high rates of family violence, it is critical that they are provided with timely, compassionate, and appropriate care and treatment (Australian Government, 2023).

Prolonged waiting can lead to Indigenous women leaving hospital before their treatment is completed. The act of leaving the hospital prior to completion of treatment has been described as a rational act of reclaiming personal power in spaces where they feel they have not had that opportunity in their engagement with the health system (Askew et al., 2021). Once women leave the hospital, there is no formalised follow-up (Fitts et al., 2024). As identified in this study, the waiting times Indigenous women experienced in the hospital were compounded by delays they encountered in other stages of their help-seeking journey, such as social and cultural care, crisis accommodation and access to community-based services.

The waiting times in clinical settings reinforce traditional relations of power that define the good Indigenous patient as being patient and adopting a 'sick patient role' that involves recalibrating to the rhythm of the ED and medical system, staying immobile in one location and relying upon the knowledge of professional health practitioners and staff. The behaviour some Indigenous women display may challenge expected behavioural norms in public spaces such as the ED (Tang & Browne, 2008). These institutional expectations do not necessarily reflect the behavioural reality of the trauma of family violence, particularly for Indigenous women who, due to the intergenerational violence of settler colonialism in Australia, are compelled to maintain high levels of distrust within government and, in particular, western public health systems. Following violence, women can also still be experiencing survival responses. Trauma-related pathologies such as post-traumatic stress disorder, for example, is more prevalent in women who experience assault and those who have experienced TBI from violence (Iverson et al., 2017; Ressler et al., 2022). The symptoms of post-traumatic stress disorder, such as hyperarousal, can manifest as irritability, panic and disrupted cognitive function. Such symptoms can be misinterpreted as impatience and non-compliance and treated through punitive measures in the ED that inflict further harm and trauma. The case of Ms Dhu, who requested medical care and help when in police custody for injuries sustained from violence prior to police custody, is an example of this misinterpretation. Health professionals considered Ms. Dhu to be an unruly and disorderly patient, described in medical notes as agitated, attention seeking and displaying behavioural issues (Klippmark & Crawley, 2018).

Implications for practice and policy

The findings suggest the need for specific attention to the design of service delivery for Indigenous women who also experience repeated concussions and TBI from family violence. Family violence and TBI training are critical to challenge racism (McLane et al., 2022) as well as strengthen confidence and reduce professional uncertainty in having conversations with Indigenous women in the ED about family violence (Fitts et al., 2024). Another aspect of service delivery planning is the design of the built environments for women that consider complex and layered trauma. Trauma-informed design is an emerging concept that addresses the psychological wellbeing, safety and security needs that are often missing in service settings such as hospitals (Bollo & Donofrio, 2022; Owen & Crane, 2022). There is a range of specially developed spaces for women generally that account for their specific needs including health clinics, supported housing and homeless shelters (Ajeen et al., 2022; Owen & Crane, 2022). Various elements of design and space are considered in the ways in which design can give women privacy and safety while also nurturing a sense of autonomy and empowerment and providing the time and space for reflection and change. Examples include building infrastructure, furniture design, colour, the presence of nature, lighting, sound as well as heating and ventilation. Settings with a trauma-informed design have been shown to increase dignity as well as feelings of safety and hope among women (Ajeen et al., 2022).

Strengths and limitations

These findings need to be considered within the context of the study limitations. As this study was conducted in one regional location in Queensland, Australia, the findings may not reflect experiences in other regional locations in Australia or internationally. Indigenous women with lived experience who participated in the project were mostly women aged between 30 and 50. Their experiences of accessing the ED may also not be reflective of women within other age categories. In order to fully understand the experiences of Indigenous women who are currently living in a family-violence context and accessing the ED and community-based services, more extensive research is required.

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