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'It's a challenging environment' health worker perspectives on domestic violence presentations to emergency departments in New South Wales hospitals in the context of the COVID-19 pandemic

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Abstract

Background Domestic and family violence (DFV) is a significant issue in Australia, with one in four women experiencing DFV in their lifetime. Emergency departments (EDs) within public hospitals are a priority setting for identifying, treating, and referring those at risk through sensitive clinical inquiry. However, there remains a dearth of evidence regarding health staff's knowledge, skills, and confidence in addressing the burden of DFV from their perspective. This research aims to address the evidence gap from the perspectives of health workers working within a diverse range of public hospital EDs in New South Wales (NSW), Australia, at the time of the COVID-19 pandemic.

Methods Semi-structured interviews were conducted online, adhering with COVID-19 restrictions at the time, and thematic analysis performed.

Results While EDs within NSW hospitals are often a first port of call for those experiencing DFV, clinician health staff perceive overwhelmingly, that they lack the capacity individually and institutionally to appropriately address presentations and had little knowledge of existing policies and procedures.

Conclusions Policy and programmatic solutions to the capacity gap need to be current, highly feasible for an ED environment and ongoing to account for rotating staff and the evolving nature of DFV presentations. The preparedness of EDs within public hospitals in NSW will be crucial to the success of strategic initiatives and recent historic law reforms in supporting victim-survivors and preventing DFV.

Keywords Emergency medicine, Family violence, Public health policy, Women's health

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Introduction

Australia is currently facing an epidemic of domestic and family violence (DFV). Nationwide, one in four women will be subject to DFV during their lifetime [1]. Every nine days, a woman loses her life at the hands of her current or former partner [2]. DFV remains the single greatest cause of death, ill health and disability for women aged under 45 [3]. DFV includes any behaviour, in an intimate or family relationship, which is violent, threatening, coercive or controlling, causing a person to live in fear and to be made to do things against their will [4]. In New South Wales (NSW), Australia's most populous state, forms of DFV including intimidation and stalking have more than doubled in the past decade [5]. This escalation has been partly attributed to increased awareness within the policing system of what constitutes DFV and policy tools guiding police on how to record instances as a criminal offence. However, it also reflects persistent and unacceptable violence against women. Further, the COVID-19 pandemic increased vulnerability to DFV due to social isolation and situational stressors such as financial stress and job security. These factors exacerbated barriers to help-seeking for victim-survivors and those at-risk of DFV [6]. In accordance with Australia's National Outcome Standards for Perpetrator Interventions, the term "victim-survivor" is employed in this paper, as it describes women and their children who have experienced domestic, family and sexual violence by a male perpetrator. This terminology recognises the gendered nature of such violence, which disproportionately affects women and their children, and inclusively encompasses children within its scope. While the term victim-survivor is used throughout this paper, the authors acknowledge the use of alternative language, such as 'women who experience violence,' focuses on the behaviour inflicted upon women rather than labelling the woman herself [7].

While the policing system is often seen as the first port of call for those experiencing DFV, reporting to police can be problematic and challenging for victim-survivors. Disclosure frequently occurs through other pathways including Emergency Departments (EDs) within public hospitals. This is reflected by the NSW Government's framework for DFV '*It Stops Here*', which acknowledges that routine screening through the public health system (in addition to other mainstream services including general practitioners and housing providers) are common pathways for seeking protection and care [8]. Adequately resourced and well-trained health staff are crucial to DFV victim-survivor safety. Previous research from the United States (US) has found that a third of women victim-survivors aged 16 years or older presenting to EDs and seen for intimate partner violence, when assessed on a validated lethality risk tool, were at very high risk of being killed by their partners [9]. Other US research has shown that 44% of women (i.e., 15/34) who were ultimately killed by an intimate partner sought help in an ED in the two years prior to their death [10]. The women in that study presented for injuries, perineal lacerations, rape and one suicide attempt. While 53% had evidence suggestive of battering, only 2 cases involved documented domestic violence, and intervention was taken in none of the cases.

EDs receive victim-survivors with a broad range of needs including severe and permanent injuries. Every week in Australia, at least three women are hospitalised with a brain injury as a direct result of family violence [11]. For these reasons, EDs are categorised as a priority setting within NSW Health for DFV, whereby health workers are expected to be skilled at preventing, identifying, and responding to DFV through sensitive clinical inquiry [12]. The capacity of a health worker to address DFV is not an inherently fixed status (e.g. either sufficient or insufficient). Instead, capability is a dynamic and context-specific state. A health worker may be adequately prepared with regard to capability to respond in one context and yet can also be under-prepared in another context. For instance, they may exhibit proficiency in handling culturally and linguistically diverse patients or addressing physical violence, yet encounter challenges when dealing with coercive control. This dynamic nature of capability underscores the need for a nuanced understanding, acknowledging that competency evolves in different contexts and situations. Yet, there is a dearth of evidence demonstrating the preparedness of ED health staff (in terms of knowledge, skills, and confidence) as conduits between health, social services and the justice system.

This research aims to address this gap by investigating the experiences of health workers (i.e., social workers and other clinicians) operating within EDs across NSW hospitals in the context of COVID-19. Specifically, the study explores: 1) how health workers experience DFV presentations within the ED, 2) how health workers perceive their roles and responsibilities in identifying, treating and referring these presentations and 3) the experiences of health workers in addressing the psychosocial needs of victim-survivors – including perceived barriers and opportunities to provide comprehensive care and support.

This work comes at a critical time. In 2022, NSW announced that it would become the first Australian state or territory to create a stand-alone offence for coercive control. Coercive control is a form of DFV involving patterns of behaviour that have the cumulative effect of denying victim-survivors their autonomy and independence. In the same year, the federal government announced a legal entitlement to ten days leave for DFV victim-survivors. While the reforms have been hailed as

historic and potentially life-saving, the effectiveness of these protections will be shaped by how DFV presentations are received and governed, with health staff within EDs as critical first responders.

Background

Overview of DFV governance in NSW

The State's health department, NSW Health, is one of two main departments responsible for addressing DFV including the Department of Communities and Justice. NSW Health oversees and funds responses to DFV delivered through the health system. The NSW Health Strategy for Preventing and Responding to DFV (2021–2026) aims to strengthen the public health system's role by identifying actions to ensure NSW Health staff obtain the support they need from the system to prevent and respond to DFV.

NSW also has in place a number of programs focussed on coordinating prevention efforts, and care for victim-survivors. The *Safer Pathway* Program provides a coordinated service delivery model for DFV victim-survivors across NSW including a streamlined referral pathway [13]. The *Integrated DFV Services* program provides a multi-agency response to prevention in high-risk target groups and targeted communities, and the *Staying Home Leaving Violence* program works in cooperation with NSW Police to remove the perpetrator from the family home so that victim-survivors and their children can stay safely in their home [14, 15]. Non-government advocacy programs support the state government through the provision of services including in assisting women in obtaining effective legal protections including Apprehended Domestic Violence Orders (ADVOs) and supporting those at risk of homelessness [16, 17].

Over the last decade, DFV has been a major priority for governments of all political persuasions. In 2015, the NSW Premier's Priority was to reduce DFV reoffending by 25% by 2023, a goal which has not yet been achieved. The *NSW Domestic and Family Violence Plan 2022–2027* now essentially extends this priority to 2027. At the time of preparing this paper, the NSW government changed hands with the opposition party for the first time in 12 years. It therefore remains unclear which of these programs and strategies will continue, and it is an optimal time to address gaps in implementation.

The governance of DFV within the health system

While there is a wealth of resources within the NSW Health system for practicing sensitive clinical inquiry regarding DFV, there may be gaps in their accessibility and relevance for ED health staff. The *Domestic Violence Routine Screening* (DVRS) program is a longstanding state-wide initiative for all women using maternity, child and family, mental health and alcohol and other drug services - not EDs [18]. Further, child protection and wellbeing concerns are a major pathway to identification, with 30% of the 16,000 annual contacts to the health Child Wellbeing Unit (CWU) from health workers involved in DFV. The CWUs assess risk and plan early interventions with health workers to prevent the need for a report to, or intervention by, the statutory child protection system whenever possible [19]. However, this is a child-focussed (rather than adult victim-survivor) service for public health workers to engage with if they have concerns about the safety, welfare and wellbeing of any child, young person, or unborn child in NSW.

Learning and development trainers offer evidence-based training and resources to support health workers through the Health Education and Training Institute and Prevention and Response to Violence, Abuse and Neglect (PARVAN) workforce (both NSW government initiatives). In addition, NSW Health has developed a DFV Flipchart intended to be an important resource for clinicians who receive disclosures of DFV. It is tailored to each district and provides brief guidance on responding to disclosures, supportive responses, and appropriate referral to state-wide and local services. An additional flip chart is available for culturally and linguistically diverse clients including information to support health workers when engaging interpreters.

Finally, the Policy and Procedures for Identifying and Responding to Domestic Violence manual was published in 2006 and is largely outdated despite a 2022 review, though an update is a priority action under NSW Health's 2021–2026 strategy [20]. As of now, it includes a section on EDs, but the most recent research informing the guidance is from 1995 (almost 30 years ago) [21]. Compliance with the policy remains mandatory. Healthcare practitioners are considered mandatory reporters and are required by law to report suspected child abuse and neglect to government authorities. With regard to adult victim-survivors of DFV, health workers have a legal obligation to report domestic violence to NSW Police in situations involving serious injury, threats with weapons, or an immediate risk to the safety, regardless of the victim's wishes. This reporting duty is intended to ensure the safety and well-being of victims and others, while also maintaining a safe environment for patients and staff [21].

Methods

Study design

This study aimed to explore the experiences of health workers within EDs in NSW hospitals in relation to their perspectives on how DFV presentations are identified, treated and referred to internal and external services. A qualitative approach was used to gather rich, detailed data through semi-structured interviews with

participants from a diversity of hospitals. Semi-structured interview schedules including pre-determined questions (Appendix A) were used to elicit participant perspectives. This approach was well suited to this study because it allows for specific enquiry and provides opportunity to spontaneously explore issues relevant to certain institutions and departments involved in the treatment and prevention of DFV. COVID-19 was both a contextual factor affecting the data collection process and a theme that emerged within the analysis, particularly in relation to changes in ED capacity, staff workload, and challenges in addressing DFV during the pandemic.

Participants

The study recruited a purposive sample of health workers employed within EDs in metropolitan, rural and regional hospitals across the state of NSW, Australia. Participants were selected based on their experience working in EDs, regardless of their specific involvement in providing care to patients experiencing or at risk of DFV, or more broadly with psychosocial needs. A summary of the participant and hospital characteristics are detailed in Appendix B.

Data collection

Recruitment and data collection was ongoing from October 2020 to February 2021, during the first wave of the COVID-19 pandemic in Australia. The study utilised semi-structured interviews conducted via videoconference in adherence to pandemic-related restrictions. During this time, Australia experienced relatively few COVID-19 cases compared to international standards. However, the impact of the pandemic on the study focussed less on case load, and more on substantial disruptions and restrictions to services. The interviews were carried out by the lead researcher (JS) and a research assistant (EL), both of whom had experience conducting qualitative interviews.

The research team identified and made contact with potential participants using the senior author's (VK) existing email list of NSW EDs. This list was developed firstly, by obtaining the Emergency Care Institutes' website listing all NSW EDs and their levels and secondly, by populating the list with contact details through calls to each hospital. There was no pre-existing personal dynamic between the interviewers and interviewees. A maximum of two follow up emails were sent, and potential participants were given the opportunity to refer us to other potential interviewees if they did not have the capacity (in terms of time, or knowledge) to participate. Interviews were audio-recorded by the research team and transcribed verbatim by a professional transcription service. Interviews lasted between 20 and 50 min. The decision to cease recruitment was informed by pragmatic considerations and when we reached consensus that the data had yielded sufficiently useful and rich information, which was determined through our iterative analysis of the data.

Data analysis

Data analysis was conducted using a thematic analysis approach, informed by the framework outlined by Braun and Clarke [22]. Two authors (JS and EL) initially familiarised themselves with the data by independently reading and re-reading the transcripts to gain an overall understanding of the content. They then employed an inductive approach to generate initial codes, which were closely linked to the data without preconceived categories. The authors compared their codes and resolved any discrepancies through discussion and consensus, leading to the development of a preliminary coding framework. This framework was refined iteratively, and the final coding structure was applied to all transcripts using NVivo software (Version 12). The authors grouped the codes into broader themes by identifying patterns across the data, with the themes developed and refined through ongoing discussion to ensure they accurately reflected the data's content and meaning. Finally the themes were reviewed by the authors to ensure they were representative of the data and coherently linked to the research questions.

Ethics

Prospective ethical approval was obtained from the University of New South Wales Human Research Ethics Committee (HC200379). All participants provided informed consent prior to their participation, and their confidentiality and anonymity were protected throughout the study. To allow hospitals to freely discuss their experiences, we have also deidentified the names of the participating hospitals in this paper, leaving only their institutional characteristics.

This study forms part of a wider project titled, 'Responses to domestic and family violence during the COVID-19 pandemic' funded under the University of New South Wales Rapid Response Research Initiative. Reporting of our findings was informed by the consolidated criteria for reporting qualitative studies (COREQ) [23].

Rigor and reflexivity

To enhance the rigor of the study, several strategies were employed. Multiple sources of data were collected, including interviews with various health workers (social workers and other clinicians) from different hospitals and geographic locations.

The research team holds experience in public health law and policy, emergency medicine, obstetrics and gynaecology and public health (with specialised expertise

in gender-based violence research). Authors JS and EL conducted all interviews and as non-health workers were able to undertake the research without assumptions about the way specific hospitals may engage with DFV cases. Reflexivity was employed to acknowledge and address researchers' own biases and assumptions, which were discussed and reflected upon throughout the research process.

Results

We generated three distinct themes. These themes were common between the district and tertiary hospitals: 1) experiences of DFV presentations in ED, 2) navigating the system: institutional and staff constraints, and 3) barriers and opportunities for improving DFV care, 15 subthemes were identified (Table 1). The 30 participant transcripts, representing interviews conducted with 30 health professionals (see breakdown in Appendix B), revealed for those that are at risk or experiencing DFV, EDs within NSW hospitals are often a first port of call. Secondly, staff and the hospital settings they work within lack the capacity they need to appropriately and sensitively address such presentations. Finally, staff felt that policy or programmatic solutions to the capacity gap needed to be highly feasible, engaging, and ongoing. There were key differences in the data emerging from medical and nursing ED clinicians and social workers, largely due to the way roles are structured. Medical and nursing clinicians emphasised their lack of knowledge or capacity in identifying DFV presentations, especially where patients had presented due to other conditions. Social workers lacked visibility over those at risk of DFV as they relied on medical and nursing clinicians to identify them in the first instance. Smaller hospitals were more likely to cite under-resourcing, and the need for policies and procedures to be tailored to the needs of smaller, rurally located hospitals.

Theme 1: "People were not accessing services the way that they normally would": experiences of DFV presentations in EDs within NSW hospitals during COVID-19

Across the diverse range of hospitals included in the study, health staff widely recognised DFV presentations as a frequent occurrence, though their impressions varied based on hospital size and context. However, in the absence of systematically collected data, the true extent of DFV presentations remained unclear. While many staff shared a general understanding that the COVID-19 pandemic exacerbated DFV, there was no consensus on whether presentations had increased, decreased, or remained unchanged, reinforcing concerns about unidentified cases due to the data gaps.

Uncertainty due to the lack of routine data collection

Without systematic data collection, staff relied on their own observations, which remained anecdotal and fragmented across different roles. Many described uncertainty in whether their personal experiences reflected broader patterns in ED presentations.

> *"...I think just from conversations I've had with people, relationships have been strained due to COVID. Relationships have existing violence within them possibly have – it's harder for women to get any time for themselves often because their families are all under the same roof. You know there has been an impact but whether that has increased presentations I couldn't say"* [P3, social worker, district hospital]

Some staff felt that the lack of data allowed DFV to remain a neglected issue within EDs. There was no formal obligation on clinicians or teams to be aware of DFV presentations occurring week to week, and knowledge about DFV presentations often stayed with social workers with little communication between other staff.

> *"It's not a question for me to be answering because I'm not sure as to what our presentations in regard to domestic violence has been...I think social work would have more of an idea"* [P12, emergency physician, district hospital]

Health workers' experiences of DFV presentations during the COVID-19 pandemic

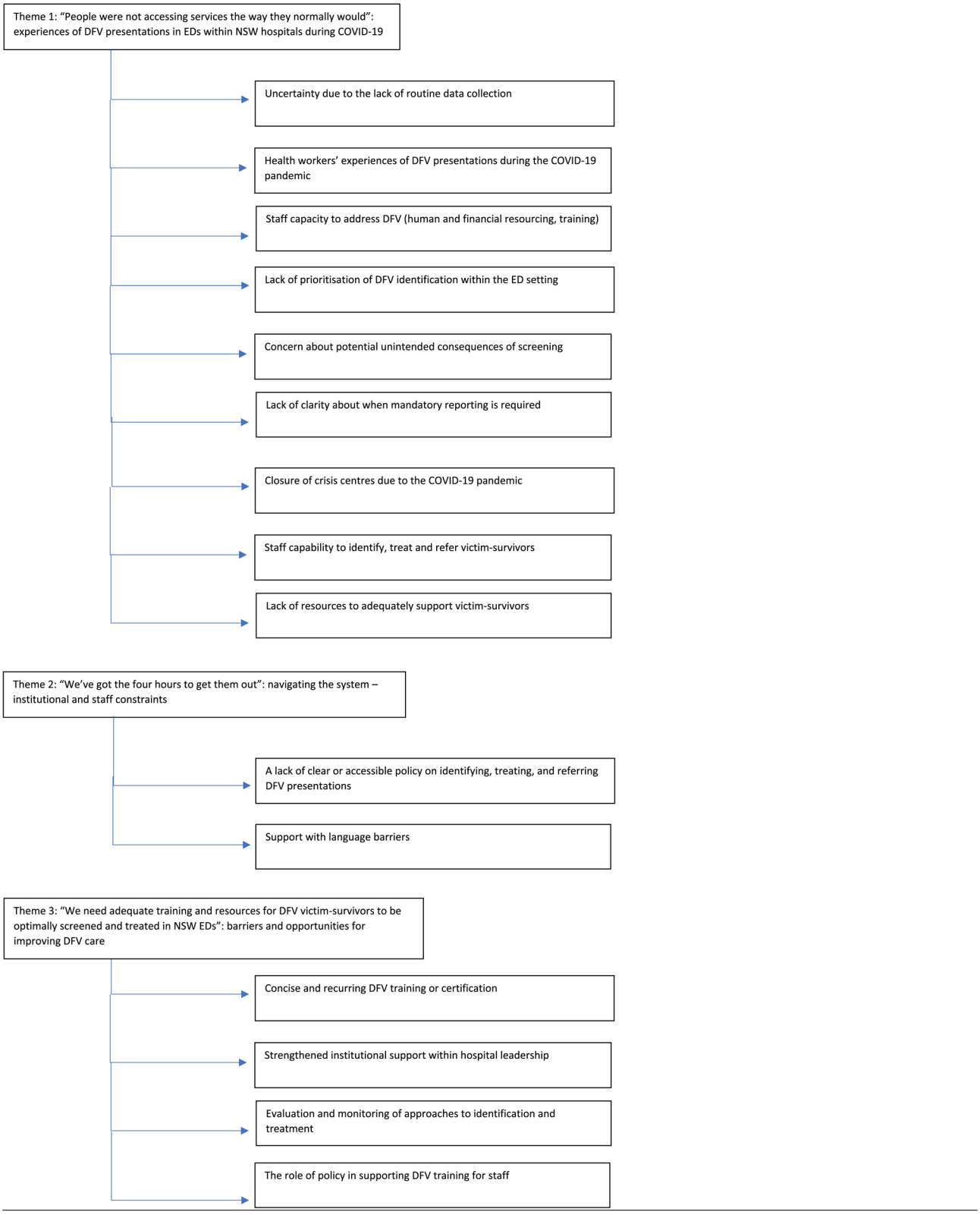
Many participants perceived that the pandemic had worsened DFV due to confinement at home, lost employment, economic pressures and social stressors and higher drug and alcohol use. Some staff described an increase in cases involving children and adolescents, as caregivers struggled to maintain safety to keep the rest of the family safe at home. Others observed a decline in DFV presentations in EDs, which they attributed to fear of COVID-19 exposure and barriers to accessing healthcare.

> *"People were not accessing services the way that they normally would have because they were too scared of COVID, well that's what we were assuming"* (P2, Emergency Physician, District Hospital)

Some clinicians had expected a rise in presentations but instead saw an increase in mental health concerns and suicide attempts, particularly among younger people.

> *"...although we saw absolutely a lot more mental health presentations, suicide attempts and a lot more younger people than what we would normally see, I didn't see the increase in domestic violence I*

Table 1 Qualitative themes and sub-themes analysis



was expecting". [P29, emergency physician, district hospital]

In these cases, clinical staff felt strongly that the fear of contracting COVID-19 kept presentations at bay.

"Women would hesitate to come…whether the night after the incident, or the next morning, or it might be three days after where they are continuing to have pain in some part of their body and primarily come in for that medical review [rather than their ongoing experience of DFV]" [P14, nurse clinician, tertiary hospital]

"We went from having an Emergency with a welcoming front door to promote accessibility, to nursing and security staff standing outside the building in a tent with significant personal protective equipment on, and that obviously sends the message that staff are worried about this disease…" [P8, emergency physician, district hospital]

Some staff hypothesised that victim-survivors may have sought help elsewhere, such as GP clinics or police stations, to avoid the perceived risk of infection in hospitals.

It was also expressed that it was likely that many survivors or those at risk had presented without it having been identified. DFV was not seen to be an institutional priority due to the critical and infectious nature of COVID-19 presentations, and the usual practice of alerting social workers in cases where DFV was suspected, was disrupted due to the pandemic.

Other hospitals, specifically those that played a role in governing those undertaking hotel quarantine did see an increase in DFV presentations.

"It's in the context of people obviously being in an underlying stressful situation having to return, they're often returning for things like a death in the family or there's medical issues…they've come back in a fairly uncertain time, a lot of emotional upheaval and they're put into a quarantine hotel where they don't get out much, don't have access to vices like smoking, and they're in a small room…any issues that may have pre-existed are being exacerbated in that environment". [P19, emergency director, tertiary hospital]

Some staff observed that as the pandemic forced smaller towns into lock downs, women presented to EDs because of a lack of access to other health and social services.

"…the patients had no knowledge of the place to go for help…partly because of the controlling environment [at home]". [P10, emergency physician, tertiary hospital]

Some social workers observed no difference in the number or nature of presentations were observed.

"You know for me based in the ED I think it's pretty much been the same. We've always had sort of high numbers of domestic violence and during the pandemic it didn't really increase for us in Emergency". [P6, social worker, tertiary hospital]

Theme 2: "We've got the four hours to get them out" navigating the system: institutional and staff constraints

Some staff expressed that while EDs continued to play a critical role in identification and treatment of victim-survivors, institutional constraints, staff capabilities, and systemic barriers could hinder effective intervention.

For example, junior clinical staff felt that DFV was not an issue that was taken seriously within the ED.

"…there is a bit of eye-rolling, 'Oh for goodness sake get out of my Emergency unless this is serious' sort of attitude amongst all nurses and doctors to some extent, because there is so much that you're just wasting my time if it's not something serious like you've got a broken arm or you've had a heart attack, or if it's not something really obvious and serious that we can pinpoint" [P30, emergency physician, district hospital]

Some participants questioned whether EDs were appropriate for addressing DFV given the lack of appropriate DFV expertise, fragmented relationships with social services outside the hospital setting, and limited opportunities to follow-up with patients. Others believed that screening for DFV would be futile, due to what they perceived to be insufficient evidence that screening and referrals in EDs would lead to reduced incidence of DFV. Some felt DFV was too complex to deal with within the administrative and resource constraints of an ED.

"I think there's maybe a slight sense of…I can't do anything about it kind of frustration about not being able to break the cycle [of violence]…I think there's a degree of staff not really knowing how to help" [P7, emergency director, regional hospital]

Others expressed concern about potential unintended consequences of screening and when mandatory reporting is required:

"Even as a senior clinician, I think my understanding has changed…I have to look it up every time because

> *there are degrees [of seriousness]. I mean there's no question about if there are kids involved, that's an easy one. But beyond that it's always a bit of a – you know your patient confidentiality versus true risk to death of the person involved and it's very hard to judge"* [P9, emergency physician, district hospital]

In the context of the COVID-19 pandemic, health staff said this ambiguity was made worse by their difficulties in referring victim-survivors to crisis centres or services due to closures.

A common perception amongst staff was that not everyone had the ability to have sensitive conversations with victim-survivors, and that some staff were naturally better suited to identifying subtle cues, confidently asking difficult questions, and responding.

The Head of Department within one ED expressed that a standardised approach would be impossible because presentations were so varied:

> *"You could even have the same clinician talk to [survivors] and in those ten different situations elicit different responses"* [P18, emergency physician, tertiary hospital]

One senior clinician questioned whether some of the soft skills required for screening and treatment could be taught. This interview participant suggested this would likely lead to many missed cases as the patients that were not identified as at risk or experiencing DFV would not be referred to a social worker.

> *"There are limits to what education and training programs can achieve. It is subtle and no matter how much training you do for someone like interns, they will never get it. Some people for whom it's just not in their empathy basket."* [P9, emergency physician, district hospital]

Staff felt frustrated by the lack of institutional capacity and resources to support them in addressing DFV presentations.

> *"…it's very draining for staff, it's very traumatic for patients and relatives affected by it and there's a frustration felt by the ED staff that we see it [DFV] but we have limited resources and opportunities to make a real kind of lasting change, just by the nature of our work and core business".* [P5, emergency physician, district hospital]

Health staff described that while in theory processes and approaches for dealing appropriately with DFV cases could be shared during group team meetings, and there was potential to institute a critical incident folder during clinical handover, DFV was not respected or seen to have value in a clinical setting. Junior clinicians described that they were therefore reluctant to raise DFV cases, particularly in a climate of reactiveness to the COVID-19 pandemic.

Missed presentations and misdiagnoses: Impact of staff capability to identify, treat and refer victim-survivors

Health staff spoke candidly about what they felt were the significant impacts and consequences of staff capability in this area. In some cases, social workers had observed that clinicians often took aspects of the patient's history from the perpetrator rather than the patient. This had the effect of further marginalising victim-survivors and closing off potential pathways for accessing legal, housing, and social services, and/or leaving violent situations.

Health staff described that DFV presentations were rarely identified if there were not visible, physical injuries.

> *"…in Emergency, family violence is generally only picked up if women come up with you know, really quite classic obvious injuries to assault"* [P30, emergency physician, district hospital]

A social worker described that due to a lack of adequate training in clinicians, woman victim-survivors experiences were often overlooked. Quick assessments were undertaken by mental health registrars with a primary focus on whether a woman is a risk to herself or her children. Social workers on the other hand were trained to see risks including DFV to vulnerable woman and children and therefore were more likely to identify those at risk or experiencing DFV.

In other cases, social workers described that the alleged perpetrator had controlled the narrative around patients' health, and junior clinicians did not have the training to address the situation:

> *"…the perpetrator is there seeing, controlling the information and saying they don't speak English. Controlling what she says [giving] a completely different narrative around what happened and then she doesn't speak English and won't leave her alone and so nobody can really check that out"* [P22, social worker, district hospital]

Some social workers described the conflation of DFV presentations with postnatal mental health concerns, and sometimes this was informed by the alleged perpetrator's practice of 'gaslighting' their partners, and providing their own account of her mental health.

"The perpetrator sets her up to be she's unstable and you know I've seen perpetrators hide things and then when she comes back it's suddenly there again and he's trying to convince her that she's crazy really severely common in the context of new mums or you know somebody who's sleep deprived, new mum, he might say something like, "Oh you know she's losing it. She's got post-natal depression." You know he kind of sets her up with that sort of gaslighting behaviour. He might ring the police and say some funny things about her behaviour but really it's all just DV." [P6, social worker, district hospital]

A social worker described a case where a woman with young children who presented with her partner who she alleged was the perpetrator and was assessed by a Psychiatry registrar. The perpetrator was not removed from the room, and the registrar obtained part of the victim-survivors medical history from him. Subsequently she was flagged for postnatal depression (which was in line with the narrative put forward by the partner). When the social worker approached the patient following this incident, she concluded that her experiences of DFV and not feeling safe in her own home had been minimised and diagnosed as postnatal depression.

Another major consequence of the lack of training were missed presentations. There were shared perspectives that DFV is frequently missed due to lack of training, and that stigma associated with DFV made victim-survivors reluctant to disclose. Some allied health staff expressed that there was significant stigma and stereotypes amongst the hospital staff and the general public around who DFV happens to. This had reinforced the reluctance of some staff in broaching the topic with patients, and led to missed cases.

Balancing critical priorities in high-pressure environments

Staff reported that competing demands within the ED prevented clinicians from optimally identifying, treating, and referring victim-survivors. Medical staff were unsure of how to feasibly approach DFV presentations when other issues deemed to be more acute arise.

"…we're so sort of focussed on treating the sickest and making them better…the whole idea of well-being isn't high up on our list of priorities" [P2, nurse manager, district hospital]

The physical ED environment was also not usually conducive to DFV disclosure. Many EDs lack safe spaces to speak to patients in private, or to separate alleged perpetrators from victim-survivors. While some have single rooms, their availability is limited, particularly in major hospitals in highly populous areas of NSW. Staff also expressed their frustration at the constant interruptions which prevented them from engaging in meaningful, sensitive conversations with victim-survivors.

"It's a challenging environment in that we very rarely have private rooms you can talk to someone in. So trying to take a history of something like that when you know the whole room can hear them, is really difficult" [P26, emergency director, tertiary hospital]

Other staff highlighted that unlike private clinics, it was difficult to build rapport within the ED because victim-survivors would likely not encounter the same clinical staff in the future, though they were often followed up by social workers.

"…they're going to see this nurse once, this doctor once, the social worker, this once: if the social worker is a bit better they'll often make a follow up phone call the next day but I think that is one of the barriers [to disclosing]" [P8, emergency physician, regional hospital]

In many cases, an additional difficulty was the fact that financial, housing, and other social services were not easily accessed within the ED setting, and even less so during the COVID-19 pandemic. From the perspective of clinicians, this made victim-survivors less likely to disclose, or to disclose and change their mind on whether to access help and the rapport built could be lost.

"But even in the hours that they're in Emergency Department the pendulum swings a bit and they're concerned about their financial security, their accommodation and having children in the picture….they go from the acute anger, frustration fear which motivates them to take action of some kind and that motivation can be lost fairly quickly". [P10, emergency physician, regional hospital]

The physical constraints on health staff within the ED were different for large hospitals compared to smaller rural hospitals. Some health staff working in a regional trauma centre at the outskirts of Sydney relayed that staff often knew patients personally, sometimes this included the alleged perpetrator.

"…that makes it really difficult…when you're dealing with the "I know the person that did this to you". [P30, emergency physician, district hospital]

In addition, the 'four-hour rule' and the pressure to have patients out of the department within four hours was also a barrier. Clinical staff felt that this window was not long

enough to build the rapport necessary with those experiencing or at risk of DFV. In addition, there was often no funding for after-hours social work, unless a child was involved. In reality, even where funding exists, health staff felt that the presentation would have to be severe to warrant a call to the social worker on call.

> *"It takes a very long time to do history and to provide that rapport and provide a safe space"* [P7, emergency physician, district hospital]

> *"In the last 5 to 10 years, there's been an increased time pressure and an increase in the number of patients, the complexity of patients and obviously also that KPI you know we've got the four hours to get them out if you don't you've breached and you're penalised etc. And that all has an impact. One you have to build rapport in order for someone to trust you and that can be difficult to do in a brief space of time".* [P16, emergency physician, district hospital]

The time constraints on victim-survivors were also a barrier. Patients often wanted to be seen quickly so they could return home to their children, to pick their children up from a friend or neighbour's house, or from school. This meant the identification, treatment and any referrals needed to happen rapidly and required dedicated attention from a team of health staff within an already challenging ED environment.

A lack of clear or accessible policy on identifying, treating, and referring DFV presentations

Knowledge regarding DFV policies to guide the identification, treatment and referral of presentations was low. Social workers were more likely to be aware of such guidance, while both junior and senior medical and nursing staff were largely unaware of whether DFV policies existed, and of the guidance they contained. Some felt that policies were not specific to local needs. Others felt that DFV policies and associated diagnostic tools were outdated and were not conducive to the practice-based learning within an ED environment where experience-based and verbal.

> *"I'm sure that there's a screening tool that social work use but I'm not sure if it's necessary, and I'm not sure that's something that medical or nursing use".* [P15, nurse manager, tertiary hospital]

Some social workers described that current guidance could even pose a danger to some staff who may also be victim-survivors with perpetrators also working within the health system and therefore able to access their partners' confidential health data. It should be noted here that in all Australian public hospitals, there are specific processes in place to safeguard patient information. Health staff can only look up the files of patients whose care they are directly involved with. The NSW Department of Health can track the files accessed, including patients that were not under the care of the staff member. However, the unauthorised tracking of patient files does do not appear as an alert. It needs to be raised as a concern in the first place to be further investigated.

Health staff also described that the application of DFV policies were not monitored, enforced or evaluated, so there was little incentive to review them. In addition, incident notification was typically informal and verbal. The large volume of policies governing the ED and hospital environment was also a significant contributor to the non-use of DFV policy guidance.

> *"You know you often see them in coroner's reports on newspapers and some people will say 'well you've got a policy, why didn't you act?' The policy? I don't know 90% of the policies because I don't have time to read through that….if I do see them I'll skim what is relevant to me".* [P11, nurse clinician, regional hospital]

New, junior, or rotating staff were at an additional disadvantage when it came to accessing and applying DFV policy guidance.

> *"I'm always aware of the fact that all of the junior doctors especially in the first two weeks, are given eight thousand things and it ranges from how to get help when someone's dying to which car park are you allowed to park in. So, when you talk about orientation-type material it's going to get lost"* [P17, emergency physician, district hospital]

Support for victim-survivors experiencing language barriers

Clinicians described that women with a refugee status or those that had migrated often faced unique vulnerabilities to DFV. They had experienced that the hospital system often failed these women due to the fragmented availability of interpreter services, and a lack of confidence in broaching the issue sensitively, particularly when a family member more fluent in English insisted on speaking for the patient. Where possible, one of the techniques clinicians had used to take patient histories for suspected DFV presentations is to ask to see the patient alone, and for a formal interpreter.

> *"Women who are migrants and refugees who, whose English makes them more vulnerable, are even more isolated. I am absolutely aware that it is has been an issue [during COVID-19] you know, the whole idea that people have been left alone with abusers that*

haven't been in the past". [P30, emergency physician, district hospital]

"Migrant populations are very hard because obviously there's the language barrier…I try to encourage my colleagues not to use the partner to take the history, just go and get a formal interpreter" [P28, emergency physician, district hospital]

In some cases, staff had kept patients overnight until they could properly review the patient with an interpreter. However, this was often only possible with the support of the nursing unit manager and was contingent on there being a bed available overnight to offer the patient.

Training needs to identify, treat and refer victim-survivors

Overwhelmingly, health staff expressed that there was a need for high quality training on addressing DFV presentations and that such training was non-existent or fragmented.

"We're not well trained to take a few extra moments to ask those questions because, Emergency is set up to be as quick as possible, basically prove they're not dying and get them out." [P20, emergency physician, district hospital]

In some hospitals, although training was generally available, it was often disrupted due to staffing changes, destabilisation in management, and consequent changeover in staff, so they were unable to keep up with the educational requirements and could not keep the momentum going.

"When new doctors arrive, social workers would generally undertake an education session. Due to COVID, orientation for new ED staff was shortened and was not conducted in the optimal environment– this may have affected staff's ability to respond to DFV" [P4, nurse manager, district hospital].

In participants' experience, few hospitals had dedicated and operational programs training clinicians.

'We train clinicians multiple times a year on what to look for, what to ask, how to separate partners without alerting a potential perpetrators by leaving them in the waiting room.' [P6, social worker, tertiary hospital]

Staff felt that a major contributor to the lack of consistent, high-quality training within the ED environment, was a lack of funding and human resources. Staff shared that although understanding of what constitutes DFV had increased over time, it had rarely translated into adequate resourcing and institutional support for improved identification and treatment.

"…there are major issues full-stop in a major Sydney hospital trying to look after a complex large, diverse, and underprivileged population. I think it's funding. I think it's resources." [P29, emergency physician, tertiary hospital]

Theme 3: "We need adequate training and resources for DFV victim-survivors to be optimally screened and treated in NSW EDs": barriers and opportunities for improving DFV care

Health staff felt that in order to equip health staff with adequate training and resources to address DFV presentations, training needed to be as concise as possible and recurring, even for those that have already undertaken training or are senior members of the clinical team. Clinicians noted that their training was too long ago to remember.

Participants felt that training needed to focus on building institutional support within the hospital for the identification, treatment and referral of DFV presentations in ways that promote the long-term health and wellbeing of victim-survivors. Rather than a static approach, participants felt that such programs would need to be frequently evaluated and monitored to ensure their responsiveness to staff and patients' needs.

"To me it's very much about prioritising that so it's not just another you know, another module to tick, it's not just another policy to tick off. I think what has to be made explicit, is that actually this is a priority this is not just something that you know social workers deal with and those doctors who are interested deal with. This is something that should be core business for all of medicine because it really is the thing that would make the biggest difference to population health." [P22, social worker, district hospital]

Further, health staff expressed that education in this area needed to be primarily training rather than policy based. Policy should be a focal point to ensure strong governance and financing arrangements, including protected funding that would not be under threat if there were changes to management. Participants felt that policies should support training by detailing a clear line of reporting within the ED environment, including formal incident notification, a review of process and journey charting led by social workers. Staff also expressed that given their past experiences in responding to DFV, policies needed to include guidance and a contact list for referring to crisis centres and support services, mandatory

reporting, as well as case studies in best-practices, particularly for those in situations of vulnerability (e.g. refugee, or migrant populations, those at risk or experiencing homelessness, or Aboriginal and Torres Strait Islander Australians).

Health staff noted that broader advocacy was necessary to ensure adequate resourcing for dedicated ED-based social workers, to ensure their immediate notification for DFV presentations, particularly for smaller, regional hospitals that often share social workers across departments, or have staff working reduced hours. In addition, changes over time are needed to the layout and design of EDs that would be more conducive to confidentiality and patient safety in high-risk situations. Staff also noted broader advocacy was needed to ensure that the flow on effect to already under resourced crisis centres could be managed and meaningful relationships developed with social services in the area, to better support women experiencing or at risk of DFV longer term.

Discussion

This research sought to understand the experiences of ED staff in screening, treating, and referring DFV presentations during the COVID-19 pandemic. The findings revealed that from the perspectives of staff, NSW EDs are often a first port of call for survivors of DFV or those at risk. Critically, the majority of staff reported that they lacked capacity individually and institutionally to appropriately receive, screen and treat DFV presentations. Nursing and medical staff had low levels of awareness of current policy and programmatic resources for practicing sensitive clinical inquiry, and staff felt ED-specific, feasible, engaging, and ongoing initiatives were needed to strengthen capacity.

ED staff were acutely aware of the importance of EDs as a priority setting for DFV. This reflects findings from a 2017 study of three EDs in NSW (one metropolitan and two in rural settings) which not only found over nine thousand presentations in six months, but that 19% of women (24% in rural sites) presented two or more times during that time [24]. Promisingly, research shows that screening by a skilled health worker directly asking questions increases the identification of women experiencing abuse; it has little or no adverse effect on women if posed in a safe and sensitive manner; and can bring about benefits to women, particularly when associated with referral to counselling [25]. Women have reported useful outcomes, regardless of whether they disclose, such as being able to re-evaluate their situation and feeling less isolated [26–28]. Yet, for health staff working within EDs there remain a number of barriers to screening, treating and referring in line with current guidelines.

Firstly, there are limiting beliefs within the system that may make it difficult for women to disclose unless there is a child involved. Moreover, the fact that NSW's routine screening program is accessible to women using maternity, child and family, mental health and alcohol and other drug services may make it difficult for women who do not fit into these categories and seek urgent assistance within an ED.

Secondly, from the perspective of ED staff, there is a low level of awareness of DFV training resources. Clinicians may not be using the broad range of educational tools to assist health staff (described in the background section) due to the overwhelming volume of resources, and the lack of institutional support for treating DFV with the same seriousness as other conditions which may shape their overall motivation to remain up to date with their training. In addition, NSW Health's policy directive for identifying and responding to DFV (which applies to all NSW Health services, not only ED) may have lost relevance due to its outdated nature at almost thirty years old (with limited updates made in 2022), despite compliance being mandatory.

Further, the ED environment is fast-paced, and resource poor given the push for the 4-hour National Emergency Access Target (NEAT) which states that 85% of patients should spend less than four hours in the ED from arrival to admission, transfer or discharge. Consequently, the operating model of care reflects a culture of seeing EDs as primarily for acute physical issues. The findings suggest that this means training modules need to be adapted for this specific environment. This could focus on developing competencies in trauma-informed care, risk assessment, and recognising coercive control, and could occur during dedicated teaching sessions, which is a requirement of all medical specialities. For example, within NSW EDs, clinicians are entitled to eight paid hours dedicated to teaching per fortnight [29]. This is an ideal opportunity to provide teaching on DFV in ways that are seen as just as important as other clinical training. Whereas, its placement during orientation, which is often the case, may suggest to clinicians that such training is only relevant to junior doctors. As the findings show, even consultants need consistent training as the nature of DFV changes, presentations change, new evidence becomes available, and policies change. This training should be repeated yearly as new doctors and nurse clinicians rotate into various departments. This training could potentially either be provided by the hospital or an accredited outside provider. The high-pressure ED environment limits opportunities for detailed assessment, making collaboration with prehospital and paramedical care providers, such as ambulance services, crucial for early identification and referral. Given recent legal reforms recognising coercive control, strengthening workforce training, screening protocols, and interagency coordination could ensure that EDs can effectively

support victim-survivors and contribute to a more comprehensive, sustainable DFV response within the health system.

However, regardless of the extensiveness of training, we know that the indicators for DFV are vast, including frequent presentations, unexplained injury, chronic gastrointestinal, reproductive or genitourinary symptoms, repeated vaginal bleeding, traumatic injury, vague or implausible explanations, and problems with the central nervous system including headaches, cognitive problems or hearing loss [30]. It is unsurprising then, and given the already immense pressure on ED staff, that DFV remains under-identified. One study found that DFV was not identified by staff for 72% of women who attended an ED after an incident [31].

Thirdly, greater funding and support is needed to ensure that particularly in under-resourced areas across the state where rates of DFV are high, hospitals have access to social workers over the weekend and after hours when cases often present. There is a strong justification for this funding given that the NSW Domestic Violence Death Review Team has advocated for hospitals to be appropriately supported by 24-hour psycho-social resources [32]. This research suggests that not all cases of DFV are treated equally and that women without visible injuries or those that are not mothers may not be prioritised. Harmful assumptions about the severity of DFV, the breadth of injuries and which deserve to be flagged as a priority, need to be addressed. Further, the findings suggest medical and nursing clinicians would benefit from greater collaboration with social workers so that knowledge and skill regarding sensitive clinical inquiry and treatment is not limited to social workers. Without this collaboration, many cases risk being missed.

The COVID-19 pandemic not only exacerbated risk factors for DFV but also introduced significant challenges to screening and case detection within EDs. Health staff noted that while DFV presentations remained frequent, the absence of systematically collected data obscured the true scale of the issue. The pandemic's disruptions to healthcare services and altered patient help-seeking behaviours may have contributed to underreporting, making it difficult to ascertain whether ED presentations had increased or decreased. This underscores the urgent need for standardised data collection and improved surveillance mechanisms to ensure that DFV cases are consistently identified, and timely policy and service adaptations can be made regardless of external disruptions and public health crises.

The absence of such data likely accounts for inconsistencies in health workers' anecdotal observations, and reflects the difficulties faced by health workers in identifying, and continually prioritising sensitive inquiry, adequately treating victim-survivors, and strengthening referral pathways with external social services to facilitate their long-term support. Key to quantifying the true extent of DFV, and accessing adequate funding, will be developing procedures for allowing DFV to be coded alongside other conditions they present with (for example, a fractured bone) as the diagnosis code which captures the reasons for presentation, attracts funding.

This paper's findings also have implications for universal health coverage (UHC). Failure to detect and refer DFV cases within EDs represents a critical inefficiency in the health system, undermining the broader objectives of UHC. While UHC seeks to ensure equitable access to healthcare, system inefficiencies– such as inconsistent screening, gaps in staff training, and the absence of standardised referral pathways– may result in preventable morbidity and increased healthcare utilisation downstream. The missed opportunities for intervention in EDs may lead to victim-survivors presenting later with more severe health consequences, ultimately placing greater strain on both the health and criminal justice systems. Addressing these inefficiencies through structured DFV response protocols, sustainable training initiatives, and robust data collection will be essential to enhancing the effectiveness of UHC in meeting the needs of vulnerable populations.

Strengths and limitations

This paper addresses the critical gap in research on DFV presentations in New South Wales. The themes uncovered in this paper will be highly relevant health practitioners and policymakers alike in other Australian and international contexts where DFV is pervasive and EDs remain a first port of call for victim-survivors. In addition, the paper includes a diversity of hospitals of varying sizes and locations (metropolitan and regional), ensuring a comprehensive understanding of the barriers facing ED staff, and the key areas where resources, administrative and policy infrastructure need to be strengthened.

A limitation of this study is that it is likely that only clinicians who are interested or concerned about EDs response to the burden of DFV in NSW would have agreed to participate in the study, which may have resulted in a biased sample. This may have led to an overrepresentation of clinicians who are more knowledgeable and interested in addressing DFV, and an underrepresentation of those that are less interested.

In conclusion, a sensitive, safe approach that promotes the long-term health and wellbeing of survivors is needed through dedicated, inclusive and ongoing training programs that are purpose-built for the unique pressures of the ED environment. This research reflects the overwhelming willingness of ED health workers in working towards a solution and better serving victim-survivors and their families and highlights four critical pathways for strengthening the health systems responsiveness to those at risk of DFV.

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Authors' contributions

J.S and E.L undertook the interviews and analysis of transcripts that formed the basis of this research. J.S developed the manuscript as lead author. All authors contributed to the conceptualisation and refinement of the manuscript.

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Data availability

The datasets generated and analysed during the current study are not publicly available due to our need to protect the anonymity of participants and their institutions. Deidentified data may be available on reasonable request, with the permission of The George Institute for Global Health.

Declarations

Ethics approval and consent to participate

Ethics approval and consent to participate This study was approved by the University of New South Wales' Human Research Ethics Committee (HC200207). All methods were performed in accordance with the World Medical Association (WMA) Declaration of Helsinki. All participants completed an informed written consent form as a requirement for study participation. Participation was not incentivised.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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