An unspoken crisis: Exploring the pathways of support for Wāhine Māori who have or are at risk of sustaining a Traumatic Brain Injury (TBI) from Intimate Partner Violence (IPV).

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Abstract

Research suggest's a strong association between taumatic brain injury (TBI) and family violence or intimate partner violence (IPV).[1] Yet, there is very little research exploring the prevelance of TBI from IPV for wāhine Māori. And, even less research into practitioner (ngā mātanga) understanding of TBI from IPV. These knowledge gaps limits the ability of multiple social services and the health sector to respond to suffering associated with TBI.

This qualilative study based on standard Māori research practices explored ngā mātanga understanding of TBI from IPV for wāhine Māori and how they navigate and support wāhine through this trauma. The intent was to identify gaps and barriers encountered in their mahi. Another goal was to map the family harm response and TBI treatment and rehabilitation process and consider its effectiveness for wāhine Māori.

The data was collected from eight interviews,where a total of ten ngā mātanga participated. Ngā mātanga included social workers, a counsellor, a physiotherapist, advocates and psychologists, who for most have in some form worked with whānau impacted by family violence.

Four key themes emerged from the data:

1. ngā mātanga awareness of a TBI from IPV
2. issues identifying a possible TBI from IPV
3. understanding and navigating referral pathways for TBI from IPV
4. gaps in current practitioner responses.

Findings of this research demonstrated the limited awareness that surrounds this kaupapa, not just for service providers but also whānau and the general population. A second key finding is the response to family harm often centres on safety with many wāhine seldom receiving treatment or rehabilitation for TBI. This makes it difficult for wāhine and their whānau to recover and break the cycle of family harm.

[1] Throughout this research the terms family violence, intimate partner violence and domestic violence are used interchangeably, depending on participants understanding or interpretation of intimate partnert violence. However for the purposes of this kaupapa my focus is on initmate partner violence.

The final key finding is that when TBI from IPV is considered the treatment and rehabilitation pathways are not well understood, obscure and inconsistent. Of concern is that Māori understandings of dealing with and healing from trauma are seldom considered as part of the treatment and rehabilitation pathway. This information was used to consider how current practice could be reconfigured to reflect Te Ao Māori health and wellbeing priorities. It is argued that mātauranga, particularly pūrākau (narratives of our ancestors) and the concept of mana wāhine, must guide treatment and rehabilitation pathways to produce better outcomes and ultimately healing for wāhine Māori and their whānau.

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa Hui e! Tāiki e!

May peace be widespread.

May the sea be like greenstone

A pathway for us all this day

Let us show love for each other.

For one another

Bind us together!

Affirm![2]

[2] While I am not sure of the origins of this karakia, I acknowledge the composer/s. Karakia is an important part of my life, passed on from ngā wāhine toa in my whānau. During this research process, I would often say karakia to protect me and guide me and to give thanks.

He mihi

Ko wai au:

> *I te taha o tōku māmā, I whakapapa back to Tongariro, ko Ngāti Hikairo te iwi, ko Rotoaira te moana, ko Otukou me Papakai ngā marae. E whānau mai ai ki Taumarunui, e tipu ake au ki Tongariro National Park, Nō Rotorua e noho ana.*

I am grateful to Associate Professor Dr Margaret Forster for her time and guidance with this mahi and making me believe in my knowledge and ability to see this research through and knowing the kōrero is important and needed.

I am grateful to ngā mātanga time and manaakitanga given to me during the interviews. You all welcomed me into your worlds and shared your knowledge and whakaaro, for this I am truly grateful and hope in some way this research can help support with the development of the awareness and resourcing needed for the mahi you do, alongside our wāhine and whānau.

I acknowledge my Uncle Jamie and my Father-in-law Noel, while the completion of this thesis was made tougher this year with your passing, your teachings of strength and determination continued to guide me.

To Will, William, Isabella, Amelia and all our whānau, while most of the time you try your best to keep up with the different things I am working on, I am grateful for your aroha, support and understanding, just know, everything I do is with you in mind x.

Contents

Chapter 1: The Research

Introduction

Understanding the impacts of family violence on the health and wellbeing of New Zealand population is an increasing area of concern with more research needed. Little research exists into understanding the prevelance of traumatic brain injuries (TBI) among women, sustained from intimate partner violence (IPV) and even more limited (if any research at all), is an understanding of TBI from IPV for wāhine Māori.

The data indicates that: wāhine Māori are significantly over-represented as survivors of IPV; that further understanding is needed on the effects of a TBI and the impact on an individual's ability to function; and, when applying a Te Ao Māori lens on this kaupapa, it is important to highlight the impact from this trauma on the tapu and the mana of the wāhine - the cultural injury.

This thesis seeks to fill a critical gap investigating the pathways to related to TBI resulting from IPV for wāhine Māori. In response to the lack of existing information, the thesis aims to provide a more nuanced Te Ao Māori perspective and advocate for a comprehensive understanding of TBI among wāhine Māori from IPV

The study focuses on the health impacts of TBIs from IPV among wāhine Māori, examining the prevalence, functional effects, and cultural implications of such injuries. It is conducted within New Zealand, particularly in regions with significant Māori populations, and targets wāhine Māori who have experienced IPV and sustained TBIs, across various ages and socio-economic backgrounds.

The hypothesis is that traumatic brain injuries from IPV significantly impact the health and well-being of wāhine Māori, both physically and culturally, and that culturally tailored interventions are necessary to address these impacts effectively. The research will explore systemic issues such as institutional racism in healthcare and social services, and socio-economic barriers that exacerbate the challenges faced by wāhine Māori with TBIs from IPV. It will investigate how these systemic issues affect the recognition, treatment, and support for wāhine Māori with TBIs.

By addressing these systemic challenges, the research aims to develop effective, culturally tailored interventions to improve the health outcomes and overall well-being of wāhine Māori affected by TBIs from IPV. The findings will contribute to a better understanding of their unique needs and inform policy and practice to support their health and empowerment.

Thesis Structure

The structure of this thesis is made up of four key parts:

Arotake | Review - Chapter 1 provides a literature review and an overview of the research completed, including the current understanding surrounding this kaupapa.

Whakamahere | Mapping - In Chapter 3, I map my understanding of the current service responses to family violence. This process helped create a hypothesis as a starting point for this research and identified questions to ask research participants.

Rangahau | Research - Chapter 4 outlines the interviews with ngā mātanga and reviews their kōrero to understand responses by family harm services. This information provides an evidence base to understand the 'service' journey for wāhine Māori who sustain or are at risk of sustaining a TBI through IPV. Moemoeā | Vision - Chapters 4 and 5 outline a vision for a new pathway focused on healing and grounded Kaupapa Māori response including mana wāhine.

My Why – My Kaupapa

I have worked within the Health and Disability and Justice sectors in some form for over 15 years. During my tenure at the Accident Compensation Commission (ACC), I worked alongside people who sustained a traumatic brain injury (TBI) as a result of an accident. This is where my understanding of brain injuries developed and the impact these lifelong injuries have on individuals and their whānau.

It was also during this time, that I became more aware of injuries to wāhine, sustained through family harm events. Often the ACC lodgment of claims description included injuries of facial wounds and sprain injuries to the body, with limited mention of head injuries or screening for concussion. This

suggested to me that injuries to the head were not always being considered or screened following family harm call outs or at community service response level.

I also had the opportunity to work within the sensitive claims unit,[3]where my understanding of Post-Traumatic Stress Disorder (PTSD) (from an ACC claim for Mental Injury) developed also recognising the similar elements across PTSD and TBI, which can impact an individual's ability to function and navigate their daily life including anxiety, depression, drug and alcohol abuse and fatigue.

I then had the opportunity to practice as a Family Law Solicitor, where I witnessed first-hand the impacts of head injuries and mental injuries on wāhine following family violence. As a family law solicitor your role includes meeting with wāhine, often a day or two post the violence, to make applications to the court for protection orders and/or parenting orders. An affidavit in support of the application was often needed. This involved an in-depth recollection of events from the wāhine, which led up to the application.

Wāhine would often struggle to recall aspects of the events and when aligned with the wāhine description of the brutality of the violence to the head, it became clear why wāhine struggled with recall. Wāhine would often speak of knocks and stomps to the head, boots to the face, their heads being slammed against walls, blows to the head, constant trauma to the head, I recall a wāhine say "I saw stars."

What also became evident was the substance abuse for some wāhine. The questions around drug use and alcohol use are standard safety question as part of an affidavit for a parenting order application. It became clear that drugs were often used by the wāhine to help manage their daily tasks, working as pain relief for constant headaches and often a mood enhancer for low moods.

Seeing wāhine and whānau navigate the court system while unknowingly living with an undiagnosed TBI and being aware of how much or little wāhine choose to disclose in concern of the possible retribution from their partner of child protective services, I became even more aware of the lack of understanding across the law fraternity and the general population and the flow on effect from the

[3] Sexual Abuse Claims covered as part of ACC

impact of this trauma. For example, the focus was often on the inability to parent, rather than considering what wrap around support was needed to ensure wāhine could continue to mother.

This need for wrap around support and an appropriate response became even more evident in my role working with rangatahi at Oranga Tamariki. For rangatahi who had been within the Oranga Tamariki system for most of their life, who not only displayed behaviors associated with undiagnosed physical and mental trauma but were being taken from their māmā who was barely functioning due to her own likely, undiagnosed TBI, only to be returned (after turning 16 years old), to their māmā who continues to live with untreated head trauma.

I also had the opportunity to be part of the women's collective for women's refuge. During this period, I developed my understanding around women refuges' response to family violence. Rightfully so the priority for advocates is to get the wāhine and children safe in the first instance. In my view however, the focus for safety became about keeping the whānau separated, through support with relevant court orders, staying in a safe home until the whānau could be transitioned into their own home and programs about empowering wāhine and drug and alcohol abuse. I am not saying that these interventions are not needed or not important but wonder what the response may look like if TBI from IPV was considered and wrap around support for the whānau as a unit.

In my view, having an understanding of head injuries and TBI and the disabling impacts these injuries have on an individual's ability to function and the flow on effect on whānau wellbeing is critical for providing diagnoses and determining appropriate rehabilitation so that TBI is not left untreated.

My why - my kaupapa, is about developing a response in how do we do this better. When I hear stories of mothers hurting their children or allowing their partners to hurt their children, as a māmā I know that 'something' is not right, espcially where there is a historty of partner violence involved. As a māmā, like so many others, my default to my children is to protect by all means what so ever.

I believe that this 'something' that is not quite right, may be from a sustained history of brain trauma from IPV, and the māmā is simply surviving, with the effects of a brain injury, unbeknown to her. My obligation as a māmā is to those other māmā who are struggling and have no idea why.

To ensure wāhine Māori are given every opportunity to heal, the healing response starts with tailoring our approach to what wāhine Māori with a TBI can fully comprehend. This starts with effective TBI screening, where the correct diagnosis is made with a culturally appropriate response that is tika.

Pūrākau

While the primary focus of this thesis is to explore the pathways in response to TBI among wāhine Māori resulting from IPV, it also aims to raise awareness about this often-invisible trauma. By sharing pūrākau from women who have experienced TBI from IPV, we are reminded of the real and personal impact faced by women as they navigate the dual trauma of a brain injury and partner violence.

TBI from IPV has been called a "silent epidemic" because the effects are not obvious to observers, so the injury is often minimised, medical treatment is often not sought, and signs and symptoms are attributed to other causes (Manoranjan et. al, 2022, p. 54).

In January 2022 stuff.co.nz published an article, Life-changing brain injuries in domestic violence survivors going unrecognised. The article recounted a māmā's purakau in their daily life, providing an insight into living with an unrecognised brain injury from IPV:

> *I was so broken, she says.*
>
> *I couldn't walk without holding on to furniture and my blood pressure couldn't regulate itself. My circadian rhythms were all out, so I didn't sleep well.* **[**The days after the assault].
>
> *Her balance went, she was incredibly sensitive to light and noise, but worst was she couldn't be around her children - even though they needed me so desperately.*

She struggled to manage routine tasks:

> *She couldn't even change a nappy. Her mum moved in to look after the children, aged 5 and 1.*

> *I just had to totally let go. It was heart-breaking, she says, "the hardest thing I've ever done in my life.*

Navigating the relevant services in support immediately following the violence was difficult:

> *Within 10 minutes of the assault, she was dealing with police. Then there was ACC to navigate, doctors' appointments, statements to give, lawyers, a protection order.*

Including trying to recall details to support her credibility in the court system:

> *Navigating all of that with a brain injury was nigh on impossible. I kept having lawyers ask me to give them an affidavit. I couldn't even remember what was in the fridge, or what the word for table was.*
>
> *She couldn't read or write – looking at black on white made her want to vomit - so she was reliant on friends and family to record the details of eight years of abuse. The assault was the first instance of physical violence, but the aggression, threats and fights were longstanding.*

Enhancing the service response to TBI resulting from IPV is of paramount urgency. It is unacceptable that wāhine continue to suffer under the weight of this unspoken crisis that remains silent.

Chapter 2: Literature Review

Intimate Partner Violence (IPV)

The World Health Organisation **(**WHO) defines Intimate partner violence as "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours" (Krug et al., 2002, p. 89). The WHO also estimates that one in three women throughout the world will experience IPV in their lifetime (Haag et al., 2019, p. 1).

New Zealand has one of the highest recorded rates of child abuse and domestic violence in the Organisation for Economic Cooperation and Development (OECD). Reported family harm events have

almost doubled in a decade, from 102,888 in 2013 to 191,640 in 2023 and are predicted to increase by a further 35% by 2025. Family harm continues to be one of the largest demand areas for Police (NZ Police, 2021). On average police receive an average of 460 reports of events every hour of the day, of these, twenty-two reports are for family harm.

From the limited research and data that is available around IPV, a survey of New Zealand women conducted in 2011, that the lifetime prevalence of physical and/or sexual intimate partner violence was 1 in 2 for Māori women (58%), 1 in 3 for European/Other women (34%), 1 in 3 for Pacific women (32%) and 1 in 10 for Asian women (11.5%) (Fanslow & Robinson, 2011).

While the data and available research in terms of the prevalence of TBI from IPV among New Zealand women is also very limited and even more limited for wāhine Māori, what the data does highlight is wāhine Māori are significantly over-represented as both survivors and non-survivors of IPV.

It is estimated, that 67% of family violence in New Zealand goes unreported (NZ Police, 2021). However, more research is needed to understand what percentage of these unreported cases of family violence may be seen in other settings including hospitals and family violence services, alongside the cases where no reports of family violence are made. Research on family violence and brain injury from Brain Injury Australia (2018) found that hospitals are likely to be the 'tip of the iceberg' and vastly outnumbered by family violence cases seen in other settings.

Traumatic Brain Injury (TBI)

A TBI is defined as "an alteration in brain function or other evidence of brain pathology, caused by an external force," (Menon et al., 2010, as cited in Haag et al., 2019, p. 1). Brain Injury New Zealand describes two types of TBI's: a Closed TBI, which occurs when there is an impact to the brain, but the skull is not penetrated or fractured; an Open TBI which occurs when there is an impact to the brain and the skull has been penetrated or fractured. TBI's range in severity from mild to severe as scored by the Glasgow Coma Scale (GCS), where a GCS of 13-15 being mild, 9-12 being moderate and less than 8 being a severe TBI (Costello & Greenwald, 2022). Approximately 80% of injuries sustained are rated as mild (Kwako et al., 2011). However, as Martin (2013) points out, while the description, "mild" may

indicate that a brain injury is minor, the impact might not be. For example, a mild brain injury can also impair an individual's ability to fully function and produce long-term damage.

Brain injury can result in physical, cognitive, and behavioural disability (Brain Injury Australia, 2018). Physical disabilities can include speech impairment, disturbance to vision and hearing, poor balance and coordination and chronic pain. Cognitive disabilities can include extreme fatigue, nausea, poor concentration, problems with memory and ability to concentrate, anxiety and depression. Behavioural disability can result from damage to the parts of the brain responsible for 'executive' function or the cognitive skills needed to control cognitive behaviours. Behavioural disability is sometimes referred to as 'challenging behaviours', including inappropriate social behaviour, verbal and/or physical aggression, inappropriate sexual behaviour and wandering behaviour.

According to Professor Alice Theadom, director of the Auckland University of Technology's TBI Network, brain injuries affect everyone differently. Individuals may experience different combinations of approximately 20 symptoms, depending on the affected part of the brain (Theadom, n.d.). The complexity of TBI symptoms can make it challenging to differentiate and diagnose, especially when overlapping with other physical or mental health concerns such as drug and alcohol impairment and post-traumatic stress disorder (PTSD) from IPV. These overlapping symptoms include poor balance and coordination, visual and hearing disturbances, frustration, irritability, depression, anxiety, and anger.

A review of current research on TBI screening tools underscores their effectiveness, reliability, and limitations. The findings suggest that these tools significantly improve the detection and management of TBI. Nonetheless, there are still areas that require additional research and development (Theadom et al., 2021).

Long Term Brain Impacts from a TBI.

The potential long-term effects of multiple mild TBI's include cognitive impairment, early onset dementia, psychiatric disorders, and chronic traumatic encephalopathy (CTE) - degenerative condition linked to repeated concussions (Brain Injury Australia, 2018). In New Zealand, recent media interest in

CTE has raised the awareness of concussions in sports, after a number of previous All blacks have been diagnosed with dementia, highlighting the increased risk of dementia associated with head injuries:

> *"Head injury has long been known to be a risk factor for progressive cognitive impairment. It may reduce "cognitive reserve," meaning there is less total working brain, so that when through ageing, Alzheimer's, or vascular problems the brain gets further damaged, there is less tissue available to resist the disease process".* (Perkins, 2020)

This increased understanding of concussions in sports has led to significant investment in campaigns and research to increase the awareness of the impact of compounding head injuries in sports. This investment in increasing awareness however has not yet been realised within the family violence sector, with TBI as a consequence of IPV continuing to remain silent.

Cultural Injury

An important focus of this research is to understand more around the assault on cultural beliefs and damage to tapu, which Dr Hinemoa Elder refers to as "cultural injury." This label acknowledges the head and brain are tapu, or sacred, to Māori, and that a brain injury also effects the wairua of the wāhine, and her whānau.

Due to the lack of research of wāhine Māori and the prevalence of TBI as a result of IPV, little is known about the cultural injury. Therefore rehabilitation programmes are not based on healing the wairua and mana of the wāhine and her whānau which encompass Te Ao Māori practices and mātauranga, kaupapa Māori frameworks, and strategies of healing within the whānau. This approach has significant merit.

In a customary Māori response to trauma, healing spaces and rituals including karakia were incited to remove any harmful influences. In a trauma-inducing event, the immediate response involved the protection of the victim or victims by the community to a space of healing and safety (Smith, 2019). The contemporary mainstream response is quite different to this customary one. The contemporary

mainstream response is deficit rather than strengths based, draws on westernised diagnostic tools and frameworks that advocate physical or psychological punishment rehabiliation (Pihama et al., 2019).

Trauma | Patu Ngākau | Pōuritanga

Understanding Māori definitions of trauma and the cultural elements and metaphors that underpin the definitions of trauma help to provide a clearer understanding of the cultural injury and support a focus on healing as a response pathway for wāhine. Smith (2019) describes trauma as including physical, mental, and emotional health. A trauma event is classified as pātu ngākau, which can be translated as a strike or an assault to the ngākau which is considered the source of emotions. Abuse, either physical, psychological or both and has an impact which is perceived as an assault to the ngākau the emotional core of a person, where memories are located (Smith, 2019).

Pātu ngākau describes the trauma or deep wound that is related to an event that causes shock (Smith, 2019). Pōuritanga talks to the affects. It refers to the pōuri - sad mental state, pō also meaning darkness, which can be associated with the various states of darkness, leading to the dawn or the new light of the day (Smith, 2019, p. 36). Pōuritanga and mamae are expressions of trauma, referring to the state of being which follows the traumatic event, pōuri is a psychological state of feeling which can include anxiety or depression (Smith, 2019). Although pōuritanga is primarily focused on a psychological or a mental state of being and mamae generally includes the physical and emotional pain. In a Te Ao Māori definition of trauma mamae and pōuritanga are both connected to pātu ngākau and its effects (Smith, 2019).

Historical Trauma

For wāhine, the accumulation of colonial trauma continues to have a significant generational impact on heath and wellbeing (Wirihana & Smith, 2014) as evidenced by wāhine suffering higher rates of physical, sexual, and psychological abuse, than non-Māori. The collective trauma, of over-lapping disadvantages of historical, colonial trauma, contemporary social impacts, and the high rates of IPV are only compounded by the daily navigation of this ‘unspoken crisis,’ camouflaged as, agitation,

depression, alcohol and drug dependency and mental health confusion of undiagnosed or misdiagnosed TBI.

The understanding and analysis of collective trauma was discussed by Pihama, et.al (2019), raising the concern that westernised frameworks of trauma informed care and the impacts for Māori do not support the pathways for healing from family violence (Pihama, Cameron & Te Nana, 2019). Māori view wellbeing as holistic, which can encompass the tinana, wairua, mind and whānau, working towards a state of balance known as mauri tau, where the mauri or lifeforce of an individual can flourish.

The concept of collective trauma was also considered in the fifth report for the Family Violence Death Review Committee (FVDRC) (2016) highlighting competing disadvantages for Māori, with both the historical trauma and social demands including living in some of the most deprived communities for many Māori whānau considered as contributing factors to the over-representation of violence in Māori whānau seen today.

Historical trauma is defined by Brave Heart, Chase, Elkins, and Altschul (2011) as, "cumulitive emotional and pychological wounding across generations, including the lifespan, which emanates from massive group trauma" (p. 283). This definition reponds to American Indian histories and experiences of historical trauma and loss.

The generational effects of historical trauma among Māori was discussed by Wirihana and Smith (2014), identifying factors such as the confiscation of land through land wars and legal imperalism that resulted in a loss of indentity and community for many Māori. The impacts of loss continued by the incapacitation of Māori traditions and beliefs including for example colonial practices of physical abuse to Māori children reinforced by the Native Schools Act 1987, where Māori children were abused for speaking their native language. Another example is the restriction of Māori healing through the Tohunga Supression Act 1907, in favour of westernised systems of health (Wirihana & Smith, 2014).

For many wāhine the impact of historical trauma included an assault on the status of wahine in society, particularly the colonal practice of viewing women as inferior to men. (Wirihana & Smith, 2014). Precolonial, violence against women was rare as the mana of wāhine was paramount. The traditional

cultural reponse to any violence against women or IPV was a collective healing response, where the whānau worked together; the event was not managed in isolation.

Background

A TBI as a result of IPV can have debilitating lifetime effects, which not only impact an individual's ability to physically function, but also psychological disruption, including higher rates of emotional disturbances, such as posttraumatic stress disorder (PTSD) anxiety and depression (Kwako et al., 2011). Sustained trauma to the head can lead to brain tissue degeneration, resulting in issues such as mood changes, aggression and impaired judgment impacting the ability to manage everyday tasks (Haag et al., 2019).

A review of available research on TBI among women in the United States, who have experienced IPV found that the prevalence of TBI among survivors of IPV seeking shelter of care ranged from 30 to 74% and that 40% of women who experienced IPV had sustained at least one TBI which resulted in a loss of consciousness, with at least 92% reporting a blow to the head or face (Kwako, Glass, Campbell, Melvin, Barr & Gill, 2011).

The serious consequences of TBI in survivors of IPV, was explored by Haag, Jones, Joseph, and Colantonio (2019). There findings indicated that TBI appears to be often overlooked or misdiagnosed and there are clinical gaps in recognising and diagnosing TBI among survivors of IPV presenting at emergency departments. The presentation of TBI can include neurological complaints such as depression, anxiety, agitation, and suicidal behaviour.

Costello and Greenwald (2022) also point out difficulties in recognising TBI secondary to IPV for women presenting at emergency departments. They argued that many patients who present do not have obvious external injuries and when they do, the injuries are often linked to other causes making diagnosis difficult. Costello and Greenwald (2022) recommended increased awareness through professional training of frontline workers to ensure the need for TBI screening is considered. This recommendation was linked to finding that only 1 in 10 physicians completed a screening for domestic violence (term which can be used for IPV) when interviewing patients. Physicians were unlikely to

screen due to concerns of timing, resourcing, and training as well as a fear of opening "Pandora's box," raising issues that goes beyond their professional scope of care (Costello & Greenwald 2022).

Kwako et al. (2011) raised awareness of the cumulative damage from repeated exposure over extended period of times to TBI through IPV. They found that 25% of survivors had received hits to the head more than 20 times over a 5-year period and 72% reported multiple TBI's. This sustained trauma to the head was supported by in Haag et al. (2019), finding that such repeated trauma can lead to brain tissue degeneration, resulting in issues such as depression and mood changes, aggression and impaired judgment impacting the ability to manage everyday tasks, leading to long term chronic health conditions such as dementia. Many clinical professionals considered these factors to be linked to mental health or an impairment from substance abuse rather than an injury, leading to misdiagnosis. In these cases, a discharge plan would include a mental health rehabilitation pathway, including psychiatric medication which can create further side effect risks to a TBI. A better treatment course for survivors of IPV would have been a neurorehabilitation pathway (Kwako et al., 2011).

A common finding in literature (Haag et al., 2019; Kwako et al., 2011) is that treatment for TBI in IPV is very limited and few studies address the correlation between the TBI and IPV.

Discussion

The Australian study on brain injury (2018) found a strong association between brain injury and family violence indicating that 40 per cent of domestic violence victims attending hospital had a brain injury.

Dr Eve Valera, an associate professor at Harvard Medical School who has spent more than two decades researching this area, says the rate could be as high as 100 per cent, but she could confidently say a third of domestic violence will suffer at least one brain injury.

By not effectively screening for TBI (in relevant settings), as a result of IPV or misdiagnosing the presentation, wāhine are not receiving the appropriate treatment and are at increased risk of further violence and possibly homicide. Wāhine will also struggle to navigate everyday life with physical and mental impairments that are 'silent', further compromising recovery.

Costello and Greenwald (2022) argue that wherever possible, victims of TBI should be recognised before they even get to a healthcare facility. Often the first responder to a family violence call out is the police officer, however when a police officer sees victims of family violence, it is not always apparent to them that these individuals may need medical care.

As TBI symptoms can resemble the effects of drug and alcohol abuse, police officers can assume that individuals are non-complaint rather than in need of medical intervention. Costello and Greenwald (2022) suggest that by educating police officers on TBI as a result of IPV, this increases the chances for the individuals to get to the medical centre and have a chance to be screened and diagnosed.

Chapter 3: Whakamahere | Mapping

This chapter presents a map of community level responses to TBI resulting from intimate IPV. The map was developed based on my own understandings and experiences working within the family violence sector. It was shared with ngā mātanga (experts) during interviews to validate my understanding of the response pathways for wāhine who may have sustained a head injury following a family violence event. Ngā mātanga confirmed that the map closely aligns with their experiences.

The starting point was to map the journey from a family harm call out by the police, as data indicates that family violence response constitutes 41% of frontline police time (Family Violence Death Review Committee, 2017). Therefore, it was appropriate to begin with the police as first responders to family harm callouts. Map 1 outlines three response pathways: a medical/primary response pathway, a service response pathway and no response pathway – often where wāhine chooses not to disclose or engage.

The mapping exercise has identified touchpoints in the pathways where TBI from IPV is not always considered and highlighted opportunities for TBI assessments. Creating this map also informed the development of relevant interview questions to explore practitioners' awareness and response to TBI from IPV.

This chapter details the information used to construct the map, including relevant definitions and context for understanding how ngā mātanga respond to TBI from IPV. It is important to note that while two response pathways have been identified, wāhine and whānau also have the option to choose no intervention from either medical or IPV services.

The map reveals that the journey for wāhine in identifying TBI as a consequence of IPV is fragmented and relies on several factors, including the responder's awareness of TBI, the capability of medical practitioners to conduct successful screening assessments and provide appropriate diagnoses, and the willingness of wāhine to disclose their trauma and injury. Effective responses also depend on wāhine recognising the signs of TBI and being supported to navigate the appropriate service response, which

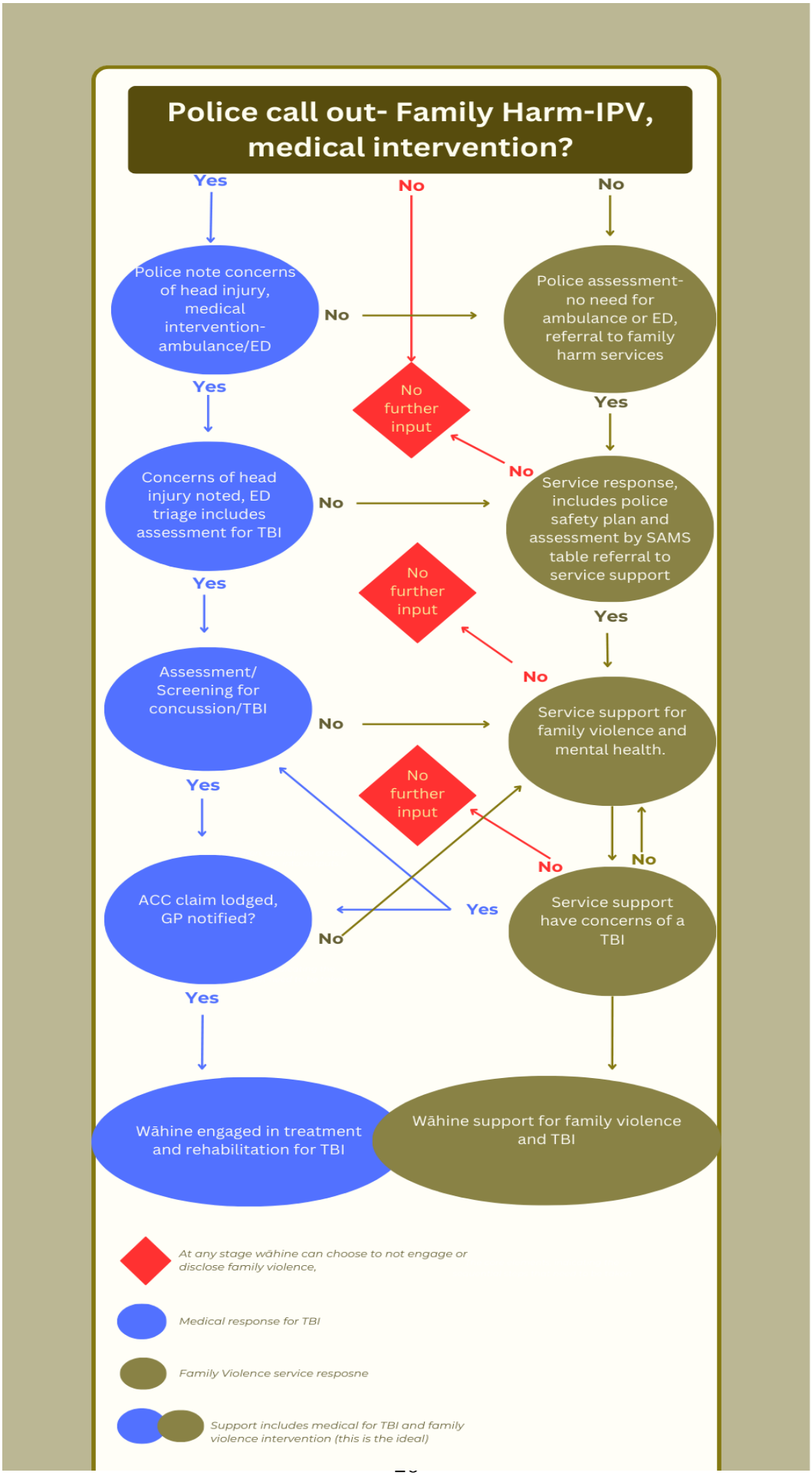
differs from mental health responses that often serve as the default for both the medical and family harm service pathways.

Methods of scoping process

To ensure the robustness of the mapping research, a detailed scoping process was undertaken. This involved contacting various organisations and professionals involved in the response to family harm across Waiariki - Rotorua. The organisations contacted included those providing Kaupapa Māori services, concussion or psychological services, neuropsychological assessments, and social services for sexual violence, primary health social work services, and counselling. The methods of contact included emails, phone calls, and in-person meetings. Responses were tracked to identify who responded and who did not.

The scoping process also involved reviewing relevant policies and documents to help create and confirm the map. This included guidelines from the Family Violence Death Review Committee and other relevant literature. Additionally, the limitations of the work were considered, such as the exclusion of NZ Police family harm teams as key informants in the mapping process

This map illustrates the community-level response pathways for wāhine Māori who may have sustained a traumatic brain injury (TBI) from intimate partner violence (IPV). The map identifies key touchpoints where TBI from IPV is not always considered and highlights opportunities for TBI assessments. It also reflects the option for wāhine and whānau to choose no intervention from either medical or IPV services.


Police call out- Family Harm-IPV, medical intervention?
Yes
No
No
Police note concerns of head injury, medical intervention- ambulance/ED
No
Police assessment- no need for ambulance or ED, referral to family harm services
Yes
No further input
Yes
No
Concerns of head injury noted, ED triage includes assessment for TBI
No
Service response, includes police safety plan and assessment by SAMS table referral to service support
Yes
No further input
Yes
No
Assessment/ Screening for concussion/TBI
No
Service support for family violence and mental health.
Yes
No further input
No
No
ACC claim lodged, GP notified?
Yes
No
Service support have concerns of a TBI
Yes
Wāhine engaged in treatment and rehabilitation for TBI
Wāhine support for family violence and TBI
At any stage wāhine can choose to not engage or disclose family violence,
Medical response for TBI
Family Violence service resposne
Support includes medical for TBI and family violence intervention (this is the ideal)

Police Response to IPV

In 2016 the intergrated safety response (ISR) model was piloted in Christchurch and now operates in both Christchirch and Waikato. The ISR model brings together Police, Oranga Tamariki, the Department of Corrections, Ministry of Justice, Ministry of Social Development, Ministry of Education, Te Whatu Ora, Accident Compensation Corporation, local iwi, specialist family violence non-government organisations and kaupapa Māori services to support victims and their families, in a response to family violence - family harm.

The police response to family harm varies across regions, often modelled on the ISR framework. My understanding is that aside from Waikato and Christchurch, for many regions the police have a family harm team whose primary role is to respond to family harm call outs.

When police are called to a family harm event, the priority is around safety for all parties, which can involve separating the individuals involved to speak to them and ascertain the issues. Police assess whether medical intervention is needed and will call an ambulance if required. Where there is a serious concern of safety to the wāhine, the police will complete a safety order, which stops the perpetrator from having any contact with her for a period of up to 10 days. The police may also make a referral to the local Women's Refuge, who can then provide safe accommodation and advocacy, and to Victim Support,[4] to provide advocacy and support.

Following an assessment of the family harm call out, family safety plans[5]are created and are categorised as either low, medium or high risk by collective agreement using an evidence-based risk assessment framework to ensure they are thorough and consistent.[6] All new episodes of family harm (some may relate to existing family safety plans) and imminent high risk family harm are referred to the Safety

[4] Victim Support provides a free, nationwide support service for people affected by crime, trauma, and suicide in New Zealand. We help our clients to find safety, healing, and justice after crime and other traumatic events.
[5] A Family Safety Plan is created for each family and is subsequently developed by participating agencies in conjunction with the victim, perpetrator and other family and whanau.
[6] Low Risk – family harm is unlikely to reoccur and there is minimal or no potential for physical, emotional, or psychological trauma. Medium Risk – family harm is likely to reoccur, but not imminently and there is potential for moderate physical injury, emotional or psychological trauma. High Risk – family harm is about to reoccur imminently or is highly likely to reoccur and there is potential for serious physical injury, emotional or psychological trauma, or death.

Assessment Meeting (SAM) daily triage meeting and discussed with relevant organisations, to develop a plan for going forward.

Following the Police family harm response, three possible pathways have been identified:

- A medical or primary health response
- A service response with no medical intervention indentified, but rather a service response from a contracted family violence service provider, in response to the violence and not the TBI.
- No further input

At any time an individual can transition by self referral or service referrals between to the response pathways.

A Medical - Primary Health Response

When police attend a family harm call out, my understanding is that police complete an assessment on safety and determine if any medical treatment is needed. The police will call for an ambulance or if needed accompany wāhine to the emergency department (ED). In the instances where the ambulance and paramedics attend, an assessment is often completed in line with the practice standards for concussion and minor traumatic brain injuries.[7] Where there are concerns, wāhine are transferred to hospital via ambulance or Police, with handover to medical staff completed.

Gaps

Research suggests there is compelling evidence between alcohol and family violence, with one in three reported cases of family violence being alcohol affected (Alcohol Healthwatch & Women's Health Action, 2013).

When first responders, the police or ambulance paramedics are called to family harm events, the impairment from drugs and/or alcohol will influence whether a concussion test, head injury assessment can be completed. If the impairment from drug and/or alcohol is significant the concussion test cannot

[7] St Johns practice standards and guidelines for concussion and minor traumatic brain injury 4.9 clinical-procedures-and-guidelines---comprehensive-edition.pdf (stjohn.org.nz)

be completed. Depending on the level of the injuries, if the injuries are assessed as not too high risk, the response will be for the victim to follow up with their GP of relevant medical services if needed.

The risk associated with this is that wāhine will not follow up for further medical treatment, if they do, they may not be assessed for TBI from IPV, especially when a discharge note may mention drug or alcohol impairment. The pathway in response then risks becoming about drug and alcohol rehabilitation or a mental health response. Disclosure is also a concern for wāhine, for reasons including lack of trust that statutory services may become involved (in relation to childcare) and the fear of retaliation or retribution from the partner.

Question for Consideration

> When our wāhine present under the influence of drugs and/or alcohol, following a family violence event what happens?

Transfer to Emergency Department (ED)

In instances where wāhine are taken to ED following a family harm event, the Manatū Hauora - Ministry of Health (MOH) Family Violence Assessment and Intervention Guideline can be administered. These guidelines contain a series of questions some linked to violence that can help practitioners determine whether referrals are needed[8]:

> Question 3: Has the violence increased in frequency and severity? Further assessment may include: Can you tell me more about that? Do you have any injuries that you would like me to look at?
>
> Question 4: Has your partner ever choked you? If yes, follow the procedures in the Strangulation Guideline.
>
> Question 5: Have you ever been knocked out by your partner? If yes, carry out further assessment for traumatic brain injury.

[8] A practical tool to help health providers make safe and effective interventions to assist victims of interpersonal violence and abuse. The VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to designated Te Whatu Ora services

> Question 7: Has your partner ever used a weapon against you or threatened you with a weapon? Assess to determine if any injuries were sustained as a result of this assault.

The guidelines state that:

> If you receive a 'yes' answer to the following questions from the health and risk assessment, further investigation is required. Physical health assessment: Given the health consequences associated with IPV, additional assessment and appropriate treatment may need to be offered to victims. This should include a thorough physical examination to identify all current and past injuries and appropriate laboratory tests and X-rays.[9]

Gaps

TBI are only being screened if the presentation is severe or wāhine answers yes to Q5 of the physical health assessment. If the wāhine does not disclose, no further assessment is considered for TBI and the mental health pathway and safety programs are the default response, rather than a hauora response. If wāhine are impaired by drugs and/or alcohol the guidelines also consider this as needing a mental health response as per VIP flowchart (Appendix 1).

Assessment for TBI Completed Concerns for TBI Noted

Depending on the level of injury, wāhine will either be admitted to hospital for medical treatment or discharged to their general practitioners (GP) for follow up care, which may include a referral to concussion services.

To help guide the practices in response to IPV, MOH provides a practice guideline (2003) for GP's called*: Recognising and responding to Partner Abuse*, along with practical training, this resource will help develop the necessary knowledge and skills for general practices in dealing with partner abuse. The guideline, outlines the need for a risk assessment:

[9]*Ministry of Health. (2003). Family violence intervention guidelines: Child and partner abuse. Section 2.3.2.*

> *"Risk assessment ascertains the level of immediate risk to the health and safety of a victim of abuse. Health care professionals should conduct a preliminary risk assessment to help identify appropriate referral options. A detailed risk assessment can then be undertaken by agencies that specialise in responding to partner abuse" (Ministry of Health, 2003).*

This resource notes the 'risk of homicide' and other factors to consider as part of the assessment including: Have there been threats of homicide? Have there been threats of suicide? Is alcohol or substance abuse involved? The resource also states that there is a strong association between partner abuse and suicide or self-harm.

Factors that are frequently associated with the risk of suicide or self-harm may themselves be symptoms of abuse. These include depression, extreme anxiety, agitation or enraged behaviour, excessive drug and/or alcohol use or abuse. If the risk is high, the MOH guidelines (2003) says to refer to the appropriate mental health service and to a specialist family violence agency. Treatment for any identified mental health disorders for victims of partner abuse should include addressing the abuse as a central part of treatment and identifying abuse is as a causative factor in their mental health problems.

Gaps

When the GP receives the discharge report (electronic platform) following the presentation to hospital, the GP's expectation would be that referrals have been made to relevant service providers and no further follow up is needed. Unless wāhine re-present to the GP, at which time the response would be a risk assessment as per guidelines and referral to relevant services.

The guide makes reference to symptoms associated with abuse, which supports a family violence programme service response and mental health response, yet these same symptoms can also be associated with a TBI and there is no mention or consideration of TBI assessment or screening.

Questions to Consider

What does the screening look like in a hopsital setting for TBI from IPV?

Does the hospital follow up on discharge?

When wāhine do present following a family violence event, what referrals are made?

What is the difference between a mental health response and TBI and why is this important?

Are notes reviewed to consider any history of family violence?

When you recognise signs of a TBI, what is your response?

ACC Claim Lodged; GP Notified.

A claim for injury following a family violence event can be lodged by the paramedic, at ED or by a GP, (or therapists). Often the ACC lodgment of claims description from family harm events include injuries of facial wounds and sprain injuries to the body, with limited mention of head injuries or screening for concussion and TBI. In my understanding, the family violence claims that do mention concussion very rarely lead onto a pathway for further rehabilitation or treatment, where the response is specific to a TBI rehabilitation needs.

Gaps

If there is no further follow up by the GP or wāhine once a claim has been lodged, there is no treatment and/or rehabilitation considered. If family violence continues, this can result in compounding head injuries or concussions.

Questions to Consider.

What is the follow up by ACC, when a claim has been lodged with ACC?

What is your understanding of the ACC process in response to IPV?

Service Response Pathway (Police assessment- no medical concerns noted, no ambulance or ED).

Where the police and wāhine deem it is not safe for the wāhine to stay at the premises, even when a safety order has been made, wāhine are encouraged to stay somewhere safe and where this is not possible, a referral for safe refuge is made. A service response following a family harm event is about safety in the first instance including advocacy for navigating the judicial system, housing, doctors,

schools and Oranga Tamariki, referrals to counsellors, Ministry of Social Development and other support services and education and support groups for women and children about living free from violence.

Whānau support services are also available and can be identified following a referral from the Police to the practitioners who sit at the family harm table.

Gaps

Research tells us that the understanding of an TBI from IPV is limited with practitioners reporting a low level of awareness of brain injury throughout the integrated family violence service system. There is also low understanding of the prevalence of acquired brain injury among victims and perpetrators of family violence. This view is supported by trauma Counsellor**,** Magdalena Durrant (2021) who found a general lack of awareness and understanding around the gravity of this type of abuse (physical, sexual abuse including strangulation) amongst practitioners. Durrant's research was the first NZ study to explore practitioner understandings of the link between acquired brain injury (ABI) and IPV. She points out there is an urgent need to start a discussion around IPV related ABI in NZ and to explore a systems approach to create a clear pathway for those affected to reduce the longer-term impacts of ABI on those affected.

Questions to Consider.

What is your understanding of TBI from IPV?

When you receive a family harm referral, is there any mention of any head trauma?

What training have you had on TBI from IPV?

What does the pathway in response look like in terms of TBI?

This map associated content and questions were used to guide data collection with ngā mātanga. The 'results' are shared in chapter 5.

The chapter provides the context in the form of a map for understanding the response to TBI resulting from IPV. Two response pathways have been identified, importantly, there's also an option for wāhine

and whānau to choose no intervention from either medical or IPV services. The journey for wāhine in response to identifying TBI as a consequence of IPV appears to be fragmented, relying on several aspects: responder awareness: recognising signs of a TBI, medical practitioners: completing successful screening assessments and providing appropriate diagnoses, safety and disclosure: wāhine feeling safe to disclose trauma and recognising TBI signs and a service response: navigating appropriate services (different to mental health response).

Chapter 4: Research design

Methodology

In shaping my methodological approach to this research, my foundation rests upon humility and continuous reflection, not only to uphold the integrity of the research but also to respect the guidance of our tupuna. My support structure is firmly grounded in kaupapa Māori principles—a framework where Māori are at the centre, with tino rangatiratanga as the guiding aspiration.

The qualitative data is formed from ngā mātanga kōrero and their understanding and practice for supporting wāhine following IPV. Additionally, I employ deductive analysis and Kaupapa kōrero narrative approach to understand and represent these stories. Kaupapa kōrero serves as the base, allowing me to layer wāhine pūrākau. This approach aligning with Te Ao Māori healing pathways, emphasising knowledge sharing.

Smith (1999) discusses the issue of 'insider/outsider' research and the dilemma faced by Indigenous researchers in their approach to research practice. Smith (1999) also addresses the importance of reflexivity for insiders who practice within their own community, outlining the need for insiders to work from a place of humility respect and honesty. This places an onus on the insider to be critical and reflective in their approach to research even more so than an outsider. This is because not only does the insider need to share back their findings and be held to account but also continue to live and be part of the community. Further, Smith (1999) touches on the need to build support structures, or whānau structures to navigate issues which arise and to ensure relationships are maintained and problems can be resloved.

Kaupapa Māori principles to guide this rangahau, were first articulated in the work of Distinguished Professor Grahan Hingangaroa Smith (2012), in his role in the development of kaupapa Māori theory in education. The principles include: whakapapa – acknowledging the connections to the rohe and the community for which I connect and live in; whānaungatanga – developing the relationships around the kōrero and the participants who share their knowledge with me; kia piki ake i nga raruraru o te kāinga – an awareness of the social impacts that surround this kaupapa, acknowledging that these aspects do

not define the wāhine, but rather a need to be considered as part of the process of healing and Māori development; taonga tuku iho – in starting and progressing this rangahau, the continued reflection on practices to ensure the aspirations for Māori are at the forefront, not the personal benefit to myself; ako – an open mind for myself to learn and act as a mouth piece to ensure this trauma is no longer 'silent' but rather an increased awareness in society to ensure an appropriate cultural response.

Arotake | Scoping

A scoping review was completed to understand the pathways of support for wāhine who have or are at risk of sustaining a TBI from IPV and to build the evidence base needed to highlight that this unspoken crisisis an urgent issue. This information is presented throughout the thesis but is mainly found in chapters 1-3. The review has been useful for informing my research direction. It was also a useful platform for identifying ngā mātanga who work alongside our wāhine and understanding gaps and key priority areas. This understanding was explored further through the lived experiences of ngā mātanga.

Ngā Mātanga

Ngā mātanga who participated in this research, included ngā mātanga who work as part of the response to family harm across Rotorua. This included specialists who provide a Kaupapa Māori service for whānau, those contracted to deliver concussion or psychological services or neuropsychological assessments, those who provide social services for sexual violence, primary health social work services and counselling. Ngā mātanga interviewed included: two psychologists, four social workers, two kaimahi, a counsellor and physiotherapist as a part of the concussion service providers. All but three ngā mātanga, have at some time, sat at the family harm table,[10] as part of the Bay of Plenty Family Harm response. Participants were recruited through my own professional networks.

The inclusion criteria for this research required participants to be ngā mātanga working in the response to family harm across Rotorua, including those providing Kaupapa Māori services, concussion or psychological services, neuropsychological assessments, and social services for sexual violence,

[10] A daily triage meeting and discussed with relevant organisations, to develop a plan for going forward.

primary health social work, and counselling. The exclusion criteria involved excluding individuals not working in these roles and those without relevant professional backgrounds in Family Harm.

A total of eight interviews were completed, six were with individuals and two were with two practitioners: a total of ten participants. Ngā mātanga were recruited in July and August 2023. The participants involved did so voluntarily and signed written consent forms prior to the interviews.

Information collated as part of the mapping exercise (see chapter 3) was used to explore the lived experiences of ngā mātanga working in this space. Interviews took 30 to 60 minutes. The duration of the interviews depended on the line of questioning and conversations that flowed from the questions and ngā mātanga area of expertise. Interviews were recorded on voice recorder and transcribed by myself.

Mātanga 1 – Social Worker - Family harm contracted provider

Mātanga 2 – Kaimahi - Family harm contracted provider

Mātanga 3 – Concussion service provider

Mātanga 4 – Social Worker

Mātanga 5 – Counsellor

Mātanga 6 – Psychologist

Mātanga 7 – Social worker- Kaupapa Māori service provider

Mātanga 8 – Kaimahi - Kaupapa Māori service provider

Mātanga 9 – Social Worker – ISSC contracted provider

Mātanga 10 – Psychological service provider

The intentions surrounding these interviews resonate with the teachings of Linda Smith, that the kaupapa of my research is about serving our Māori communities, empowering our Māori wahine and their status as mana wāhine and for some, as mothers (Smith, 1999).

My initial thoughts around sharing this baseline data was as a report to those who participated at a hui or forum. By sharing results in this way I am recognising their koha and simultaneously raising awareness and providing a space for ngā mātanga to reflect on how they work with wāhine.

Data Analysis

This research used a form of deductive analysis as the process to test the concepts and theories, known as deduction (Tolich & Davidson, 2018) and a form of kaupapa kōrero as the framework for analysis of the interviews. Dr Felicity Ware (2019) describes kaupapa kōrero as:

> *"A Māori narrative approach that has specific implications for gathering kōrero and representing and understanding these stories. Like previous Indigenous narrative approaches, it is created by Māori, for use with Māori, and expresses Māori aspirations, values, and perspectives. It may involve āhuatanga (Māori attributes), tikanga and te reo and is an expression of mātauranga" (p.3).*

Kaupapa kōrero is a narrative approach, which Dr Felicity Ware says is based on a Māori oral tradition of discussion, sharing of knowledge, and drawing on a shared understanding of Māori spiritual, historical, social, cultural, and political experiences (Ware, 2019). Furthermore, Dr Felicity Ware states the application of a whakapapa framework locates individual kōrero within a web of interrelations and analyses the layering of kōrero and kaupapa that influence each person's story.

In considering my approach to analyse the interviews, it was important to capture the kōrero of ngā mātanga, who for some, spoke of how their own personal journey with family violence influenced their current pathway of practice. Kaupapa kōrero provided the papa which means the base or foundation, to build on the narratives of ngā mātanga and the wāhine they support. When shortened papa also comes from Papatūānuku from whom Māori descend and are nourished (Ware, 2019, p. 87), this aligning with a Te Ao Māori healing pathway of kōrero through ngā mātanga sharing of knowledge.

The data analysis was completed by myself the researcher and involved transcribing the interviews from the recorder to a word document. This data was then reviewed many times and the data broken down into key themes and copied into a table – a key themes table.

The key themes table was then reviewed again by the researcher with sub themes identified by the commonality of participants kōrero in the interviews, also highlighting key quotes which supported the common threads. This data analysis was in consultation with her supervisor.

Ethics

Ethical issues associated with this project were explored with peers as part of a postgraduate level methodology course, with Te Pūtahi-a-Toi lecturers, and my thesis supervisor. This section outlines key ethical considerations and mitigating strategies. A low risk notification application was submitted to the Massey University Ethics Committe on 22 June 2023 (reference number 4000027672).

My research practice was based on the Te Ara Tika ethics framework (2010) particularly the four principles of whakapapa, tika, manaakitanga and mana. This approach enable the use of tikanga frameworks to support an ethical response to improving outcomes for Māori. In my view to achieve a genuine ethical response which encompasses the needs of Māori, Māori must be at the centre, guiding the development and the competencey around understanding of Māori belief systems. Sytems built on the true essence of Te Ao Māori, rather than a adaption to fit. Ensuring this approach is embedded, rather than just considered in my research, will act as my guide. By placing Māori at the centre of my research, I am clear on my intent which is to create effective outcomes for our wāhine to flourish, through developing the understanding and response to the prevelance of TBI's sustained through IPV. By placing Māori at the centre I am practising tikanga and the duty placed on me as Māori to ensure I am culturally safe.

A key consideration is recognising my role as kaitiaki of information. A decision has been made to ensure interviews remain generic to ensure anonymity of the participants and the observations they share, recognising that behind the observations are wahine. Although anonymous, the findings will be secure and as I act as the kaitiaki of the information and continued to be guided by tikanga principles, acknowledging that this baseline data is about increasing the awareness to develop the response of healing for wāhine Māori, who live with the trauma of IPV.

Whakapapa - In what ways are relationships being developed and maintained with iwi, hapu, whānau and Māori communities? The premise of this research surrounds understanding a practitioners response and identifying the gaps they see in services for wāhine who have or are at risk of sustaining a TBI from IPV. The practitioners I have identified to interview work accross the Rotorua region with whānau who live within this region. In understanding this, I have identified the principle of partnership.

Tika – Can the research achieve its aims? In what ways will it impact on Māori? Will the research protect the rights and interests of Māori and contribute to building Māori capacity and welfare across the research stages and roles?

The aim of this research is to explore practitioners understanding and response of TBI as a consequence of IPV for wāhine Māori. This qualitative research will provide an evidence base to highlight concerns that surround the response to TBI as a result of IPV for wāhine Māori. Practitioners who work alongside wāhine following family violence events are in a good position to provide their perspective and consider the service gaps they see in their roles surrounding this kaupapa.

There has been very little research conducted in New Zealand that provides a practitioner's view on this kaupapa, and to my knowledge there has been no research for wāhine Māori in terms of what a service response looks for wāhine who may suffer or are at risk of suffering a TBI from IPV. In working alongside claimants who have sustained a TBI and supporting their rehabilitation programmes in response to their TBI, my understanding of the complexities of individuals with TBI faced developed. By aligning this understanding with of the court system, alongside my mātauranga Māori akonga journey, it is evident to see a link between not only TBI and IPV but also the impacts of a cultural injury for wāhine Māori.

By completing this initial stage of the research, these findings highlight the concerns identified in research completed to date, which surround this kaupapa: that the understanding of TBI as a consequence of IPV is limited among practitioners and is a fragmented across service providers. By highlighting these concerns, further research can then consider what a mana wāhine pathway could look like in response for wāhine Māori who have or are at risk of suffering a TBI from IPV.

Manaakitanga – Does this research treat people with cultural sensitivity? In what ways will the research ensure that the dignity and respect of all parties is upheld? Kaupapa Māori is research that is 'culturally safe'...that is culturally relevant and appropriate (Smith, 1999). Considering the practitioners work alongside Te Arawa whānau, I am wāhine Māori with whakapapa links back to Te Arawa and having worked all my adult life within the local community.

Linda Smith (1999) also outlines the cultural ground rules of respect, of working within communities, of sharing processes and knowledge. In practice these elements of the kaupapa Māori approach are negotiated with 'communities of interests'.

Ngā mātanga identified as part of this research include ones who I have worked alongside at some stage or who I know through networks. Not only does this hold me accountable to ngā mātanga, in terms of their time and knowledge to this research, but also reciprocity of knowledge. In my view, I have an obligation to share what I already know and support the development of a mana enhancing response for wāhine Māori as I progress through this research. This is about upholding the dignity and respect of all people involved in this research.

Mana – Who will benefit from the research and how will the research strengthen and protect Māori culture, values, practices, and language? This research is the initial step needed to highlight the issue that surrounds TBI as a consequence of IPV for wāhine Māori. As identified above, this is achieved through interviews with practitioners who provide support in response to family harm events, identifying gaps they see at a front-line service response level.

Through research conducted to date, we have established that wāhine Māori are exposed to elevated levels of IPV, yet we have not considered a pathway of response considering the cultural injury for wāhine Māori to this trauma. This research will support the need for further research in how we develop a Te Ao Māori response, which is mana enhancing for wāhine, encompassing healing for the physical injury and the cultural injury, ultimately supporting our whānau to flourish.

Chapter 5: Key Findings

Table 1 outlines the key themes that came across in the interviews with ngā mātanga: four themes and ten sub themes: (1) Ngā mātanga awareness of a TBI – causes and signs (2) Screening of TBI following IPV – complexities of trauma, mental health vs medical health response to TBI (3) Referral pathways following a TBI -ACC, concussion services, timing (4) Gaps in response to TBI from IPV – knowledge and barriers. This chapter will explore these themes in more depth.

Table 1

Theme: Ngā mātanga awareness of a TBI from IPV
Subthemes: Causes and signs; Disclosure
Theme: Identifying a TBI
Subthemes: Screening; Family harm referral; Complexities of Trauma; mental health vs TBI response pathway
Theme: Referral pathways following a TBI
Subthemes: Concussion service; ACC; Timing
Theme: Gaps
Subthemes: Knowledge; Barriers

Ngā Mātanga Awareness of a TBI from Family Violence[11]

The findings from the interviews show that the awareness of a TBI from family harm events, varied among ngā mātanga. Ngā mātanga were confident in articulating the causation of a TBI including, blows to the head and strangulation, however the understanding of a TBI depended on the experience ngā mātanga have had working with individuals with a TBI and any self-directed training they may have completed.

> *…if you are going to be hit or get thrown against something there is going to before or velocity towards your head, you're probably going to have something impact on your brain some may resolve some may not… That's the mechanically end of it. The*

[11] Not all ngā mātanga were asked about their understanding of a TBI, for example the two psychologists interviewed, have considerable experience when working with individuals with TBI.

> *other part of it too is the hypoxic injuries that you are going to get through the strangulation, which you are going to present differently.* (Mātanga 9)

The impact of compounding concussions was also highlighted, "…small, repeated ones are probably just as bad as one big one" (Mātanga 5).

Signs of a TBI

Ngā mātanga were confident in recognising the signs of a TBI, describing the behaviours individuals can present with, including irritation, slurred speech, and aggression, also the impact on the person's ability to think:

> *The thinking can be scattered, there is no calmness in their thoughts… there is a lot of aggression with head injury and confusions. Women present different to men when it comes to head injury, men have that aggression, women become introverted, don't raise it, don't seek help, I think they have lower self-esteem and no confidence. I think it's an emotional reaction.* (Mātanga 8)

> *This is where it is hard, as a front-line worker you are seeing our whānau… I look for burst blood vessels, slurred speech, cognitive, sudden behavioural changes - daily routine is changed all of a sudden-women who experience violence have the same routine because it's all about the safest routine.* (Mātanga 1)

Recognising the signs of a brain injury associated with strangulation was also raised by two ngā mātanga, following their self-directed training on: 'Strangulation in the context of Intimate Partner Violence – A Public Health Issue', provided by RobVeale.com:

> *So, for me, it is seeing the signs… there are signs there, often they don't speak about it, it takes a long time until they speak about it, often because of fear. And when they do, often those signs are not being recognised… she had all these little red dots all on her and she was swollen… I remembered him (Rob) speaking about strangulation if all these little dots came up… I would have never had known if I hadn't learnt what I had.* (Mātanga 7)

This increased understanding and training aligns with the increased awareness and publicity surrounding the passing of the new Family Violence (Amendments) Act 2018 that came into law in 2019, replacing the Domestic Violence Act 1995 and including among other amendments, the new family violence offence of strangulation or suffocation.

Considerations from these Findings

The limited research completed in New Zealand around the prevalence of TBI from IPV, supports the kōrero from ngā mātanga, that while ngā mātanga who work within the family harm space may have some awareness of TBI, there remains limited awareness which contributes to the disconnect for some ngā mātanga, to consider a TBI as a consequence of IPV as part of their practice, "didn't even think about it… I didn't even know to marry those together [TBI and IPV]" (Mātanga 4).

In considering the initial steps involved for ngā mātanga when they receive a referral in response to a family harm call out, it becomes evident how the focus on TBI as a consequence of IPV can become lost, following the initial safety response.

In their kōrero, ngā mātanga spoke about the process once they receive a referral about a whānau who need support as part of the family harm response, "sometimes you are seeing whānau 15 days after any episode or sometimes within 24 hours" (Matanga 1). According to ngā mātanga, for many of the whānau it is about going around and visiting a few times, to build the trust before whānau will let ngā mātanga work with them:

> *Initial engagement and cold calling were new to me, and they would be like nah I'm alright. So, it would take a couple of attempts until they would start to talk about what was going on for them.* (Mātanga 2)

For Mātanga 7 developing this trust was through manaakitanga and as part of whānaungatanga:

> *It's the way we build the relationship with the māmā, it's the first time we meet them, being who you are and allowing them to be who they are. Our approach is so*

> *important, manaakitanga is so important, whānaungatanga building those relationships.*

The value placed on whānaungatanga and manaakitanga associated with tikanga, was outlined by Mead (2019, p. 32):

> *"Whānaungatanga embraces whakapapa and focuses upon relationships…All tikanga are underpinned by the high value placed upon manaakitanga -nurturing relationships, look after people, and being very careful about how others are treated".*

Whānaungatanga can reach beyond whakapapa and includes relationships with non-kin persons through shared experiences and a common cause (Ware, 2019). The connections and the collective group depend on the support and participation of its individual members (Barlow, 1991; Mead, 2003 as sited in Ware 2019, p.22). Groups who are connected by whānaungatanga and united by a common goal are sometimes referred to as kaupapa whānau.

Whānaungatanga is not bound by timeframes, it is however through whānaungatanga that wāhine will decide when they are ready to disclose. For some ngā mātanga, disclosure is one of the contributing factors which impacts on their decision to consider a TBI as a consequence of the family violence event:

> *Disclosure is hard, because when women don't want to disclose, we are limited on the TBI response, so we go down the Mental Health response. Even considering a symptom of TBI there is the substance abuse and the follow up is not on the head trauma but on the symptom e.g., Drug and alcohol impairment…*
>
> *… our women can't be empowered to potentially know somethings actually wrong with me I need to go and see a Dr and not be whakama… you can get them to the nurse or Dr and their like no, no, no and your sitting there and their like no 45 mins you couldn't even tell me.* (Mātanga 1)

These views were also consistent with findings in the report, *The prevalence of Acquired Brain Injury among victims and perpetrators of family violence* (Brain Injury Australia, 2018), where a low-level awareness of TBI from IPV was also identified among practitioners as a barrier to identifying cases of TBI. This research found that those who were aware of the potential for brain injury rely on their individual awareness to alert them to the potential for a brain injury. Also, once concerns of a brain injury were identified there was no formal system for recording or following through on brain injury concerns:

> *"There is also no guidance available for family violence practitioners on how to follow up on a client's potential for brain injury -what questions to ask, and how and why to make a referral for a clinical assessment and diagnosis*" (Brain Injury Australia, 2018, p.44).

In considering this research alongside ngā mātanga kōrero, what becomes evident is that there are many aspects needed to consider as part of the initial family harm response, with the primary concern of safety. However, with no clear guidance to support a TBI pathway, the focus on the TBI can easily become lost.

Identifying a TBI

Ngā mātanga identified barries to identifying TBI following family harm events, this included understanding and recognising signs of a TBI to consider screening and a referral pathway.

Screening

Ngā mātanga acknowledged that screening for TBI following a family harm event was not always at the forefront of their minds. The practice varied with ngā mātanga and depended on their own understanding of TBI to recognise the signs.:

> *…unless you have done TBI training you're not going to consider TBI associated with head injury, or contusion to head -they'll be like aw cool they got a cut, unless you have done the individual training, you're not thinking TBI.* (Matanga 1)

> *There are not a lot of counsellors that will do TBI, I do because I am a TBI survivor, that's my go to and as I am talking, I am making the assessments… I'll say give me some examples and they'll say, smashed me against the door smashed me against the wall, I hear all sorts so when I hear that I say what do you mean smashed, I know it's a TBI.* (Mātanga 5)

For ngā mātanga, who did recognise the signs of a TBI for wāhine, the understanding and access to the appropriate services in terms of a screening for a diagnosis of a suspected TBI was difficult. One mātanga said she had an informal arrangement with community nurse to complete appropriate assessments:

> *… I usually introduce them to one of my local nurses if there are any niggles there, she'll do some screening as needed… I wouldn't ask specifically for TBI, if she has any major concerns, she will go to the Doctor for an opinion… I think she has only done one for me… It is not funded* [the nurse], *we make muffins* [to thank her for her time]. (Mātanga 1)

Another mātanga spoke about her experience when seeking medical intervention for a wāhine who presented with the signs of a TBI as well as a visible laceration to her head. This highlighting the difficulties when no pathway or screening measures are in place:

> *… there was a wahine who was blacked out… you could see the blood on her forehead, we came back to the office, we contacted the ambulance, they screened her said that she had a concussion, she was given panadol, she was told she would be given a referral for concussion and that was it, but she was never contacted again, because she stayed with us for a long period of time and I kept asking her how's it all going and she said no one has contacted her. To be fair, her phone changed multiple times, so I had to keep contact with Te Whatu Ora, if I wasn't there as the link, then they wouldn't have had her updates*. (Mātanga 5) [no further follow up was made for her concussion]

Screening Following a Referral from a Police Family Harm Call out

In their work supporting whānau, at some point, many mātanga have sat at the family harm table and this is where many of their referrals for family support come from. When asked whether a head injury or trauma to the head that may prompt a screening response for a TBI was considered, ngā mātanga could not recall any time that the need to consider a TBI was raised in the family referral sheet nor a discussion at the family harm table *"...they don't consider a TBI"* (Mātanga 1) and *"... Absolutely not, not spoken about, that's what I mean about Rob Veale's wananga he is the only person that I know who has spoken about it"* (Mātanga 7).

The sharing of information between Te Whatu Ora and the Police for services provider was also raised by Mātanga 7 as an area to consider as part of the referral assessment:

> *There is a disconnection between Te Whatu Ora and the police as you know, so there are times when you step on to Te Whatu Ora with your whānau your wahine and you find out all this information that is not in the police system and you as a service have been given none of that information you have absolutely no idea and all of this comes into play and you actually see over these years its increased from strangulation through to head trauma you know all of it, it's there it's in their files but we don't get to see that and that needs to change.* (Mātanga 7)

This feeling that there was limited awareness and education around TBI from IPV across the services who make up the family harm response was shared among ngā mātanga:

> *... I also sit on family harm-table, and I have seen discharges, I don't see any of this though. I have never heard of a head injury coming up, nobody is testing that seriously, it's the first time I have heard it sitting here with you now.* (Mātanga 4)

Mental Health and Drug and Alcohol Abuse

Recognising the differences and complexities that can impact the presentation of a TBI, including when there are drugs or alcohol involved, trauma from the violence and underlying mental health conditions which could influence the appropriate service response varied among ngā mātanga.

> *… it is a tough one. So, I actually screen them together, I don't do a checklist, so I do narrative… hoping to be key things I ask, you know with mental health there is going to be a one-way response and potentially with TBI, they can present the same way, so you have to continue having a conversation, sometimes I'll try and get both assessed at the same time… I will get a different professional to assess for MH and for TBI.* (Mātanga 1)

Again, this lack of awareness to consider a TBI as opposed to other possible influences, means wāhine may not be provided with the appropriate care, *"Someone this morning, she had a headache and panadol for pain, no screening happened. We sent her home, put it down to intoxication"* (Mātanga 4).

Similarly, Mātanga 1, highlighted that the consideration of screening for TBI from IPV also depended on ngā mātanga and their practice at the time:

> *… that is something you have to take on in your own time and mahi to consider and its often something that's only secondary or third thought when screening for mental health addictions or cognitive impairment or stuff like that. Sometimes we will go to TBI before we go aw this is mental health or this is psychosis or drug abuse, some people I have worked with in the past have thought this is fetal alcohol syndrome, before they think TBI, because of the processing speed and mood swings can often present similar.* (Mātanga 1)

Mātanga 9 also discussed the pathway in response for a mental injury associated with a sexual assault and the potential for a similar pathway for a physical injury from IPV:

> *… there is going to be mental health condition right, so where does head injury fall under that, it doesn't, but there is going to be sequalae. For sensitive claims, you get through the door by having a mental injury relating to the event. If that sexual violence had physical violence associated with it, whats going to get you through the door is going to be the mental injury associated with the sexual violence, even*

though sequalae from the brain injury that is [?] so potentially there could be a pathway when currently there is not, so that is a gap. (Mātanga 9)

Discussion

Police continue to be the key first responder to events involving mental distress. In 2020/21 police attended 70,225 events involving a person having a mental health crisis or threatening or attempting suicide. This is a 10% increase from the previous year. Mental health-related events have also increased by 60% over the past 5 years and are predicted to increase by a further 44% by 2025 (NZ Police, 2021).

Distinguishing the difference between a TBI and other multiple issues such as post-traumatic stress disorder and drug and alcohol issues is problematic. This was also reported by practitioners in a family violence study (Brain Injury Australia, 2018), with practitioners raising the concern around allocation of attention to a potential brain injury alongside the primary concern of safety.

Mātanga 6 who has practiced as psychologist for over 20 years, also raised the importance of distinguishing the difference between a TBI and mental health concerns and drug and alcohol abuse, to ensure the appropriate treatment pathway for wāhine:

It's a completely different service, it requires a multi-disciplinary team (MDT) response not just mental health (MH) professional. We would give some education, some understanding about their concussion or severe/mild TBI, and some reassurance, we would do some testing with them, we would do some screening around mental health but also screening around their balance and other symptoms and if they are doing well we would probably get them into a gym, test their cardio threshold, that's their physical health and initially we'd see them, do some education, reassurance, put together plan could include social worker and probably in domestic violence it would, we have a social worker…

They need the reassurance and education around it but also that understanding about their brain, probably could be a motivator for doing something about their situation. And actually you can talk about that in a non-threatening way, where we just talk about athletes returning to play and rugby players American football players return to play during the game when they

have been knocked out and you can give them that education in a really non-threatening way that is not at all related to domestic violence, but it is exactly the same.

Trauma Symptoms

Separating the trauma symptoms in response to the violence from the TBI was also raised by one mātanga and to be considered when recognising a TBI:

I guess the thing that is hard is are we dealing with a brain condition or concussion or mild TBI…or are we dealing with the trauma condition or are we dealing with a combination of both and that makes it tricky from an assessment perspective. (Mātanga 6)

…there is probably a mixture of TBI symptoms and trauma symptoms at the same time and people will often contribute these to trauma, when its partly trauma but not all trauma. (Mātanga 9)

The complexity of the presentation along with not disclosing was also highlighted by Mātanga 10:

…there are other things going on, anxiety, her GP had a good relationship, she had an MRI 20 years post, she wouldn't talk about it in her 20's it was a teenage relationship, she got out of that one and then another one was in her 20 she just never recovered… she spoke about the memory difficulties that kept coming.

Neuropsychological assessment took 5 years [varying reasons], *not organic, outcome was needed, she couldn't really tell, we can talk about how do we work on your cognitive efficacy how do we build that up, how much of that was the violent relationship and not being able to think for herself and how much of that was potentially a mTBI that lasted a long time, the compensation she had to make for that, that she has this assessment 20 years later but she's stuck with the way she coped with it, she had severe vertigo for months, but she didn't know to get an assessment.*

In their research, Valera and Berenbaum (2003, as cited in Darrant 2021) found that in relation to alterations in cognitive function as a consequence of IPV trauma, symptoms can be related back to both the mental health consequences of the trauma of abuse and a possible TBI, further stating that previous studies had either failed to consider head injuries or had excluded them in their design. This raising the concern that researchers may find it difficult to separate the consequences related to the physical injury from those as a result of the trauma from the IPV.

The Diagnosis and Referral Pathway for a TBI

Ngā mātanga reported that the consideration of a TBI from IPV, and the referral process for intervention for wāhine was very rarely considered, if at all.

> *Nothing, I don't see it happening…no further intervention on discharge, just panadol…discharge report will go to GP, she may not have a GP and most of them don't wait for a discharge as it takes too long. She will likely present for something else…Referrals are made in to in services ear checks etc, as far as knowing this community, we are two worlds apart, we don't have a lead for community, I have been in community, and we are too different worlds.* (Mātanga 4)

> *No, I've never really thought about it, or I have thought there was already something in place with their Dr visits, I've just assumed that has happened*. (Mātanga 7)

The limited consideration for referrals of a suspected TBI was supported by the minimal number of referrals to the concussion service:

> *I don't think we have had any referrals into concussion* [in reference to TBI from IPV]… *In the last year probably one… I can only think of one case, there may be one or two more, that's under neuropsychology assessment… we get lots from ED but not for domestic violence. If they are going there, then they should be getting sent down to us.* (Mātanga 6)

The limited awareness of TBI among wāhine and whānau also impacts the referral pathway, "The issue is recognising it is a problem, that's the biggest issue, that getting knocked around my head is good enough to be called TBI or mTBI" (Mātanga 5).

Discussion

It is clear from ngā mātanga kōrero and as previously identified that a barrier for ngā mātanga is that there is no formal pathway for ngā mātanga, which guides the access to screening and diagnosis for wāhine, when ngā mātanga suspect wāhine may have sustained a TBI from IPV. This difficulty in accessing an appropriate pathway in response, further compounding the concerns ngā mātanga have identified around the limited awareness and knowledge of TBI in a family violence setting.

When TBI was suspected, ngā mātanga spoke about the difficulties navigating the process to get support:

> *... I think my biggest challenge was…they were `wāhine Māori…over the age of 55, where it was hard communicating [to ACC over the phone], that it's not old age… that with TBI it, f…ing hard to understand people on the phone and the long pauses while she was thinking and processing…the person on the other end of the phone was like "are you there?" is that a yes or a no…really rushing her…and I'm sitting there going look she's thinking.* (Mātanga 1)

> *We had our own nurse practitioner, but we ran out of funding. You need to have someone there in that space, she would prescribe when she needed to. She would go with our social worker out to see the whānau, she would give great advice, she still does now, the funding was cut, so she was someone we lost.* (Mātanga 7)

Guidelines for practitioners around referral pathways and the many varied and often complex needs of their clients, meant that practitioners were often not sure of the pathway to get support, if there was a suspected brain injury (Durrant, 2021). Guidance in navigating the appropriate support and funding for TBI from IPV is also an area of consideration, as at times there can be a cross over of service funding, which can be complex to understand. At times when there is a history of mental health, this treatment and rehabilitation will be funded by the MOH and funding for the TBI from IPV should be considered

by ACC. Assessments are needed to determine the level of funding from the two different avenues. The concern is however that navigating such complexity can leave wāhine without the correct services in place.

> *The Crisis Assessment and Treatment (CAT) team came in they assessed her… they said it was mental health, she was then discharged, she could leave, and she attempted again. I was on the phone with the CAT they said it was behavioral, and so I couldn't get the support she needed. Everyone is saying to me that they are over worked and understaffed.* (Mātanga 7)

I also refer to a recent decision by the Health and Disability Commissioner where the assessment to determine whether the women's presentation was related to her TBI or her underlying mental health needs, meant there was a disconnect in terms of support between ACC and the Ministry of Health and the women was dropped off at a regional hospital with no patient treatment plan or medication.[12]

Timing of Referral

Recognising the timing for wāhine may not be quite right, was also raised by Mātanga 6:

> *First of all, some people might not be in the right space… so just have to take things slow, you probably need to address the acute stress and probably just take your time. Here we would probably include a SW maybe and understand the psychological variables first. Trauma variables. They are coming with the referral, it might be they don't want to talk about it and the other issue is that if there is physical/domestic violence, there can also be sexual violence and they might not want to talk about any of it or they might be thinking aw he's gonna ask me about this… it's a difficult area that requires us building trust and rapport and that takes some time.*

[12]When the woman's behaviour deteriorated, her ACC-funded psychiatrist assessed her as presenting "with a manic relapse of her bipolar mood disorder". The psychiatrist started an application for compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act). The woman was then taken to a mental health service for assessment, but it was determined that she did not meet the criteria to be admitted or placed under a compulsory treatment order.

Mātanga 6 also raising the issue of timing in terms of rehabilitation, where individuals who are impaired by drugs or alcohol limits the rehabilitation pathway, however noting, that clinical support can work alongside other service's until the wāhine is in the right place to engage with rehabilitation services for the brain injury, "We can't do rehab with people who are on drugs, but we can work alongside services until they are ready to do something about it."

Discussion

Resistance to having a TBI identified by wāhine can also be an area of concern for ngā mātanga. Wāhine and whānau may have many reasons for not wanting to consider a TBI pathway in response, this may be due to fear of retaliation from the partner with disclosing the violence, or a fear of children being taken into statutory care.

Understanding the timing for referral to consider a diagnosis for TBI and the rehabilitation is important and ngā mātanga must have a reasonable level of knowledge of TBI to ensure wāhine engage in the appropriate rehabilitation for the injury. Mātanga 6 further highlighting the importance of timing:

> *If we had a referral where they said look this person is acutely traumatized now, the other thing is what the risk they are going to be injured again.* [Concussion services], *not that important now because we think you are at risk of another concussion and that's probably the important thing. We need to refer to another social service agency and we would probably work with them maybe do some education and some motivational work.*

Gaps

Education

Ngā mātanga who had attended self-directed training around strangulation and TBI in the context of family violence admitted that this was not on their radar prior to attending this training. Ngā mātanga felt if they had not attended this training, they would still not be aware of the signs of strangulation and trauma:

> *To be honest before I went to that strangulation and family harm with Rob Veale it wasn't even on my radar. I wasn't taught it at any studies with SW there's no posters theres no adds, theres no promotion or theres nothing that I can think of. Once I went to that and I learnt what I learnt, it was then on my radar*.

Ngā mātanga felt education surrounding TBI from IPV was needed for whānau and services, acknowledging that because a brain injury is not always physically visible it remains a silent injury:

> *I have never had a woman come to say they have a brain injury, there are other people who don't recognize or understand what a brain injury is, it's the silent injury isn't it, massive impact and unless there is a spare sticking though my head no one is going to recognise it.* (Mātanga 1)

This concern around education for whānau was also raised by Mātanga 7:

> *So this is happening to you to your body, to your hinengaro, to your tinana, to your wairua and to your whānau, how do we feed that education from becoming something to the services fluidly so we all have the same thing and not get different stories through to our whānau and then how do we give them tools numbers that they can utilize, it's their journey, so it's better if we can empower them with the knowledge, they know what to do and recognize it. So that young wahine, I taught her the signs, I taught her the signs and what to recognise. The moment that she recognised I knew; we had a different relationship straight away.*

Similarly, while ngā mātanga felt that education needed to be increased, there was a concern around the difficulty in finding the appropriate services and delivery of education:

> *Education, there is none, I couldn't tell you on my hands where I could go, where I could get information or where I can send people too. Te Whatu Ora is a large beast, when you go there you get lost in that system. If you are going to bring in Te Ao Māori and it's going to be led that way, there are people who are right for it and*

there are people who aren't, so whoever you are bringing it, its starts from the top down, so whoever you are bringing in A) need that life experience, B) need to recognise the unspoken side of things and C) need to be able to deliver it to our whanau so they are not going to leave confused and broken.

Mātanga 7 also spoke about the difficultly for whānau when work in isolation to each other:

The next thing is we are so disjointed; you've got the services that are all living in their own space. We are actually all doing the same thing and if you look it at, we are almost passing whānau on to agency on to agency, this is traumatizing them on a whole other level and within that again there is no education of who they are.

Knowledge

Ngā mātanga spoke of having limited knowledge about TBI and how it relates to IPV with most having minimal to no training. Mātanga 4 was also concened that she had never thought about marrying the two together, TBI and IPV:

No understanding, no follow up, no knowledge. It needs to be addressed because these incidences are regular. What about the long term that we are not looking at…

… the knowledge I didn't even know to those marry together and we have trainers' family harm coordinators, didn't even know they should be married together, so its knowledge visible would be where the injury is, and they circle the sheet that's it. (Mātanga 4)

Ngā mātanga were aware of needing to raise awareness and include promoting the education around signs of a TBI:

I see the biggest gap knowledge [this] needs to be shared when we are doing the white ribbon stuff, we should be talking about well whānau protect our woman…we have decades of physical abuse sometimes we have 6/7 generations of family abuse. We should promote what is the consequence in terms of death, what is the physical

> *and mental consequence…so then our whānau are encouraged to say hey I actually think I have this, or hey my mum is suffering from this."* (Mātanga 1)

This research also confirmed the findings in Durrant (2021) that the gaps in knowledge of TBI and the disconnect in associating TBI with IPV sat with not only practitioners but also in the general public. And that ngā mātanga wanted more information and training to support wāhine with a suspected TBI Durrant (2001).

Moemoeā | Vision

In Te Ao Māori, moemoeā encompasses everything that supports a vision, or aspiration. In this section of the thesis the focus becomes about considering the research and ngā mātanga kōrero in how these learnings can be applied to develop the moemoeā of this kaupapa, where wāhine Māori and whānau who experience such trauma are supported in their journey.

Kaupapa Māori, mana wāhine and whakapapa kōrero are discussed in this section, recognising that for some ngā mātanga they are already incorporating aspects of kaupapa Māori frameworks in their practice within the family harm space. The moemoeā becomes about incorporating te Ao Māori concepts and beliefs as a key part of the healing response for wāhine Māori who suffer a TBI from IPV.

Kaupapa Māori Response

With the limited research surrounding the prevalence of a TBI from IPV among wāhine Māori, and the awareness surrounding this kaupapa, there is no clear pathway steeped in Māori beliefs and traditions to guide ngā mātanga in their response. A kaupapa Māori response incorporates rehabilitation programmes for wāhine, based on healing the wairua, and the mana of wāhine and her whānau, encompassing mātauranga Māori and tikanga. This is contrast to rehabilitation developed around research that is focused on the impacts of trauma from a deficit view, on blame and isolation, westernised diagnostic tools and frameworks (Pihama, Cameron & Te Nana, 2019).

A healing response is the focus of kaupapa Māori frameworks and strategies working as a whānau unit. In a traditional Māori context, healing spaces and rituals including karakia were incited to remove any

harmful influences from a trauma-inducing event and the immediate response involved the protection for the victim or victims by the community in a space of healing and safety (Smith, 2019).

The understanding of a Kaupapa Māori response for wāhine and the prevalence of TBI following IPV varied among ngā mātanga. For ngā mātanga who identified as Māori, they felt confident to articulate the importance of a Kaupapa Māori response. In her kōrero Mātanga 5, described the impacts of a head injury in an Ao Māori context:

> *TBI any injury to the head, effects our thinking also the Kaupapa Māori context, is a wound to our sole, breach of whakapapa. Everyone is affected, wider context whānau violence because, better position because everyone in that household and in that circle of support are affected whether directly or indirectly, they want to do something about it, but they won't cross that line, or their protecting themselves.*

Building trust through whānaungatanga with wāhine and whānau was also a consistent theme in the kōrero with ngā mātanga and supported their Te Ao Māori approach as part of the whānau healing response. This understanding of Te Ao Māori view as part of a practitioner's response to TBI from IPV was also outlined as an area for further research. This position is support by Durrant (2021), who also noted limitations applying a Te Ao Māori view and how it differs to western thinking, *"with no holistic approach in the DHB's, [Māori world view] could not be explored further and was highlighted as a need for further research"* (p. 49).

Mana Wāhine

In thinking about the adversity our wāhine Māori face as a result of violence and trauma, in an attempt to develop the response, understanding the essence of mana wāhine is vital. When I think of what defines mana wāhine, I think of the wāhine who have gone before us and the wāhine Māori who follow. I also think of the struggles wāhine Māori have faced and continue to face throughout the decades, to reclaim their culture and identity as mana wāhine.

I think of my Nana, navigating, the aftermath of western civilisation ideals, alienation of land, identity, and culture. For many of our whānau, this included finding solace in whiskey and gambling. For Nana

solace was held in her whānau and her faith. A reminder that it is not the struggles of the past that define mana wāhine, but rather the strength and determination which wahine Māori needed and continue to embody to endure the struggles.

Mana wāhine is about maintaining the identity as a Māori woman, in the aftermath of alienation from land, from culture and from language for example. Mana wāhine is not conforming in the face of adversity, it is having the ability to embrace Te Ao Māori and to carry that knowledge to share and teach future generations.

Within the 'new' colonised world and for many aspects of Te Ao Māori way of life, the standing of Māori women in society diminished from that of authority and power to a category of 'other'. As Linda Tuhiwai Smith (1991) identifies, *"As women we are defined by our differences to men, as Māori we are defined by our differences to colonisers and as both Māori and women, we have been defined by our differences to that of Māori men, Pakeha men and Pakeha women"* (p. 34).

In traditional Māori times, wāhine Māori held roles of Rangatira and their standing complimented that of Māori men, forming part of the collective whole. Wāhine played a crucial role in linking the past, present and future. Māori cosmology provides rich stores of wāhine toa, such as Mahuika and Hine-nui-te-pō. However, the process of colonisation disrupted this balance. With the erosion of traditional practices, loss of cultural identity and land had a profound impact on wāhine Māori and their standing in the community. The essence of tikanga Māori, the natural order and collective responsibility was undermined. As a result, wāhine Māori faced marginalisation and challenges that persist today (Mikaere, 1994).

It was not until the colonial experience which led to the displacement of wāhine Māori in their own culture (Irwin and Ramsden, 1995). This complimentary standing is evidenced by the lack of gendered pronouns in the Māori language for example - 'ia' meaning both he or she and tona/tana his or hers (Smith, 1994). However, this is not to say that pre-colonial times, Māori gender relations were considered an ideological place of equality, as mana - power existed as did hierarchy likely through claims to whakapapa rather than gender (Mikaere, 2003).

Nepe (1992) identified four key concepts essential for securing mana wāhine - rangatiratanga, wairua, kotahitanga and whānau. The concept of tino rangatiratanga, identifying this as the essence which verifies the unique identity of Māori women. The dimensions of wairua, where wairua is considered vital to the balance and well-being of Māori women, with a direct link to Papatūānuku, the Earth Mother. Also, kotahitanga, referring to the solidarity, the mauri and source of survival. The dimension of whānau, the security of not only existence but one's survival.

While this assimilation of Māori to the new colonial experience, impacted the traditions of Te Ao Māori, the concept of mana wāhine, while diminished can continue to be strengthened and guide the practices of generations of wāhine Māori today.

Within Māori mythology, wāhine Māori symbolise power and endurance through their unwavering commitment to whānau. This is evident in the separation of Rangi and Papa, where Papatūānuku the peacemaker, provides protection for her children from Rangi's wrath, while enduring the pain of separation from Rangi.

By continuing to nurture her children, Papatūānuku becomes the vital source of life, the deity which resources the universe and sustains humankind. The legend of Rona and the moon, also portrays the steadfast duty of a mother, fetching water from the well in the middle of the night for her child. Only to be captured by the moon in retaliation for her cursing at the moon. This capture also seen as a symbol of power, with a woman occupying the main source of light in the evening sky (Jenkins, 1992).

Mana wāhine encompasses Māori beliefs, incorporating the elements of traditional Māori practise, passed on through generations in narratives and metaphors, whether in the form of waiata or whakataukī. For some wāhine Māori, mana wāhine may be that of Papatūānuku, the symbol of endurance and determination through times of struggle. Mana wāhine is about drawing on the life force from that of our mana tupuna, to want more for future generations.

The understanding of mana wāhine and its place in the response to family violence, was noted by Mātanga 5:

> *When they come to me, they take time to build up trust with me and it's about giving them the permission to have those discussions and whakamoemiti and whānaungatanga and acknowledge what it took for them to get here and it doesn't matter where we start I am not here to advise you, but I am here to help you build your awareness grow some clarity, and give you choices, options for the future, but at the end of the day the mana still sits with you and it's up to you what you do with the mana, mana cannot be taken away.*
>
> *The mana is still here its fractured but it's still here, our role here is to try and restore, reclaim, and renew, whatever we need to do to bring us back to some kind of normality. And sometimes I will have just a whole half an hour of them having a tangi, the reality that someones gonna give them the time if day, not ask questions, then we might get somewhere.*

This essence of power and survival for wāhine Māori, was also supported by Mātanga 10, who spoke of a level of spirituality and working in ways that incorporate safety from a Te Ao Māori view, incorporating Māori models of health:

> *Māori wāhine that I have worked with are incredibly capable like more engaged and more capable, they have a more holistic sense of themselves, and their spirituality and I think the level of healing is more profound too, possibly you can encompass everything…I want to establish an agreement, its spoken or unspoken… I'm trying to think of models so I'm trying to structure how I am thinking , so in that way I am working in a safe way I know the person is not going to know I am a safe person to work with but I don't think about that, other than when I am talking to you, e.g. the meihana model, that early on in my establishment… I don't do that with Pakeha.*

In Dr Leonie Pihama's research around Mana Wāhine theory, Dr Leonie Pihama argues that Mana Wāhine theory is a kaupapa Māori theory that is dedicated to the affirmation of Māori women within Māori society, within whānau, hapū and iwi and is an essential development for Māori women. Dr

Leonie Pihama states that it is a theoretical framework and like kaupapa Māori theory, is based within mātauranga Māori and is committed to the articulation of Māori women's ways of knowing the world.

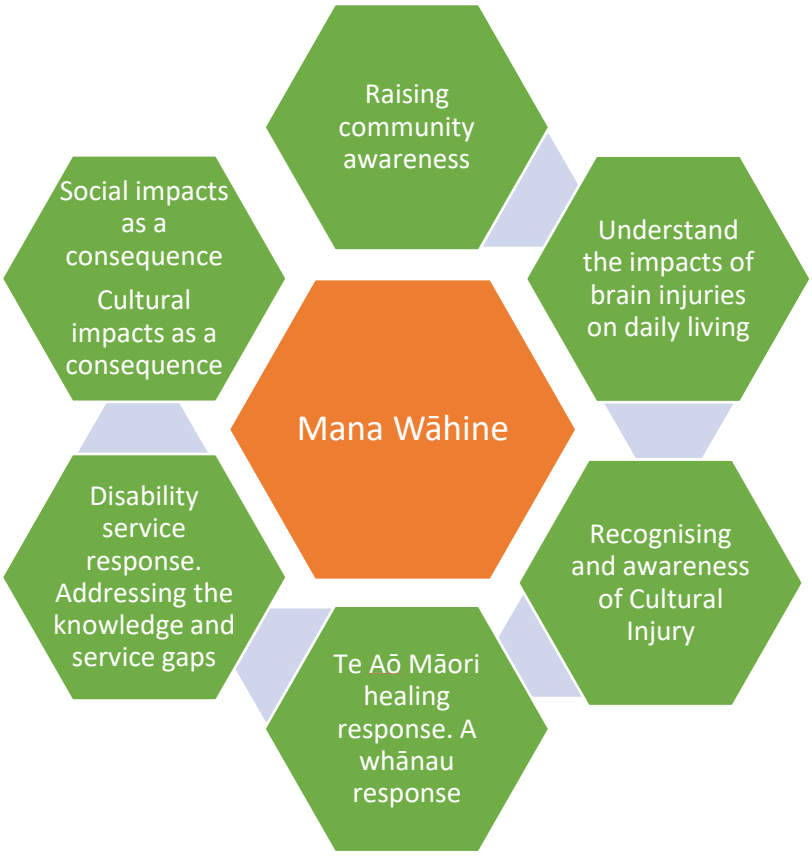
In considering this research and the moemoeā, development of a mana-enhancing pathway is a high priority. This pathway would be drawn from mana wāhine theory reflecting Dr Leonie Pihama notion of a Māori women's theory that remembers our tupuna wāhine, our atua wāhine and which affirms wāhine Māori as critical actors for change.

Dr Kathy Irwin's research (1991), centred on the various aspects of mana wāhine, advocating the importance of providing wāhine Māori with resources and space to explore, reclaim and celebrate 'herstories', stories as wāhine Māori. A key focus is promoting the need for wāhine Maōri to develop the tools that work for Māori women (Irwin, 1991). Such an approach would support the need to control our own theories of the world and construct theories that embrace the experiences and realities of all wāhine Māori.

Mana wāhine can also be perceived as a framework through which we can develop theories that will support the projects of Māori women (see for example Te Awekotuku, 1992; Smith, 1992; Irwin, 1992). Kaupapa Māori theoretical framework that attends to the multiple issues that are faced by wāhine Māori and through this process, Dr Leonie Pihama says wāhine Māori are exploding the colonial myths that have been constructed, whilst simultaneously redefining the boundaries.

In considering Dr Leonie Pihama's research on mana wāhine as a theoretical framework, it is fitting to apply this framework to this research and towards the development of a healing response. Diagram 1 is an attempt to encapsulate key foci in regard to TBI from IPV. In this framework mana wāhine is at the center and fanning out are key areas of focus or elements to consider supporting the healing response pathway. Wāhine themselves determine the priorities, what is important as part of their healing process at a specific point of time.

Diagram 1



Below is a summary of each element of the framework and a commentary of how this is reflected in the data or thesis.

Raising Community Awareness - This is about the evidence-based approach to highlight the unspoken crisis and emphasis that TBI is a significant issue. While the physical and emotional impacts on individuals and whānau from IPV are given considerable attention with programs developed in response, the unspoken crisis of TBI as a consequence of IPV remains unnoticed. Raising the awareness to recognise and respond to a TBI from IPV was a key theme which emerged from the data, emphasising the need for more awareness, and understanding among the public.

Understand the Impacts of Brain Injuries on Daily Living - The pūrākau section of this thesis, tells the stories of wāhine and the impact for wāhine on their daily living often navigating with an undiagnosed TBI from IPV. The prevalence of TBI as a consequence of IPV is underestimated, this is due in part to under-reporting and no formal screening protocol across health and service providers. Through effective screening and identifying of TBI, the impacts associated with a TBI will be better understood, supporting the need for a more integrated, family harm service response including, kaupapa Māori and healthcare providers who work in collaboration to tailor a mana wāhine - centric response, this may also help with reducing the stigma associated with family violence and encourage early intervention.

Understanding and Awareness of Cultural Injury – Increasing the understanding around the impact an assault to the head has on the wairua and the tapu of a person is critical in raising the awareness of a cultural injury. With the lack of research for wāhine Māori and the prevalence of TBI as a result of IPV, little is known about the cultural injury, therefore rehabilitation programmes encompassing Te Ao Māori practices and mātauranga with kaupapa Māori frameworks are not based on healing the wairua and mana of wāhine and whānau. By increasing the understanding of Māori cultural elements and metaphors that underpin the definitions of trauma this will also support a clearer understanding of the cultural injury and the development of a mana enhancing response.

Te Aō Māori Healing Response – A Te Ao Māori healing response recognises the traditional knowledge and practices of Māori, encompassing the physical, mental, emotional, and spiritual elements. By integrating the services which practice the western medical concepts alongside the Kaupapa Māori services balance can be restored and well-being is strengthened.

Disability Service Approach – A disability service approach refers to the support and assistance provided to individuals with a disability and/or impairment. A disability service approach is tailored to meet the individual needs. This service response, goes hand in hand with a hauora, Te Ao Māori healing response, support wrapped around the wāhine, tailored to her needs at the time as she navigates the impacts on her daily living from a TBI. These supportive services may include care assistance, therapy

services, rehabilitation services and rongoā Māori. By implementing a comprehensive disability service approach, wāhine are supported to access the support they need and overcome barriers.

Social and Cultural Impacts of TBI as a Result of IPV – TBI as a consequence of IPV can have significant social and cultural impacts on the individual experiencing the injury and their whānau. These impacts can manifest in various ways including social isolation -struggling with social interactions as they navigate the challenges of having a TBI and the trauma from the violence, the sense of stigma or discrimination as a whānau, associated with partner violence.

The cultural impact to their sense of cultural identity and belonging, where cultural practices and values may be disrupted leading to a loss of connection. Addressing the social and cultural impacts of TBI as a consequence of IPV requires a comprehensive approach. This includes providing the clinical support alongside the trauma informed Kaupapa Māori support.

Healing pathways

Understanding the Traditional Responses to Trauma

Understanding the traditional responses to trauma can help guide the healing pathways needed for wāhine Māori, their whānau and future generations. Traditional responses to trauma have been focused on the restoration of balance, trauma or pōuritanga which is caused by pātu ngākau and traditionally has been considered an unnatural balance. Pātu ngākau were also a patu mauri -an assault on the mauri, accompanied by the loss of mana as the mauri is located within the ngākau, “Restoring the balance was considered a resetting of the mauri and a resolution to the imbalance of the traumatic event” (Smith, 2019, p. 36).

A key consideration of this restoration has included mana and the protection of uri whakatipu (future generations). There is the belief that unresolved traumatic events in one generation can affect the wellbeing of the future generations and if the traumatic event was significant enough, this was recorded as whakapapa kōrero held in kōrero or waiata (Smith, 2019.) The definition of TBI applied earlier to the concept of pātu ngākau, both are described as an assault or force to the brain or the ngākau where

our feelings and memories are stored. Also, the state of being following an assault or TBI, where for both pōuritanga and TBI symptoms can include depression and confusion, a period of darkness, Te Pō, as we work towards the realm of potential through healing and rehabilitation. Traditional Māori views of health and wellbeing are holistic, the physical and mental health of an individual are not considered in isolation to each other. Traditional therapies which incorporate tikanga and practiced in safe, ancestral spaces can complement treatment and rehabilitation and support the healing process. When all factors are considered and balanced, the wairua will be too.

Whakapapa Kōrero

Traditional Māori knowledge or whakapapa kōrero comes from the kōrero or narratives which describe the history of our tūpuna and accounts of iwi the extension of whānau relationships, whanaungatanga - connections and the nature of all living things Smith (2019). By including potential frameworks, such as mana wāhine and whakapapa kōrero, this supports the moemoeā, using Māori narratives to as part of the development of a healing response for this kaupapa.

Whakapapa kōrero is also a framework which encompasses all dimesions important to balance Māori wellbeing, including a spiritual dimension, supporting Te Ao Māori belief that everything is connected, within the spriritual, cultural, physical and intellectual realm and that this collective connectedness is considered critical for whānau well-being (Pihama, Cameron & Te Nana, 2019). Smith (2019) describes whakapapa kōrero, as “stories about ancestors” (p. 2), narratives of significant events and the relationships of people and the environment. These beliefs are held in the cosmological narratives and are considered a starting point, providing insights, symbols, and metaphors of the role of wāhine Māori (Tomlins-Jahnke, 1996).

For wāhine Māori understanding these narratives supports the pathway to understanding Māori ways of healing. Smith (2019) discuss two separate realms of darkness as depicted in Māori narratives. The first realm of darkness is identified in the creation of the world and the second Hineahuone, recognising darkness is also the realm of potential.

In considering the concept of whakapapa kōrero and how it may apply to a healing response for wāhine, the narrative of Hineahuone, speaks of the realm of darkness. Hineahuone, who suffered pōuritanga upon realising the incestuous relationship with her father and is said to have attempted to flee to the underworld Te Pō, away from Tāne, and from Atua. However, as an act of rangatiratanga and as part of her healing journey she was guided to turn back by her elders and instead tasked with protecting her offspring from permanent darkness and placed at the entrance of Te Pō. For wāhine Māori who experience the trauma of a head injury from IPV, understanding these narratives works as a tool to support the pathway to understand the impacts of a cultural injury and work towards Māori healing.

The narrative of Hineahuone is about restoring mana and essentially acts as a reminder for wāhine Māori suffering trauma or in times of darkness, that our tupuna can continue to guide us in the spiritual dimension to a state of mauri ora. Māori relationships with their tupuna are an example of the deep connection with spirituality. Māori spirituality is an absolute wonder, which is strongly connected to wellbeing and guiding the healing process (Wirihana & Smith, 2014).

By incorporating whakapapa kōrero, we are integrating traditional narratives and metaphors that highlight resilience and perseverance of wāhine in response to trauma and traumatic events. This inclusion contributes to the healing pathways.

This chapter delves deeper into the critical themes. Despite limited research on the prevalence TBI from IPV among wāhine Māori, there is no clear Māori healing pathway to guide ngā mātanga in their responses. A kaupapa Māori approach, encompassing healing and rebuilding the mana of wāhine and their whānau, incorporating mātauranga Māori and tikanga. This in contrast to westernised frameworks, emphasising deficit views and colonial ideologies. Understanding the essence of mana wāhine is vital—a concept that honours the strength of wāhine Māori and our place of standing, historically and in contemporary contexts.

Chapter 6: Whaiwhakaaro

Introduction: As I delved into this research journey, reflection emerged as a pivotal aspect of the research process. Whaiwhakaaro - weaves together my reflections and the research journey. In this concluding chapter, I explore this research's limitation and identify opportunities for future research.

Reflections and Journey

I went into this research knowing that there needed to be more awareness and understanding on TBI from IPV and more so for wāhine Māori. I knew I had a vantage point for this kaupapa, not only from previous roles I have held, my aroha for wāhine Māori and māmā who struggle from this trauma but also just a knowing that our traditional Māori ways of being and doing could help heal our wāhine and our whānau.

At the beginning of this research process, my thoughts were often consumed by imposter syndrome: *"what do you know about this topic… if it was so important surely it would have already been researched by now, by someone who knows what they are doing…maybe it's just not that important".*

However, these thoughts soon subsided, with the guidance of my Supervisor Marg and the opportunity to meet the ngā mātanga who work with our wāhine and whānau. Hearing their responses when I spoke to the kaupapa and their acknowledgment that this was an area that for many they had not thought much about: "No body talks about brain injury" (Mātanga 7). And also having the opportunity to raise their awareness in the important mahi they do, "I think it's important what you are doing, just you coming here has raised my awareness and I think it's important" (Mātanga 7) and "I will be going back and considering these things" (Mātanga 4).

This research has been many years in the making and only just starting, from those initial niggling thoughts over the years that this kaupapa was needing attention, to this final year of research in bringing the thesis to fruition. Upon reflection, I think of my own journey over the past 24 months, managing multiple demands and navigating significant life events; becoming a nana for the first time to my moko, Elouise and then to Āpera, to navigating the health system for one of my biggest advocates - Uncle

Jamie, then at the beginning of 2023 working through the loss of Uncle Jamie, while at the same time navigating the health system for my elderly father-in-law Noel following a traumatic medical event. I then decided to take on the challenge of learning a new job and finally at the end of 2023, navigating the loss and pōuritanga as a whānau with the recent loss of Noel.

Reflecting on navigating these life events, I can't help but think of the pūrakau, from māmā identified earlier in this thesis and the wāhine, ngā mātanga spoke of who are left to navigate everyday tasks, while under a cloud of māmae and pōuritanga, often without them really knowing that they are experiencing the impacts of a TBI. While I find navigating the health system complex even having worked in some form within the system, I can only imagine the difficulties wāhine face with not only managing daily tasks but also being expected to navigate a clunky system in response to their TBI from IPV.

At times it has been difficult to stay on task with this thesis, the times of reflection of what many wāhine face in their everyday life has been a driver in the importance of completing this thesis and supporting the campaign to raise the awareness and education surrounding this kaupapa, working towards a pathway of healing.

Limitations and Future Research

This thesis is an initial scoping exercise with geographical limits - the interviews were only completed within the Rotorua -Waiariki Region. The geographic limit was also a strength as I was able to work with mātanga from the area I can whakapapa back to, an area I have worked and supported for many years. I acknowledge that the experiences in the Rotorua-Waiariki Region may not reflect the rest of Aotearoa New Zealand so there is still much research that needs to be done to ensure a more complete knowledge of TBI in relation to wāhine Māori.

Participants at some time, have sat at the family harm table. This is a space where family violence referrals from NZ Police are shared with a range of specialists providing services for victims of violence. Unfortunately, I was not able to interview anyone from the NZ Police family harm team. Their perspectives and insights would be a useful addition to what is known. On a positive note, that kōrero

with ngā mātanga who sit across the family harm table provided an opportunity to educate service providers, health practitioners and others about this kaupapa.

The hospital mātanga provided significant insight into emergency department practices, where it became apparent that there was no screening for a possible TBI from IPV. While this research was isolated to exploring ngā mātanga responses (rather than an organisation response) the local concussion service provider confirmed no referrals from IPV for the past 12 months, interviewing more hospital practitioners would have to helped understand the spread of awareness and practices surrounding screening within the hospital in response to TBI from IPV.

Going forward, there is enough evidence to support that wāhine Māori are severely impacted by family violence and that there is limited knowledge and awareness that surrounds TBI from IPV. While this same methodology can be considered across other regions to determine the awareness and understanding of frontline ngā mātanga, a simultaneous focus on rehabilitation pathways is needed. The concern is that while further research will increase the awareness of this 'unspoken crisis, there is a more pressing need for medical pathways to engage with Te Ao Māori to facilitate healing, and address wāhine Māori struggling to engage in a system where they do not feel safe.

In terms of Māori research and future research, this thesis supports the need to always consider the purpose of the research and who will benefit from this knowledge. This Māori worldview is supported by Fiona Cram (1993), where for Māori, knowledge is about upholding the mana of the group, this knowledge is not about an individual's gain, but rather how the group or whānau will benefit as a whole.

Further research could be considered through a pilot, where the response is a multi-disciplinary team response, including the family harm team, Kaupapa Māori services, concussion service and ACC. Incorporating a medical response to the brain injury and Te Ao Māori elements as part of the healing process.

Although there have been advancements in TBI screening tools, there remain gaps in their accuracy and accessibility, particularly in the context of IPV. To address these issues, further research is essential to

develop innovative approaches that can enhance the effectiveness of TBI screening for survivors of IPV.

Conclusion

At the beginning of this thesis, I introduced the generic definitions of TBI and IPV to highlight that these issues are often considered in isolation. As discussed, TBI from IPV is considered an "unspoken crisis," not only because there are often no visible injuries, but also because the pathway to support for wāhine who suffer from this trauma is difficult to see and, at times, hidden.

A key focus of this research was to understand the concepts surrounding the meaning of trauma for Māori, including the impacts of historical trauma and the connection between trauma and cultural injury from a Te Ao Māori perspective. This knowledge can be incorporated into the healing pathways for wāhine Māori. It also highlights that the māmae (pain) and pōuritanga (sorrow) that wāhine Māori experience as part of family violence, along with TBI, are not often considered in the response.

By introducing the relevant definitions and belief systems surrounding trauma from a Te Ao Māori view, this research provides insight into not only the trauma of TBI from IPV but also the moemoeā (vision) of what a response pathway may look like. This pathway is developed around traditional responses that incorporate the restoration of the imbalance of the mauri (life force) from the assault of the traumatic event.

This research integrates both conceptual and theoretical frameworks to achieve the primary objectives: understanding the prevalence and impact of TBI resulting from IPV among wāhine Māori and developing culturally tailored interventions. The conceptual framework focuses on key concepts such as TBI, IPV, health and well-being, and cultural impact.

The findings provide data on the prevalence of TBIs, the associated health and functional impacts, and qualitative insights into the cultural injury and effects on tapu and mana. By connecting these findings, the research offers a comprehensive and coherent understanding of the issue and its wider implications.

This approach highlights the necessity of culturally tailored interventions for wāhine Māori affected by TBIs resulting from IPV.

By mapping out my understanding (informed by the experiences of ngā mātanga) of what the pathway in response currently looks like following a police family harm call out, I identified two possible pathways, the first being the medical or primary health response, when an ambulance is called or when further treatment is sought. The second response is when medical treatment is not considered but rather a safety response to the family harm event. Reflecting on this map helped identify the gaps in response and the development of questions to consider for the interviews with ngā mātanga and support my whakaaro and the research available, surrounding the silence of this silent kaupapa.

Through ngā mātanga kōrero, common themes were identified. The variable awareness of TBI. Ngā mātanga could easily articulate signs of a TBI. However, it became clear that while TBI is a significant concern, it often remains overlooked within the context of IPV. This was because the focus for family harm is safety in the first instance with no clear guidance for ngā mātanga to support them in their response to a potential TBI. Also considering the complexities whānau face in the family harm space, the response therefore very rarely transitions from safety in response to the family violence event.

The focus for many of the services stays on the treatment of the symptoms of the family violence and family violence prevention, including, programs on anger management and drug and alcohol abuse, where other potential underlying issues including TBI are not considered. Integrating TBI awareness into family harm responses is crucial. By considering underlying issues like TBI alongside safety measures, we can provide a more comprehensive support to wāhine and whānau.

For ngā mātanga who had completed self-directed training on TBI, they were more confident in identifying the signs of a TBI from IPV. However, it was evident that the referral and treatment pathways were not well understood or easily accessible. Mātanga spoke of making muffins as a form of payment for nurse practitioners to complete medical assessments when there were concerns noted of a head injury for wāhine they supported. This approach was considered easier rather than the time and effort to support wāhine to lodge a claim with ACC. Practitioners also indicated that the process with

Te Whatu Ora was disjointed and wāhine who had been screened for a TBI, often ended up leaving the service before receiving treatment and rehabilitation.

The referral pathways and the lack of guidance in terms of a response to TBI from IPV is evident in the limited to no referrals in the last 12 months to the local concussion service provider, highlighting the fact that TBI's are not being considered as a result of IPV and/or referrals are not being made for rehabilitation input, supporting the concern that the understanding of a medical response for a TBI is not well understood as part of the response.

Towards the final sections of this thesis, I discussed mana wāhine and the impact on mana wāhine from the changing attitudes and belief systems as part of colonisation, this undermining status of mana in wāhine Māori what Māori scholar Moana Jackson described as "colonisation of mātauranga Māori." (Dhunna, Lawton & Cram, 2018, p. 6193)

Ngā mātanga kōrero highlights the critical gaps that surround the understanding of TBI resulting from IPV, and the research on TBI from IPV remains limited. Even more limited is the understanding of wāhine Māori experiences of TBI from IPV even though wāhine Māori are disproportionately affected by IPV and have a greater risk of living with violence.

There is a disconnect in understanding pathways to healing particularly pathways inclusive of traditional Māori beliefs, highlighting the devasting effects of colonising tikanga Māori, particularly for wāhine Māori, (the ongoing Mana Wāhine claim[13], lodged almost 30 years ago seeks to address these injustices which continue today). In moving forward, it is critical to bridge the gap between the research on TBI from IPV and the cultural understanding that will support a mana-enhancing response.

Mana wāhine, along with Kaupapa Māori kōrero and whakapapa kōrero frameworks, outlined in the moemoeā component of this thesis, play a significant role in shaping the discourse within the context

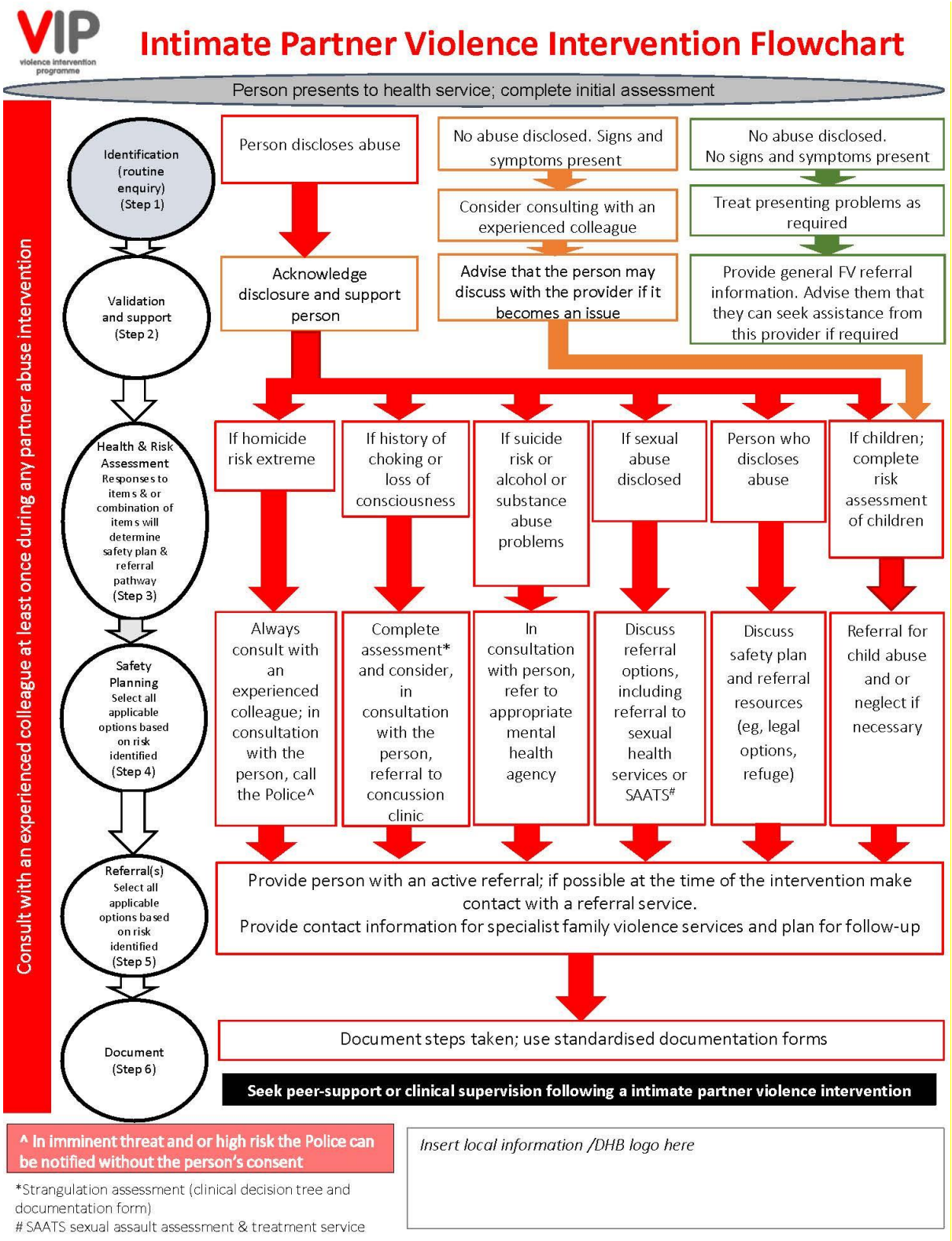
[13] Wai 2700 Mana Wāhine kaupapa Inquiry. The Waitangi Tribunal is hearing claims which allege to the Crown's denial of mana wāhine has had serious consequences for the social, economic, cultural, and spiritual wellbeing of wāhine Māori and their access to leadership roles.

of this kauapapa. These frameworks affirm the places of mātauranga Māori as an essential element in the pathway in response.

Moreover, there has been an increased understanding and awareness of trauma, with acknowledgement that trauma is an integral part of the healing process for Māori. This recognition has become more prominent in contemporay literature today particularly over the past decade. While there is still much work to be done in developing effective healing reponses that incorporate mātauranga Māori, it is encouranging to see some momentum.

Initiating the healing response begins with identifying the TBI through safe screening. When wāhine feel safe to disclose, we can then create the environment for the healing to begin. Until we can recognise this ‘unspoken crisis’ and reset the mauri and resolve the imbalance of the traumatic event our wāhine may be left to delve deeper into Te pō, unable to not only manage daily life, but also impact their ability to navigate those significant life events.

Appendix 1 IPV Flowchart



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