Abstract

Background and Objectives

Emergency departments are essential providers of compassionate, immediate treatment and referral for women experiencing intimate partner violence. Intimate partner violence, largely perpetrated by men against women, exerts a substantial burden on the health systems and economies of all nations. There is little known about how staff in Australian emergency departments respond to the challenges such violence generates. We therefore examined the clinical team response to women experiencing intimate partner violence in two large Australian metropolitan hospital emergency departments.

Methods

We undertook qualitative semi-structured interviews and focus group discussions with 35 social workers, nurses and doctors. Transcripts were recorded and transcribed verbatim. We analyzed the data thematically. We first undertook line by line coding and organized content into descriptive categories. Latent and manifest patterns were identified across the data and mapped to key themes in negotiation with all authors.

Results

Respondents emphasized challenges identifying intimate partner violence resulting from professional uncertainty or discomfort and women's fear of the ramifications of disclosure. Emergency clinicians routinely referred women to social workers after medical treatment and described effective collaboration across professions. Social workers outlined difficulties coordinating care with health and community agencies. Staff highlighted challenges maintaining non-judgmental attitudes and managing their own feelings - especially clinicians who had personally experienced violence.

Conclusions

EDs can provide caring environments for women experiencing intimate partner violence. Effective interprofessional teamwork across nursing, medical and social work professionals may mitigate the need for formal screening tools. Supportive workforce environments can improve staff understanding, reduce stigma, enhance appropriate treatment and counsel health professionals experiencing violence. However, staff training and advocacy, and referral relationships with local programs require strengthening. A connected multi-systems-level response is required to co-ordinate and resource services for all affected by violence.

Introduction

Intimate partner violence (IPV) is a significant public health issue in high income countries with an overall 12 month period prevalence of 4%[1]. IPV is largely perpetrated by men against women and is therefore a key determinant of women's and children's health that exerts a substantial burden on the health systems and economies of all nations [2]. IPV is defined as the preventable physical, sexual or psychological abuse of a past or current intimate partner [3]. This form of violence causes more illness, disability and deaths than any other risk factor for Australian women aged 25-44 [4]. In the United States IPV represents the second leading cause of death and injury among women of child-bearing age [5]. There are significant associations between lifetime experiences of partner violence and self-reported poor health [6]. In 2016, approximately one in four Australian women (2.2 million) had experienced intimate partner violence (IPV) [7], with an estimated annual cost to the national economy of $12.6 billion, including $617.2 million specifically on health costs [8].

IPV causes acute and chronic injuries, pain syndromes, depression, post-traumatic stress, substance-use disorders, and gynaecological and maternal health concerns [9]. Women experiencing IPV seek care from hospital emergency departments (EDs) three times more often than non-abused women [9]. Women experiencing IPV who present at EDs require immediate evidence-based care to ensure their safety and well-being [10-12]. Australian research has highlighted gaps in emergency health providers' responses to IPV, particularly the underreporting of IPV in regional hospitals [13]. For example, evidence for underreporting was found in one study where 4 per cent of women who did not report IPV indicated experiences of

abuse on nine measures of types of violence, including six taken from the Conflict Tactics Scale [14].

The ED is usually the first – and sometimes the only – place where women experiencing IPV interact with the health system. Women experiencing IPV are more likely to seek health care than to contact criminal justice or social services agencies [9,11]. This offers emergency clinicians a unique opportunity to identify, treat and enact a coordinated response, supporting women and managing their immediate and ongoing care [15]. While there are many reasons why IPV may be undetected in EDs, two prominent reasons are the reluctance of women to disclose such experiences and inadequate training of health care clinicians in the recognition of signs and symptoms of IPV [16-18].

There are relatively few studies in Australasian hospital EDs focusing on the experience of health professionals caring for women with IPV. Some research has evaluated education and institutional protocols to assist clinicians to identify and respond to IPV [19-21] and has demonstrated improved clinician knowledge, assessment and referral practices up to six months post implementation. Another study surveyed ED staff about screening practices [22] finding that medical officers and nurses lack knowledge and capacity to identify and respond to IPV. Qualitative research with ED health professionals remains limited. One New Zealand study interviewed 11 Emergency nurses about screening for partner abuse [23] finding that nurses who felt comfortable asking women about IPV were more likely to do so. Two Australian studies investigated the attitudes, perspectives and practices of Emergency nurses [24,25] reporting that nurses distanced themselves from women and felt that they were lacking in skills and

institutional support to adequately respond. There is therefore a lack of studies examining the characteristics that shape team work, decision making, practice and approaches to IPV by Emergency clinicians, .

This study aimed to examine the knowledge, opinions and motivations that shape the decisions and practice of teams of clinicians in busy metropolitan EDs when caring for women who experience IPV. We undertook a qualitative study to understand how nurses, doctors and social workers recognize and respond to IPV.

Methods

This study was informed by the concept of teamwork, specifically interprofessional collaboration (IPC). Petri [26] describes IPC as: the process of working together in a team with more than one person from a different professional group; working towards a common goal through mutual trust and respect, and with effective communication skills; recognition of different roles and responsibilities that contributed to outcomes. Literature has described the benefits of IPC in improving team work, patient-centered care [27] and clinical outcomes [28,29].

Study Design

Qualitative research has the potential to generate valuable new insights about how to best prepare, manage and support Emergency clinical teams to improve women-centered care. We adopted a descriptive qualitative design to examine participants' experiences regarding events and actions specifically related to IPV in their workplace [30]. As in naturalist inquiry[31], we sought to examine everyday responses to IPV and the associated knowledge and attitudes of ED professionals working in large metropolitan hospitals through semi-structured individual and

focus group discussions. The local health authority and university human research ethics committees approved the study.

Participants

We interviewed 35 health professionals across two hospitals (Table 1). This included fourteen face-to-face interviews and five focus groups, ranging from three to five nurse participants. Three social workers worked exclusively in the participating EDs; two worked occasional shifts in the ED in addition to other roles. Twenty-eight participants were female. The seven men were doctors or nurses.

Table 1: ***Hospital characteristics and study participants***

Setting

The study took place at two tertiary teaching hospitals in metropolitan locations. Both are public hospitals with about 600 beds; their EDs received approximately 80,000 presentations in 2016 [32]. Both are comparable with respect to attendance patterns, clinical leadership positions, under/post-graduate training, staff education programs, information systems, resources and staffing. They were selected for their diverse catchment areas: Hospital 1 is located within 10km of the city centre in a relatively affluent area of the city; Hospital 2 lies within 20 km of the city centre and serves an area that is younger in age profile and more mixed ethnically and socio-economically.

Recruitment

The lead author met the senior staff in each hospital to seek interest and support for the study. This was facilitated by one author [de-identified] who is an academic emergency nurse. The study was open to all clinical staff working in the two EDs. They were invited to participate via a flyer and information sessions provided by clinical nurse consultants in both hospitals, who arranged convenient interview times with interested individuals. We used purposive heterogeneity sampling[33] to recruit clinicians in the two EDs to identify common patterns across the three groups of health professionals. Clinicians were therefore recruited purposively by clinical nurse consultants who gave targeted information sessions to doctors, nurses and social workers and gained consent for the researchers to contact them. Table 1 indicates response rates.

All respondents gave informed consent to participate in the study. Interviews and focus groups were held until the concurrent analysis process revealed saturation of themes and no new insights. At this point, all researchers agreed that saturation had been reached and recruitment and interviewing ceased[34]. No participants dropped out of the study.

Interview and focus group discussions

Three female researchers, comprising two nurses and one public health social scientist, conducted the interviews and focus groups in hospital training rooms. One author worked in the hospital where she conducted interviews, but not in the ED. The discussions took place between July and December 2016 and lasted between 13 and 49 minutes. Twenty-one nurses participated in seven focus group discussions held during continuing professional development sessions; more senior nurses (nurse unit managers), clinical nurse educators, doctors and social workers were interviewed individually after their shifts. This approach was tailored to participants'

149 workload and time availability. While the environment of the interviews may have been more
150 conducive to sharing personal details about their experiences, focus groups rendered a collegial
151 setting where nurses were able to build upon and confirm each other's experiences, perceptions
152 and needs.
153
154 The interviews and focus group discussions were audio-recorded with participants' consent,
155 professionally transcribed and then imported to NVivo 11 for management and analysis. The
156 transcripts contained no identifying information.
157
158 A semi-structured schedule (see Figure 1.) was systematically used for all focus group
159 discussions and interviews and consisted of eleven questions. These addressed participant
160 experience with women experiencing IPV (Qs 1, 2, 4 and 6), the ED's policies and procedures
161 for working with affected women (Qs 3, 4, 7, 8 and 9), challenges in providing effective care (Qs
162 2, 5, 8 and 10) and suggestions for new policies services or processes for caring for women who
163 have experienced IPV (Qs 5, 6, 9 and 11).
164
165 **Data analysis**
166 We analyzed the data thematically following the approach outlined by Terry et al. [35]. We initially
167 grouped responses according to interview questions to gain a sense of the data. The data were
168 then coded iteratively, line by line led by one researcher in discussion with the other researchers
169 who undertook the data collection. Categories were then determined based on emergent patterns.
170 These were discussed with all authors and categories combined and re-named as themes.
171

Results

The analysis resulted in seven themes related to identifying women experiencing IPV, meeting their needs appropriately, and responding to the challenges of IPV personally and professionally. Themes are outlined in Table 2 and illustrated by quotes from participants from all professions and both hospitals.

IPV: identifying a hidden problem

Most respondents recognized the pervasiveness of IPV. However, many affected women were reluctant to disclose IPV, hampering identification by Emergency health professionals. Some clinicians were unsure about recognizing signs and symptoms of IPV. Despite these challenges, some respondents reported improved capacity to identify women presenting with IPV, following education programs and greater public awareness. Several respondents felt better able to identify women with IPV over time as they became more experienced and exposed to the range of emergency conditions.

Respondents reported that some women were more inclined to reveal IPV to female doctors or to nurses; the gender of clinicians may influence a woman to disclose her injury and situation.

Asking the right questions

Some respondents referred to asking the “right questions”, which might encourage women to disclose IPV and stay at the ED. One social worker suggested “more direct” questioning (Social Worker1 Hospital 2) as the best approach, while others highlighted different ways to gain rapport: “you need to be non-judgmental; you have to be kind and soft” (Doctor 4 Hospital 1).

Other clinicians reported feeling uncomfortable asking about IPV and that they lacked skills in eliciting disclosure.

One nurse noted that she hesitated when questioning women "because there's been situations in the past where a nurse asked all the questions and the social workers thought that that impacted on *her ability to open up later on down the track*" (Nurse 6 Hospital 2, emphasis added). Although respondents agreed that nurses should pursue and potentially confirm their suspicions, social workers maintain responsibility for investigating potential and confirmed IPV and for counselling women.

Some nurse and medical participants indicated that standardized questioning for IPV was not common practice within their EDs; some were unaware of any formal screening tools. Others felt that screening for IPV in addition to other risk factors in ED would be burdensome. Clinicians were also largely unaware of IPV-related polices, directives and protocols, although one manager described "a pathway, the domestic violence pathway… and every month or so I scan it and send this out to staff… It's on our website" (Nurse Manager 1 Hospital 1). One doctor reflected that knowing about such documents was not enough "Nearly always our issue is three-fold: identifying, knowing there's a policy and knowing how to use it, and the fact that it's actually there" (Doctor 4 Hospital 1).

Clinicians routinely reported referring to social workers after asking brief questions. Social work participants were clear about hospital protocols for responding to IPV; they reported using some questions to elicit a woman's situation rather than specific screening tools. Social workers were

actively involved in educating ED staff, offering in-service and mandatory training about recognizing and communicating with women about their experiences of IPV.

Despite the ED's potential for identifying and caring for women experiencing IPV, many respondents recognized practical limitations, given the physical environment and hectic pace in most EDs.

Women may attend EDs for IPV-related conditions accompanied by the perpetrator, adding to the complexity of communicating with women about violence. Nurses and doctors described strategies they used to give women the opportunity to disclose.

Keeping women safe

ED clinicians highlighted their role in establishing women's immediate safety as well as treating medical conditions and potentially planning longer-term options. Participants referred to various strategies employed to separate women from suspected perpetrators who accompany them to hospital and to support women remaining in the ED overnight and seeing the social worker.

Staff also recognized security concerns particularly when the suspected perpetrator wished to accompany or visit the women.

Social workers reported emphasizing to women that they were welcome to return to the ED if they felt unsafe. Two participants specifically mentioned how some women re-presented given the opportunity, such as during office or school hours.

"Call social work"

Nurses and doctors described the accepted practice of referring on to social workers any women with disclosed or suspected IPV once they had provided the necessary medical care. One doctor encapsulated ED procedure: "So I think our system is: call social work" (Doctor 1 Hospital 2). Women were referred to social workers regardless of their requests or wishes.

Working as a team

There was a strong sense of collaboration between staff in the ED in both hospitals when describing the response to IPV: "the team part, that communication between us all is really important" (Nurse in Group interview 5 Hospital 2). This collaboration extended across nursing, medical and social work professions.

Clinicians clearly appreciated the role social workers played: "I think social work is our biggest fallback and our biggest support" (Doctor 1 Hospital 2). Many respondents described the trust and collaboration between professions; two social workers specifically reported feeling "very respected" (Social Worker 2 Hospital 2).

All professionals acknowledged their specific role within the team, collaborating to ensure women receive necessary medical care and support. Social workers were also clear about their role focus that was to address women's safety and psychosocial needs while supporting clinicians to deliver medical care.

Providing continuous care

Social workers are critical to supporting women presenting to ED. However, both the resources constraints in most EDs and their primary purpose of providing immediate medical care limit their capacity to provide longer-term support or advocacy. Social workers also recognized their limitations in providing continuous care from their position in ED.

Participants described multiple services and facilities to help women experiencing IPV. They listed crisis housing, albeit as “last scenario” given the disruption it causes to young children, and liaison with police, Centrelink (government income support) and child protection authorities if appropriate. Yet, several participants reported the limited support options available to women attending ED in crisis. Many IPV agencies are over-loaded, unable to support women discharged from the ED. Community services are often unavailable after-hours, further limiting options. Respondents highlighted the need for better coordination and integration of services across acute health and community sectors at all levels.

The intersection of the personal and professional

Participants discussed their personal experience of IPV and how their interaction with women with IPV had affected them. Some participants noted that it was sometimes hard to control their values and feelings about the women involved and the perpetrators.

Clinicians encountered IPV not only professionally; some also spoke of their direct personal experience.

Discussion

This qualitative study provides important insights into the knowledge, attitudes and practices of professionals in large metropolitan EDs about IPV. The findings indicate consistent teamwork and commitment to keeping women safe. Many nurses and doctors were not aware of screening tools or IPV-related polices and protocols within their hospitals. Social workers were cognizant of hospital directives but did not use screening tools. Nearly all emergency nurses and doctors were clear about the need to refer to social workers if they suspected IPV or if a woman had disclosed it.

There is insufficient evidence to support universal IPV screening in health-care settings, with a recent Cochrane review concluding that targeted strategies may be more effective [36]. The authors propose training "health professionals to ask women who show signs of abuse or those in high-risk groups, and provide them with a supportive response and information, and plan with them for their safety" [36]. In our study, emergency clinicians reported that training; increased experience and public advocacy had helped them to consider IPV when assessing women in the ED and to refer to social workers. Despite this, some nurses felt uncomfortable asking women potentially sensitive questions and cited the challenge of engaging in meaningful rapport with women in the fast-paced ED environment where maintaining privacy can be difficult. This highlights the need for role clarification of different providers, to ensure providers do not ask women the same questions, thereby reducing unnecessary additional trauma and improving efficiency,

While the World Health Organization recommends women-centered care as key to health service responses to IPV [37], the ED's focus on medical emergencies means that appropriate referral is required to facilitate appropriate in-depth primary and social care [11,38]. This highlights the importance of female clinical staff reiterated by participants in our study. Other research has noted that female healthcare staff score significantly higher than their male counterparts in understanding abusive relationships[39] and that women show a preference for female staff, significantly staff who are empathetic and compassionate[40]. Staff with lived experience of IPV may also be beneficial in supporting women[41]. While female staff, or those with lived experience may be unavailable to attend to women presenting with IPV, appropriate attitudes and knowledge remain key to effective detection and communication with women. This requires targeted professional training and supportive supervision.

Our study also draws attention to the central role of social workers to deliver women-centered care within the ED. This highlights the importance of adequate workforce planning, resourcing and support particularly for social workers to counsel and refer women. Emergency clinicians were consistent in alerting social workers when encountering women with IPV. While they did not always consult the women specifically, their intention appeared to be to provide them with the opportunity for individualized and confidential consultation. Recent research has investigated trauma-informed organizational models of care, noting women's voices and the need for private one-on-one consultations in the ED with social workers[42].

Counselling and referral for ED patients has been found to increase women's willingness to complete safety plans and access local IPV resources [43]. On-going training for social workers is

essential to increase referrals to advocacy services [44] and improve the identification of women affected by IPV [45]. Training programs have been found to be more effective if conducted in conjunction with changes at system and organization level, including standardized documentation and protocols for improved assessment, management and referral [21,46]. Training must also aim to improve clinicians' knowledge of national and local hospital policy on IPV and to raise awareness of screening tools.

The healthcare partnership between the ED social worker and the broader health system is critical to linking women experiencing IPV to community, social and primary health care services. However, due to the complex nature of IPV and the numerous sectors involved, continuous and coordinated care is challenging. In our study, participants described repeat ED attendance for non-urgent issues, demonstrating that women are not always able to access the care they need in the community. Formalizing links between the ED social worker and community, social and primary health care agencies may assist to strengthen relationships and build a broader safety net for those at risk or experiencing IPV.

Clinical contact with IPV raised strong emotions among the health professionals in the sample, although they did not indicate that they felt it affected the care they provided to women. Feelings about perpetrators did appear to reinforce their resolve to keep women safe within the ED. Professional development about IPV issues should address clinicians' own responses, mindful of the fact that some may have personal as well as professional experience of IPV.

Improved referral relationships for IPV could help support professionals across sectors to better co-ordinate their actions to respond and support women. For example follow-up outreach through home visiting has been effective in minimizing IPV and improving outcomes [47]. In the case of women with young children, child and family health nurses, or social workers within child protection agencies in collaboration with the ED social worker could facilitate this. This requires more than a comprehensive health system approach to IPV [48], and demands a coordinated multi-sector process that acknowledges the complex social determinants of violence. This approach is recognized by the United Kingdom's safeguarding measures that co-ordinate responses to abuse and neglect for children and adults at risk, including women affected by IPV [49,50], through integrating care and support across local authorities and health services.

While our research indicates that health professionals take responsibility for their emotional well-being, the study has also highlighted the importance of workplace-based confidential counselling and leave for staff who are experiencing IPV. The prevalence of IPV among health professionals been found to be higher than the general population, calling for health workplace policies and protocols to acknowledge this common trauma[41]. The Royal Women's Hospital in Victoria Australia has, for example, established a new program "Strengthening Hospital Responses to Family Violence" [51] that provides training for healthcare workers to support both staff and patients. In addition, the Victorian Government has introduced several policies to help staff who have experienced IPV, including access to twenty days of family violence leave[52].

Limitations

The study was potentially limited by its focus on women rather than on all individuals experiencing IPV. Sample bias may be present given participants self-selected and comprised

clinicians who expressed interest in discussing IPV. Notably, even within this sample, some respondents indicated limited awareness of women experiencing IPV. Moreover, findings rely on self-report, rather than observation or documentation of actual practice. The focus on large metropolitan hospitals may differ from other settings – facilities and resources may be more limited in smaller hospitals, and women seeking health care in smaller communities may face additional issues of privacy or limited ongoing support options.

Conclusions

Emergency departments can provide compassionate, immediate treatment and referral for women experiencing IPV. This study demonstrates effective interprofessional collaboration between all professionals in two busy metropolitan EDs with the aim of optimising the health and safety of women experiencing IPV. It further illustrates that social workers play a key role an anchoring the professional team together and optimising the transition of care back to the community for women experiencing IPV. The research identifies the need for role clarification around detecting IPV to improve the quality of care. Staff training and advocacy, and referral relationships with local community programs also requires strengthening.

An integrated multi-systems-level response is required to better co-ordinate and resource services for all affected by violence. Supportive workforce environments can improve staff understanding, reduce stigma and counsel health professionals experiencing violence.

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