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Literature Review

Specialist domestic abuse training for emergency department clinical staff: A review of the literature

Jess Goldie [1a], Paul Regan [b]

[a] East Lancashire Hospitals NHS Trust, Blackburn, UK; [b] Senior Lecturer in Adult Nursing, School of Nursing and Midwifery, University of Central Lancashire.

Key Words: *Domestic abuse; intimate partner violence; domestic violence; accident and emergency; ED*

Abstract

Aim: Emergency departments are often the first point of contact for women suffering from domestic abuse and identifying how healthcare staff can support women is important to tackle missed opportunities for timely intervention. **Method:** A review of research studies was undertaken between 2012 and 2024 using electronic databases AMED, CINAHL Ultimate, MEDLINE, EBSCO, and the RCNi. The search words "emergency department, ED, accident and emergency, A & E, domestic abuse, domestic violence, intimate partner violence, family violence, staff- training education, development, learning" were used and retrieved n=93, reduced n=18, and finally n=7. **Findings:** The findings identify a training and role-specific issue related to emergency department nursing, and the need to have a supportive environment for positive action to be taken on behalf of the victim and their families. Four themes were identified; "don't ask," "stereotyping," moral distress" and "systemic support." In 'don't ask' the thread of conscious incompetence ensures staff reluctance to talk to women in case it opens a 'can of worms.' **Discussion:** The difficulties experienced by emergency nurses were compounded by staff being unaware of their departments policy on dealing with domestic abuse. Contrary to WHO recommendations, the evidence identified domestic abuse screening in most emergency departments happens on an ad-hoc basis and is subject to the experience and confidence of the individual clinician. **Conclusion:** Training is required to myth bust the factors related to domestic abuse, yet training is not enough, there needs to be a shift in attitudes toward domestic abuse, and in an institutional context, staff should feel supported and empowered to respond to women appropriately.

Introduction

The Royal College of Emergency Medicine (RCEM) identified up to 12% of emergency department attendances in the United Kingdom (UK) were women suffering from domestic abuse (Boyle et al., 2015). In Australia, women suffering domestic abuse (DA) present to emergency departments (ED's) three times more than other women (Dawson et al., 2019) and ED's are often the first point of contact with healthcare providers (Tarzia et al., 2020). The impact of DA contributes to a variety of presenting illnesses in ED's such as mental illness, self-harm, drug and alcohol abuse, depression, and overdoses (Boyle, 2015). Due to 30% of DA occurring during pregnancy, there is also a strong correlation with termination of pregnancies, sexually transmitted disease, and other medically unexplained symptoms (Boyle, 2015). With up to 70% of all female murder victims in the UK having suffered DA (NIA, 2022), the role of ED's is vitally important in helping women disclose it (Tarzia et al., 2020). Due to the importance of ED's in tackling the health outcomes of DA, the RCEM recommend training staff to ensure they are willing to ask direct questions about DA, to believe women when confidentially disclosing DA, interact in a non-judgemental and holistic way, undertake assessment of their immediate safety and contact Police in the relative safety of the ED (Boyle, 2015). Firstly, the Department of Health (2017) resource entitled *Responding to domestic abuse* defines DA as….

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged sixteen or over who are or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, emotional…" (DH, 2017, p. 8).

NICE (2016) guidelines suggest DA includes psychological, physical, sexual, emotional, and financial abuse, as well as honour-based violence and female genital mutilation (FGM). However, FGM is not addressed in this paper due to specific NICE (2016) guidelines on this

[1] **Corresponding auther:** *East Lancashire Hospitals NHS Trust, Blackburn, UK.*
Email Address: jessica.goldie@elht.nhs.uk.
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issue. Whilst recognising some women prefer the term "survivor," which is a matter of ongoing discussion, those who have experienced DA are referred to as victims, to recognise the significant ongoing impact and trauma of DA when presenting to ED's in crisis (DH, 2017).

Domestic abuse prevalence and societal change

Domestic abuse costs the UK's National Health Service (NHS) approximately £1.75 billion per year (Home Office, 2019) and is considered by the World Health Organisation (2021) to be a violation of women's human rights. In the report by Oliver et al. (2019), on behalf of the Home Office, estimate that in 2018, the fiscal impact of DA for England and Wales was £66 billion, and in 2021 £74 billion (DAC, 2021). Domestic abuse is a major public health concern, causing both acute and chronic health issues and affecting 1 in 3 women in the UK (Women's Aid, 2022). Domestic abuse is experienced in a majority of cases by women perpetrated by men, and the Office of National Statistics (ONS) identified 1.7 million women (6.9% of women) and 799,000 (3%) of men aged 16 to 74 years to be victims (ONS, 2022a). There has been an increase of 7.7% from 2021 with 5%, or 2.4 million adults, experiencing DA in the year ending March 2022 (ONS, 2022a). This is not to say that violence against males is unimportant, but to recognise the dynamics of female-on-male or male-on-female violence are different (Hine et al., 2022). However, once the numbers are reviewed, a clear pattern emerges whereby not only are women overwhelmingly the victims (77%) and males the perpetrators (96%), but women also suffer more severe and more frequent incidences of DA, over longer periods, with worse outcomes than male victims (Women's Aid, 2022). Typically, women experience thirty-five instances of DA before seeking help (DH, 2017). Professional training should therefore be women-focused to specifically address the needs of the primary victim group (Hine et al., 2022).

It is not possible to understand the dynamics of DA without considering wider social context and the role of women within society. Marital rape was not made illegal in the UK until 1992 (Williamson, 2016) and as British society changes, so do attitudes towards DA. This is reflected at a systemic level; for example, in the recognition of 'coercive control' as a crime in 2017 (Brennan & Myhill, 2022). Social movements such as the 2017's '#MeToo' sparked awareness around issues of sexual politics, even influencing educational policy for primary schools (Maricourt & Burrell, 2022). At the same time, the rise of the misogynist 'incel' movement, which refers to the self-proclaimed involuntary celibacy movement (Thorburn et al., 2023) and the proliferation of graphic online pornography, combine to influence negative views about women as property (Sharpe & Meade, 2021). A survey by Ipsos UK and King's College London found that over half of the younger generation's surveyed believe that women's equality had 'gone too far,' and that 29% avoided speaking about women's rights for fear of reprisal (Campbell et al., 2024). This highlights the complexity and contradictions within wider British society, as the pendulum of online opinion gains influence (Tietjen & Tirkkonen, 2023).

Domestic abuse response in Law and healthcare

The World Health Organisation (2005; 2014) reinforced DA as a priority indicator to optimise women's health and emphasised healthcare professional's significant role in tackling DA. In response, the HM Government's (2009) aimed to develop new ways of tackling DA by improving criminal justice response to DA, targets of 72% successful prosecutions and supporting victims through the Independent domestic violence advisors (IDVA), multi-agency risk assessment conferences (MARAC), and increased early detection of DA. The Department of Health (2017) in *Responding to domestic abuse* suggest health services take a leading role in recognising and responding to DA and referred to a raft of measures such as having a designated safeguarding professional, serious case reviews, Frazer and Gillick competences for under sixteens and domestic violence protection orders. The Domestic violence disclosure scheme (*"Clare's law"*) also gave people the right to ask Police about a partner's previous violent offending so they could make informed choices about the relationship.

More recently the *Domestic Abuse Act* (2021) in section 1 "domestic abuse" refers to behaviour that is abusive if it consists of any of the following: physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse, psychological, revenge porn, emotional or other abuse. The Act (2021) states it does not matter whether DA behaviour consisted of a single incident or many. The Act (2021) includes economic abuse and adverse effect on an ability to; acquire, use, or maintain money or other property, or obtain goods or services and lastly, to protect against the impact of emotional, controlling, or coercive and economic abuse. The Act (2021) when it came into effect was expected to cost £247 to £300m per year once fully implemented and have a DA commissioner with a set function and power to improve local authorities provision (DAC, 2021). The DA commissioner's responsibility aimed to improve the availability of safe and secure accommodation, create a presumption of specific measures, and clarify circumstances for civil and family Courts in England and Wales to ensure children do not remain silent victims of DA (DAC, 2021). We now present the search strategy and critically appraise the retrieved research studies to identify key themes in supporting women DA victims (and their families) attending ED.

Search strategy

The literature search used the 'problem/ population, intervention, comparison, outcome' (PICO) method (Schardt et al., 2007) to develop a research question. From PICO, key terms were identified, and electronic databases searched including AMED, CINAHL Ultimate, MEDLINE, EBSCO and RCNi. The following key search words were used with Boolean operators 'and' 'or' but not limited to the "emergency department (ED) or ED or accident and emergency or accident & emergency or A & E and/ or domestic abuse or domestic violence or intimate partner violence or family violence and staff training or staff education or staff development or staff learning." Due to ongoing developments in understanding DA and changing cultural attitudes, the search was limited to documents from 2012 to 2024. This yielded n=93 studies and included if they specifically referenced DA in the ED, nurses, and female victims, but excluded if the focus was directed toward common comorbidities such as mental health issues or substance abuse (*see table 1 entitled: Inclusion/ exclusion criteria and figure 1: entitled: PRISMA flow diagram*).

Table 1: Inclusion and exclusuion criteria

Inclusion/ Exclusion Criteria	Rationale
Papers from 2012 onwards	To reflect changing attitudes and policies: DH guidelines written in 2015 along with NHS pocket guide to safeguarding.
Peer reviewed, full text, and in English	To find the highest quality evidence. The extract is insufficient to conclude from. I can only speak English!
References to DA, ED, nurses, females	To keep the number of papers manageable and relevant. Many papers are from a social work perspective- I want the nursing perspective. ED offers challenges do not present in other clinical areas. Females are the primary victim group
Comorbidities	Discussion of how ED staff address DA victims with mental health issues is a separate lit review.
UK & Ireland, Western Europe, Canada, Australasia	Demographically, culturally & systemically comparable.
Secondary sources & opinion pieces	Only primary sources are included as they are highest in the hierarchy of evidence. Opinion pieces are excluded on the same basis.
IDVA related research	This is an excellent but initially expensive initiative. This proposal concerns training for existing staff during a period of unprecedented demand and underfunding.

Geographically, differing demographics and cultural understanding of DA was considered, in addition to the structural accessibility of health care. The United States (US) was therefore excluded, although it is like the UK demographically, historically, and culturally, the healthcare system is not free at the point of use and there is evidence to suggest this results in the exclusion of women most at risk of DA (Klap et al., 2007). Countries with large conservative religious populations, or theocracies, were also excluded. The search was limited to the UK, Western Europe, Canada & Australasia, which reduced the number to n=18, after being manually reviewed. Research studies that focused exclusively on independent domestic violence advisers (IVDA's) were ruled out because this literature search is concerned with the training of existing clinical staff rather than the creation of recently developed specialist roles not routinely found in ED, despite recommendations they should be (Mason et al., 2020). Research studies were appraised using the critical appraisal skills programme (CASP, 2022), and given a CASP score, although the score alone did not determine inclusion due to the relative paucity of evidence. The remaining studies were assessed according to Evans (2002) hierarchy of evidence, and n=7 articles met the criteria for inclusion in this review [Basu & Ratcliffe, 2012; Dawson et al., 2019; Lundh et al., 2022; Ritchie et al., 2013; Saberi et al., 2016; Spangaro et al., 2021; Vonkeman et al., 2019]. (*See table 2 entitled: Table of findings*).

A mixed methods quality improvement report by Basu and Ratcliffe (2012) studied referrals to a new DA service over a 12-month period, alongside informal interviews with healthcare professionals to establish staff satisfaction. Whilst the quantitative results of this study initially appear impressive (172 referrals in 12 months, up from one the previous year before the intervention), there was no analysis of whether these referrals were appropriate, or whether they resulted in improved outcomes for DA victims. Furthermore, whilst the study also found high staff approval for the new DA initiative, one of the researchers was an ED doctor working alongside those he interviewed, so it was possible that healthcare professionals did not feel able to give an open response. Dawson et al. (2019) and Lundh et al. (2022) both used semi-structured conversations and focus groups, whilst Lundh et al. (2022) used a semi-structured interview technique. A semi-structured approach offers a degree of flexibility, allowing the researcher to delve more deeply into a response, or seek clarity (Williamson & Whittaker, 2020). Focus groups of healthcare professionals are a convenient method of gathering multiple opinions in a straightforward way, although feeling pressure to give the 'correct' answer rather than a most truthful one is an issue (Williamson & Whittaker, 2020).

In Spangaro et al. (2021), the mixed methods feasibility study was conducted over six months and across 3 ED's using a quantitative survey of multiple-choice questions and focus groups. Again, the closed-question survey does not allow for depth but does grant anonymity, whilst the focus group findings may be subject to participants feeling uncomfortable or pressured to give a certain answer. Each method in this instance, compliments and offsets the limitations of the other, giving an overall richer and more robust picture. A longitudinal quantitative study by Ritchie et al. (2013) was completed over 9 years and accessed a random selection of clinical records to

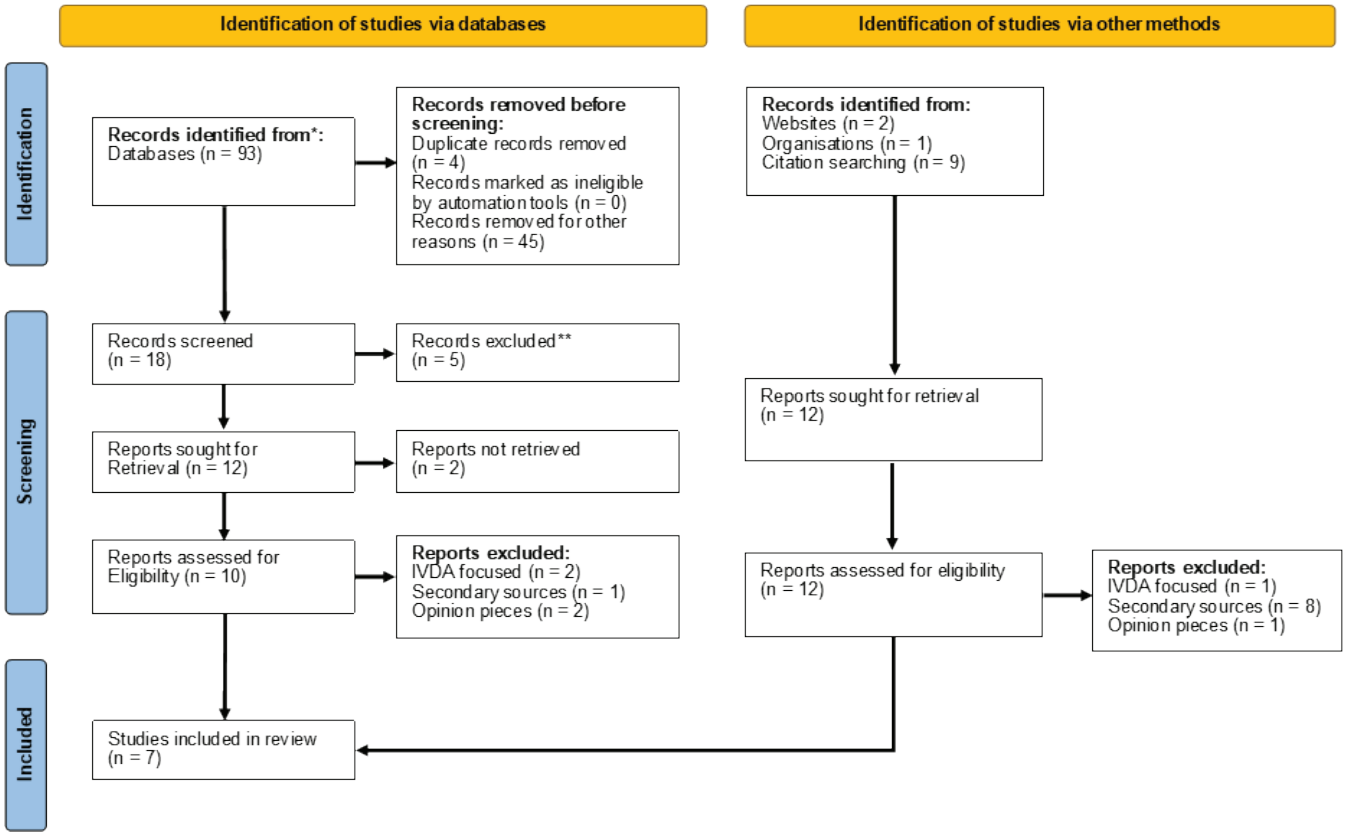

Figure 1: PRISMA flow diagram

assess the extent to which new DA training and accompanying documentation had been implemented. The study took steps to ensure that confidentiality was maintained and gives a good picture of the way that change is implemented over time. However, it is limited in that it only considers one intervention in one ED. The quantitative research study by Vonkeman et al. (2019) was quite specific as it sought to assess not only what had happened in the past (through an anonymised health record review), but also what current practice and healthcare professionals were willing to do in the future (through a multiple- choice survey of ED staff).

Key papers

Overall, a range of study designs were used within the included literature. All the studies (except for Ritchie et al., 2013) were subject to potential self-selection bias, wherein the participants had taken part because they already had an interest, or something to say, about DA. Furthermore, although not stated in any of the papers, it is possible that in each case except for Ritchie et al. (2013), there was an element of 'convenience sampling,' for example: researchers approached their nearest ED, where they had existing relationships, to ask for co-operation. This could have far-reaching consequences because when all participants are nurses and medical staff within a professional network, there may be a desire to give professionally acceptable answers rather than truthful ones (Williams & Whittaker, 2020). Additionally, none of the studies selected spoke to victims of DA, relying instead on secondary sources to communicate the patient perspective, and none spoke to non-professional clinical ED staff, such as health care assistants who provide much of the interpersonal care in ED's, with valuable insights to offer (Clark & Thomson, 2015). Whilst each paper has limitations as discussed, all of those using qualitative methods did so with a reflexive approach, acknowledging and taking clearly explained steps to be transparent. We will now discuss four key themes identified from the n=7 research studies: don't ask, stereotyping, moral distress, and systemic support.

Key themes

'Don't ask'

A thread of conscious- incompetence runs throughout the literature. Clinical staff reported their reluctance to enquire about DA for fear that it would 'open a can of worms' which they felt ill-prepared to deal with. Basu & Ratcliffe (2012) discussed the 'apprehension' that ED staff experience when they encounter DA situations. Ten years later, Lundh et al. (2022) described the insufficiency that emergency nurses felt in the face of DA situations. Dawson et al. (2019) also found that most healthcare professionals interviewed were not aware of any of their Trust or department specific policies relating to DA, which resulted in less supportive action for women presenting in the ED. Saberi et al. (2017) found that nurses reported inadequate knowledge as a major barrier to addressing DA in the ED. In the survey by Spangaro et al. (2022), nurses reported feeling only 'somewhat' or 'slightly' confident when encountering situations of DA, and 67% of

Table 2: Table of findings

Authors	Methodology	Sample	Data collection tool	Main findings	Strengths
Basu and Ratcliffe (2012)	Mixed methods. Qualitative- i.e., numbers of referrals to specialist agencies Quantitative- i.e, interviews with staff. Case study. Single site	ED Dept in NW England, over 1 year. HCP's	Ongoing discussion with n=12 nursing staff & 10 medics, over 12 months	Referrals to specialist DA services increased from 1 to 127. Nursing staff felt more comfortable around DA victim's and more confident in the process	Authors knowledgeable of ED. 12-month timeframe. Study authors specialise in emergency medicine. No conflict of interest
Dawson et al. (2019)	Qualitative, multi-site	Interviews conducted with HCP's across 2 large metropolitan ED's, diverse demographic.	Semi-structured interview & focus groups. Lead by impartial research nurses from out of area	HCPs expressed lack of confidence/ knowledge. Training needed. Role clarification, policies & processes needed to back up staff. "Pandora's box/ can of worms."	Clear aims well met. Study well designed with clear outcomes
Lundh et al. (2022)	Qualitative, single site.	Semi structured interview of RNs in one ED.	Interviews conducted by trained interviewer in a private setting. 1 interviewer known to participants	Common themes of frustration at lack of knowledge, insufficient time, focus on patient flow & 'easier option'. Need to structural change Not wanting to start something they can't deal with	Clear aims, addressing a clear gap in research. Limitations acknowledged
Ritchie et al. (2013)	Quantitative, single site	Longitudinal- 9 years	Random selection of clinical records assessed	Training alone has no impact on quality of care for victims of DA, accompanied by robust systems for documentation & referral	Authors specialists in field. Good to see the impact of intervention over time. Confidentiality maintained. No conflict of interests or biases
Sabheri et al. (2017)	Quantitative census survey, single site	Cross sectional survey of ED staff from 1 hospital. n=69 in total- n=58 nurses, n=11 medics	Multiple choice anonymous survey	Majority of staff support routine screening in ED. Training shown to overcome many of the barrier's staff discussed. Structural support at institution level is needed to empower staff Selective screening will miss people at risk	Well considered, good response. Authors are specialists in field of DA and ED
Spangaro et al. (2021)	Mixed methods feasibility study, qualitative & quantitative	Mixed HCP's across 3 EDs in Australia	Surveys & focus groups over a 6-month period	Staff supportive of routine screening. Challenges are time, busyness, lack of privacy, and high number of women requiring screening	Clear statement of aims strong study design & effort to incorporate all staff
Vonkeman et al. (2019)	Quantitative	Review of health records & anonymous clinician multiple-choice survey. Single site	4-month window for record review. Surveys shared 3 x over 6 months	Lack of confidence, lack of training, fear of offense, no use of existing documentation, eagerness for training	Clear statement of aims confidentiality Researchers are appropriately qualified

respondents requested further training. In contrast, medical staff reported feeling 'somewhat' or 'fairly' confident. Vonkeman et al. (2019) found that, even though clinical ED staff considered addressing DA to be their responsibility, there was a lack of training which resulted in staff feeling uncomfortable and unprepared. Dawson et al. (2019) found that there was a general awareness of the prevalence of DA due to increased cultural recognition, but this did not translate into practice, and when staff were unaware of their Trust's policy they had a diverse range of views on the best way to screen for and address victims of DA.

Stereotyping

Cultural barriers and lack of common language are difficult to legislate for, but there are also common myths surrounding what a victim of DA looks like, and these stereotypes influence who a nurse considers to be at risk. Saberi et al. (2017) found that the decision to ask DA screening questions in ED's influenced nurses' perceptions of the patient's demeanour. Vonkeman et al. (2019) found that health professionals failed to consider DA in women from higher socio-economic classes. Whilst there are undeniable links between DA and poverty there are other factors centred around power and control, which is why DA is prevalent across all social strata (Women's

Aid, 2022). A common misconception throughout the research studies is that broaching the issue of DA with women may cause offence (Lundh et al., 2022; Saberi et al., 2017; Vonkeman et al., 2019). On the contrary, the evidence suggests women are supportive of DA screening (Dawson et al., 2019) and that victims of DA believe that healthcare professionals should have compulsory training (Basu & Ratcliffe, 2012). Women identified healthcare providers as the most trustworthy professionals to disclose DA to in the ED and were more likely to disclose DA when directly asked (Vonkeman et al., 2019).

Moral distress

Pauly et al. (2012) define moral distress in health care "…with the ethical dimensions of practice and concerns related to difficulties navigating practice while upholding professional values, responsibilities and duties…" (p.2). In other words, it is the ethical anxiety that the nurse faces when unable to deliver the care the patient needs, within the confines of ED, and in this situation, caring becomes a burden. The consequence of moral distress is significant and can lead to a lack of empathy, and women reporting coldness and lack of compassion contribute negatively to seeking help in the future (Duchesne et al., 2022). Although the studies reviewed here do not specifically identify 'moral distress,' Dawson et al. (2019), Saberi et al. (2016) and Vonkeman et al. (2019) suggested healthcare professionals may recognise an intervention is required but they were reluctant to screen for DA due to a lack of confidence. Lundh et al. (2022) identified that nurses priorities may conflict with a patient's needs, and the resources in ED's, resulting in feelings of powerlessness for both them and women suffering DA.

Systemic support

A contributing factor to the 'moral distress' theme discussed above is a lack of structured support for nurses and other healthcare professionals assisting women victims of DA. Duchesne et al. (2022) found one of the negative experiences commonly encountered by DA victims in receiving ED care is repeated questioning from professionals who could not meet their needs further, leading to feelings of hopelessness. Dawson et al. (2019) identified a three-fold issue: identifying those at risk, knowing there was a policy in place, and knowing how to implement that policy. Healthcare professionals reported having the skills to identify victims, but due to poor referral systems, there were limited options available to them (Basu & Ratcliffe, 2012). Vonkeman et al. (2019) stressed that where policies and documentation were in place, the absence of appropriate training and education undermined such initiatives, whilst Ritchie et al. (2013) found that staff training had no impact on the numbers of DA victims identified, unless accompanied by robust procedures and documentation.

Identifying which healthcare professional should screen for DA is an issue. The assessment of the implementation of a new screening tool by Spangaro et al. (2021) found that 87% of clinical staff were in favour of DA screening in ED's. Saberi et al. (2017) found that 82% of ED healthcare professionals surveyed believed that screening for DA should be routine, whilst 83% stated they had received little to no DA training. Vonkeman et al. (2019) reported the same positive staff attitude, accompanied by the same lack of confidence- in this case, 81% of staff had received no training. Dawson et. al (2019) also found that, although staff requested training and role clarification, ED healthcare professionals were consistently committed to keeping women safe. Dawson et al. (2019), Saberi et al. (2016), and Spangaro et al. (2021). all found that both nurses and medical staff viewed screening and responding to DA as part of their role responsibility. Basu and Ratcliffe (2012) found medical staff were resistant to screening at the outset of a DA trial programme, believing this job should fall to nurses, although this attitude changed over time. There was some disparity between nurses and medical staff when it came to who should be screened, with nurses believing screening should be targeted whilst medical staff favoured a routine enquiry tool (Saberi et al., 2017). Nurses also reported fewer DA training opportunities and less confidence than medical staff (Spangaro et al., 2021). At the same time, nurses reported time constraints prevented DA screening at more than triple the rate that medical staff did (Vonkeman et al., 2019).

The WHO (2013) recommend healthcare professionals ask about DA when assessing health conditions caused by DA, such as termination of pregnancy or sexually transmitted diseases, but the WHO does not advocate for universal screening. NICE guidelines (2016) suggest training for all frontline clinical staff at level 1 (responding to a disclosure) and level 2 (the skills required in screening for DA) and identify people presenting with indicators of DA. However, the indicators that NICE (2016) suggest are broad and open to interpretation; who is 'at risk' is therefore a decision made by the healthcare practitioner who may have preconceived, cultural or stereotypical ideas of victimhood and may fail to act (Saberi et al., 2017).

Victims of DA do not necessarily present with obvious deliberate injuries; exposure to DA has many long-term physical and psychological health implications associated with post-traumatic stress disorder, anxiety, and suicidality (WHO, 2013). Therefore, it is not clear how women could be identified as 'at risk' and in addition, Warren-Gash et al. (2016) suggest use of universal screening may remove the stigma of being asked if suffering with DA. If applied to all women and deemed a waste of time in most instances, the counter perspective is that time-pressured health and social care practitioners might overlook screening altogether (Dawson et al., 2019). Training should therefore pay attention to dispelling the common myths that surround DA so that healthcare professionals feel empowered to use both

their clinical judgement and experience alongside WHO (2013), NICE guidelines (2016) and local Trust policy, to determine who needs screening.

Discussion

NICE guidelines (2016) require NHS commissioners to commission services in which frontline staff are trained to respond appropriately to disclosures of DA, and that referral pathways and specialist services are accessible. Although stated in the search strategy section, research studies focusing solely on independent domestic violence advisors (IVDA's) were excluded, but if they were available in ED's, then DA support could be improved. Some IVDA's are based in ED's, develop timely referral process, protect victims from violent partners or ex partners, be proactive in developing safety plans and be the primary contact (HM Government, 2009). The evidence suggests IVDA's in hospital's work well and have developed a close working relationship with community IVDA services, MARAC, and integrated referrals (Mason et al., 2020). ED staff highly value hospital based IVDA's due to the increased ED attendance of DA victims prior to referral (Dheensa et al., 2020; Mason et al., 2020). One suggestion is IVDA's become permanent members of hospital staff and be based in ED's (Mason et al., 2020).

NICE (2016) recommend routine enquiry about DA in ED's but it remains inconsistent (Dheensa et al., 2020). Despite IVDA's in hospitals being found to be highly effective and supportive of women, they are not universally found in UK ED's (Mason et al., 2020). A study by Baird et al. (2019) highlighted that staff continued to feel ill-equipped to deal with DA, and they requested specialist training, education, and tailored policy. Due to a lack of consistent training and screening tools (Fang & Donlie, 2021), healthcare professionals in ED felt they were left to assess DA related safeguarding concerns in an ad-hoc manner (Duchesne et al., 2022). This ad hoc approach resulted in missed opportunities for intervention, leading to half of women murdered by an intimate partner within 24 months of their deaths after attending ED (Duchesne et al., 2022). In Christensen et al. (2021), the literature review focused on the experiences of ED nurses dealing with DA and revealed the depth to which the nurses themselves were affected by the abuse they witnessed, such as recurring themes of feeling grief, despair, and hopelessness. This is a complex cultural landscape, and it is important that ED training is woman-focused and with specialist knowledge of DA.

The moral distress that healthcare practitioners have experienced when caring for victims of DA should not be underestimated, and the range of emotions experienced by those providing care to victims of DA must be considered in the training. Healthcare practitioners describe feelings of helplessness, sorrow, and grief, tied to thinking there is little they can do to help and worry about the danger a women may be in following disclosure of DA (Lundh et al., 2022). Their concern is not without foundation because women are statistically at greatest risk from their abuser when they seek help (WHO, 2013). In her groundbreaking 1995 book 'what makes women sick' Lesley Doyal discussed the 'learned helplessness' common of DA victims, in which a sense of personal worthlessness, combined with economic dependence, often caused women to return to an abusive situation. The evidence suggests this is still the case and so any training programmes must include the reasons women may return to an abusive relationship, emphasise shared decision making and highlight the negative outcomes for women who experience coldness, paternalism, or pity when disclosing DA in the ED (Duchesne et al., 2022).

Dawson et al. (2019) found that female healthcare practitioners were more likely to have higher awareness and empathy of DA than their male counterparts, and that abused women were more likely to disclose to female staff. The systematic review by Duchesne et al. (2022) discovered that between one fifth and one third of ED staff had personally experienced partner violence- statistically, the majority of these were women. As the nursing workforce in the UK is 88.6% female (NHS, 2021), it is likely to conclude that victims of DA are over-represented among nursing staff. Therefore, it is disappointing that nurses receive the least DA training of professional ED staff, and as a result, report the lowest levels of confidence in this area (Dawson et al., 2019; Vonkeman at al., 2019). The Department of Health (2017) and NICE (2016) guidelines make no distinction between nurses and medical staff in their training recommendations, and both professions have a small element of DA awareness in their undergraduate training programmes, so the discrepancy in knowledge must arise from Trust-level training priorities. Nurses have more patient contact, for more prolonged periods than medical staff, combined with the suggestion that women find it easier to disclose to other women, reinforces the need for nurse DA education to be as thorough and robust as that of medical staff (Ullman & Davidson, 2021). The training provided should therefore ensure that it acknowledges the impact that subjective experiences have on those providing care to victims of DA.

Limitations

These findings should be considered alongside the limitations of this literature review. Only n=5 databases were searched via the University portal and inevitably some studies will be missing. The search was also limited to studies in English, so some European research which met all other inclusion criteria but were not in English, were excluded. The search parameters were quite narrow, focussing specifically on ED's and experiences and behaviours of nurses. Although careful consideration was given to geographical exclusion, only n=1 of the n=7 research studies reviewed was produced exclusively in the UK. Cultural caution should therefore be taken when

applying these findings to UK ED's.

Conclusion

Currently, and contrary to WHO (2021) recommendations, the evidence suggests DA screening in most ED's is happening on an ad-hoc basis and subject to the experience and confidence of individual healthcare professionals (Dawson et al., 2019; Lundh et al., 2022; Saberi et al., 2017; Spangaro et al., 2021; Vonkeman et al., 2019). NICE guidelines (2016) state that healthcare professionals should deliver a trauma-informed approach, and that Trusts should make policies and procedures clear. Trauma informed care seeks to recognise the widespread impact of trauma, to recognise the signs and symptoms of DA, to promote a sense of safety and to actively prevent re-traumatisation (Office for Health Improvement & Disparities, 2022). Emergency departments present a uniquely challenging environment to deliver trauma-informed care, but despite this changeable environment it is possible to improve assessment, referral and support to women attending ED with DA induced injuries. Healthcare professionals training should seek to 'myth bust' and empower them to identify women most at risk based on the best evidence and recognise the often-overlooked issue of coercive control (CPS, 2017). Any assessment tool adopted should be user friendly, quick to complete and integrated within the referral process to IVDA's in ED's (Warren-Gash, 2016). Training alone is not enough, because a shift in attitudes at a systemic level is required so that ED healthcare professionals feel supported and empowered to respond appropriately to women presenting with DA symptoms in ED (Saberi et al., 2017).

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Author Biographies

Jess Goldie

https://orcid.org/0009-0002-8269-1492
East Lancashire Hospitals NHS Trust, Blackburn, UK.

Jess Goldie studied for a BSc Hons degree, adult field at the University of Central Lancashire. Jess is now working at Royal Bolton Hospital emergency department full time.

Paul Regan

https://orcid.org/0000-0002-8775-933x
Senior Lecturer in adult nursing, School of Nursing and Midwifery, University of Central Lancashire.

Before joining the pre-registration team at the University of Central Lancashire in 2010, Paul worked in the NHS for 28 years from 1982-2010. Paul has clinical experience of adult nursing, acute mental health nursing and as a generic health visitor.