


Review Article

Domestic Abuse in the Context of Life-Limiting Illness: A Systematic Scoping Review

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Domestic abuse is a worldwide public health and social issue which impacts the health and wellbeing of those experiencing abuse and their families. People living with a life-limiting illness are at increased risk of domestic abuse because they are often frail, isolated, and dependent on others. Little is known about domestic abuse and the coexistence of life-limiting illness and existing support for those experiencing or at risk of abuse. A scoping review was conducted to identify factors that shape and characterise experiences of adults with a life-limiting illness affected by domestic abuse and the health and social care practitioners and other organisations that support them. The Joanna Briggs Institute (JBI) methodology and checklist for Preferred Reporting Items for Systematic Reviews and Meta Analyses-Extension for Scoping Reviews (PRISMA-ScR) were applied. Five databases were systematically searched from 2000 to 2021: MEDLINE; CINAHL; PsycINFO; Social Sciences Citation Index (Web of Science); and ProQuest Dissertations and Global. Twenty-one papers met the inclusion criteria. Most studies were conducted in North America, with female participants living with cancer, and conducted in health and community settings. There were no studies involving third sector organisations. A range of abusive behaviours was reported resulting in missed medical appointments, delays in screening leading to late diagnosis, and palliative rather than curable treatment. Abuse also impacted on the physical, emotional, and psychological wellbeing of the person experiencing the abuse, which increased stress levels and could have a detrimental effect on their health. Identifying domestic abuse within the context of life-limiting illness was reported to be challenging for health and social care professionals, as was responding to and managing a disclosure. Further research is needed to address existing knowledge in order to inform policy and practice to identify and manage domestic abuse where it coexists with life-limiting illness.

1. Introduction

Domestic abuse is a global public health issue which impacts the health and wellbeing of victim-survivors and their families [1, 2]. Between March 2019 and March 2020, an estimated 2.4 million adults (1.6 million women and 757,000 men) experienced domestic abuse in England and Wales [3]. Since the start of the COVID-19 pandemic, reported incidences of domestic abuse to third sector and statutory agencies have increased across the UK by 60% [4, 5], with similar patterns across the world [6]. “Stay at home” measures imposed by the UK government as a response to the pandemic increased

opportunities for perpetrators to abuse and elevated the threat of abuse for those living with an abusive partner or family member [7].

In the UK, domestic abuse is a national and local policy priority driver for health and social care. In April 2021, the introduction of the Domestic Abuse Act in England and Wales brought about changes that go beyond criminal justice reforms to include the following: health and housing; placing a legal duty on local statutory authorities to provide housing and safe accommodation; and creating a statutory definition of domestic abuse [8]. The new definition encompasses not only physical and sexual abuse but also violent or threatening behaviour, coercive or controlling

behaviour, economic, psychological, or emotional abuse, perpetrated towards another person aged 16 or over who are, or have been, personally connected to each other through marriage, civil partnership, an intimate relationship, parental relationship to the same child, or are family members.

While prevalence of domestic abuse is consistent amongst individuals and groups, some experience additional inequalities, vulnerabilities, and risk factors. This includes people living with life-limiting illnesses such as incurable cancer, neurological conditions and progressive heart, pulmonary, and renal conditions, who are at increased risk of domestic abuse because they are vulnerable, frail, isolated, and dependent on others [9–12]. People with a life-limiting illness are more likely to spend long periods in the home, in close proximity to the perpetrator who may also be their caregiver, and experience multiple barriers to accessing and seeking support and may be less willing or able to escape the abusive situation. Lockdown and social isolation measures implemented to combat COVID-19 exacerbated the risk for those with a life-limiting illness experiencing domestic abuse. Existing patterns of abuse increased in terms of frequency and type [13, 14].

Those living with a life-limiting illness are likely to access health and care services more frequently for the management and monitoring of their condition resulting in them receiving continuity of care from a health and care professional and the development of interpersonal trust between patient/client and practitioner [15]. Establishing a trusted relationship is a key to early intervention and support [16], and while in “usual” times, those experiencing domestic abuse are more likely to disclose to a health or care worker [17–19], social restrictions imposed by the pandemic greatly impacted on statutory health and care services capacity to support vulnerable adults. The move to remote working significantly affected home visits and assessments, leading to virtual healthcare and safeguarding practices [20], with few opportunities for identifying new incidences of abuse or cues that existing abuse had worsened [21]. In 2020/21, more than 120,000 community support contacts were delivered virtually, including services provided by hospices, with increased use of remote communication both with patients and between services, and greater use of technology [22, 23]. As a result, there has been pressure on community hospice and palliative care to develop flexible service provision and workforce roles [24]. In the UK and elsewhere, remote practices have continued with the lifting of COVID restrictions, which has left those who are vulnerable, unsupported, and at risk [25].

To date, little is known about domestic abuse in the context of life-limiting illness, including the experiences and support needs of those affected; awareness, knowledge, and understanding of domestic abuse and life-limiting illness amongst health and care professionals and third sector organisations or their views and experiences of enquiring about, responding to, and supporting adults living with a life-limiting illness impacted by domestic abuse. This review has been undertaken as part of a wider study (DALLI) to coproduce a toolkit to enable hospice and palliative care practitioners to identify and respond to domestic abuse. The review is needed to inform understanding about the co-existence of domestic abuse and life-limiting illness, address

gaps in academics and practitioners’ knowledge, and identify areas for further research.

2. Design and Methods

While ethical approval was not required for this review, approval for the main DALLI study was granted by the East of Scotland Research Ethics Service REC 2 (21/ES/0086).

2.1. Methodology. A scoping review applying the Joanna Briggs Institute (JBI) nine-stage framework [26] (Table 1) and the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist [27] to demonstrate selection of the final included papers was carried out. A scoping review was selected because it allows flexibility to consider different kinds of evidence and was particularly useful given that the topic has not yet been extensively reviewed [28].

2.2. Review Questions and Objectives

2.2.1. Review Questions. What is known about domestic abuse in the context of life-limiting illness?

What are the factors that shape and characterise experiences of adults with a life-limiting illness affected by domestic abuse and the health and social care practitioners and other organisations who support them?

Specific objectives were as follows:

2.2.2. Objective 1. To systematically map the existing evidence base relating to domestic abuse and life-limiting illness.

2.2.3. Objective 2. To identify and characterise the experiences of adults living with a life-limiting illness experiencing or at risk of domestic abuse, their support needs, and existing support mechanisms provided by health, social care, and third sector organisations.

2.2.4. Objective 3. To identify and characterise the views and experiences of health and social care professionals and third sector organisations of identifying, responding, and supporting adults living with a life-limiting illness impacted by domestic abuse.

2.3. Inclusion and Exclusion Criteria. Eligibility criteria were developed in line with the JBI framework using the population (P) to be included, concept (C) to be explored, and the context (C) within which the evidence will be generated (PCC) and other limiters within which the search was bounded (Table 2).

2.4. Evidence Searching and Selection. Searches were carried out in two stages, between February and June 2021, and in consultation with a specialist subject librarian at University of Southampton. Stage 1 comprised an initial search in MEDLINE (EBSCO). Search concepts were captured using

TABLE 1: JBI nine stage framework for conducting scoping reviews.

Stages	Components of review process
1	Defining and aligning the objectives and research questions
2	Developing and aligning inclusion criteria with the objectives and questions
3	Describing the planned approach to evidence searching and selection
4	Searching for the evidence
5	Selecting the evidence
6	Extracting the evidence
7	Analysing the evidence
8	Presentation of the results
9	Summarising the evidence, making conclusions, and noting findings implications

MeSH and subject headings and text-word searches in title, abstract, and keyword heading word fields. Results from Stage 1 yielded 1,553 results which were imported into Endnote V.X. 9.2 and assessed by MM and SL. Following analysis of relevant records, additional terms for inclusion in the search strategy were considered. Further strategy development resulted in a final MEDLINE (EBSCO) strategy for use in Stage 2 which was then translated appropriately across four additional databases: CINAHL (EBSCO); PsycINFO (EBSCO); Social Sciences Citation Index (Web of Science); and ProQuest Dissertations and Global (see Appendixes 3-6). This generated 9,871 results. Database searches were supplemented by searches in Google Scholar, identifying further 8 papers and a total of 9,879 results.

2.5. Selecting the Evidence. The screening process following the PRISMA-ScR framework for reporting scoping reviews is illustrated in Figure 1. Results from Stage 2 searches were imported into the same EndNote library as Stage 1 and duplicates were removed ($n=1,947$). Following deduplication 7,932 records were exported to the Rayyan web application (<https://rayyan.qcri.org>) for title and abstract screening. In line with JBI methodology, title and abstract screening was undertaken by two reviewers (MM, SL) for relevance against the eligibility criteria. Following title and abstract review, 7,784 papers were excluded, resulting in 148 for full text review. The reference lists of the 148 papers were searched and further 3 papers were identified, resulting in 151 records for full review. This was undertaken by MM and SL and any disagreements were resolved by ST. One hundred and thirty papers were excluded, leaving 21 papers for inclusion in the final review.

2.6. Extracting and Analysing the Evidence. Descriptive characteristics from each included paper, including authors, study setting, participants, aims/objectives, methodology, analysis, findings, and conclusions were extracted into a data extraction tool and are reported in Table 3. Studies listed in Table 3 are referenced in the text by the study ID number in square brackets. Findings, discussion, and limitation sections from papers were also extracted into the tool and treated as qualitative data and subject to thematic analysis by MM, SL, and ST applying Braun and Clarke's approach [46].

2.7. Presentation of Results (Charting the Evidence). The 21 records that met the inclusion criteria were analysed in line with review objectives.

2.8. Objective 1: To Systematically Map the Existing Evidence Base Relating to Domestic Abuse and Life-Limiting Illness

2.8.1. Publication Type. Out of the 21 texts included, there were 19 journal papers (1, 2, 3, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21), one thesis (4), and one online article (6).

2.8.2. Year of Publication. The search limit was set between 2000 and 2021 but no included papers were published prior to 2003 or after 2020. Eight papers were published between 2003 and 2010 (14, 15, 16, 17, 18, 19, 20, and 21) and 13 between 2011 and 2020 (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13). Four papers (12, 13, 14, and 16) reported findings from one study but were included as each paper addressed different themes. In addition, as a scoping review aims to map the breadth of evidence, the issue of bias is not critical in the same way as with a systematic review.

2.8.3. Country and Setting. The majority of papers ($n=16$) reported studies conducted in the USA (1, 3, 4, 5, 12, 13, 14, 15, 16, 17, 19, and 20), with two in the UK (11 and 18), two in Australia (6 and 21), and one in Turkey (2). In terms of settings, eight papers were set in hospital (2, 5, 6, 7, 9, 17, 20, and 21) and eight in the community (1, 3, 8, 12, 13, 14, 16, and 19) with two in hospital and community settings (4 and 7), two in social care (11 and 15), and one in a hospice (18).

2.8.4. Methodology Design. Seventeen papers reported findings from empirical studies (1, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18), nine were qualitative studies (4, 6-7, 10-14, and 16), three were surveys (1, 3, and 15), three mixed methods (8, 17, and 20), with one case study (9) and one case audit (18). Four papers reported findings from literature reviews (2, 5, 19, and 21), two were systematic reviews (2 and 5) and two did not state the review methodology applied (19, 21).

TABLE 2: Inclusion and exclusion criteria.

	Inclusion criteria	Exclusion criteria
Population (P)	<p>Patients/people living with a life-limiting illness (<i>adults over 18 with life-limiting illness, affected by domestic abuse</i>)</p> <p>Health and social care professionals (<i>nurse, doctor, HCSW, paramedic, social worker, psychologist, and safeguarding leads</i>)</p> <p>Support organisations (<i>DOMESTIC ABUSE charities, Citizens Advice</i>)</p> <p>Religious personnel (<i>Chaplain</i>)</p>	<p>Children, young people, and adolescents</p> <p>People living with dementia</p> <p>Pregnancy</p> <p>Pre- and postnatal</p>
Concept (C)	<p>Domestic abuse and violence (<i>sexual assault/violence; rape; verbal abuse; financial abuse/control; coercive control; threatening behaviour; neglect; maltreat; mistreat; intimate partner violence; emotional abuse; psychological abuse; domestic homicide/murder; gender-based violence; and elder abuse</i>) and life-limiting illness (terminal illness; degenerative illness; end-of-life; and incurable disease)</p>	<p>Nondomestic abuse/violence</p> <p>Curable illness/disease/condition</p> <p>Dementia</p>
Context (C)	<p>Hospice and palliative care settings</p> <p>Primary care settings</p> <p>Community-based care</p> <p>Acute settings (e.g., emergency department, ambulatory care, and outpatients)</p> <p>Prehospital care</p> <p>Social care</p> <p>Third sector organisations</p>	<p>Paediatric settings</p> <p>Ante-natal settings</p> <p>Maternity services</p>
Type of evidence source	Empirical peer-reviewed research (qualitative and mixed method); literature reviews; grey literature (conference abstracts; theses); policies and protocols; and clinical guidelines	
Language	English language	Nonenglish language papers
Year of publication	2000–2021	Papers published before 1st Jan 2000
Abstract and full text availability	Papers with a published abstract and full text paper available in English language	Studies without a published abstract and full text available

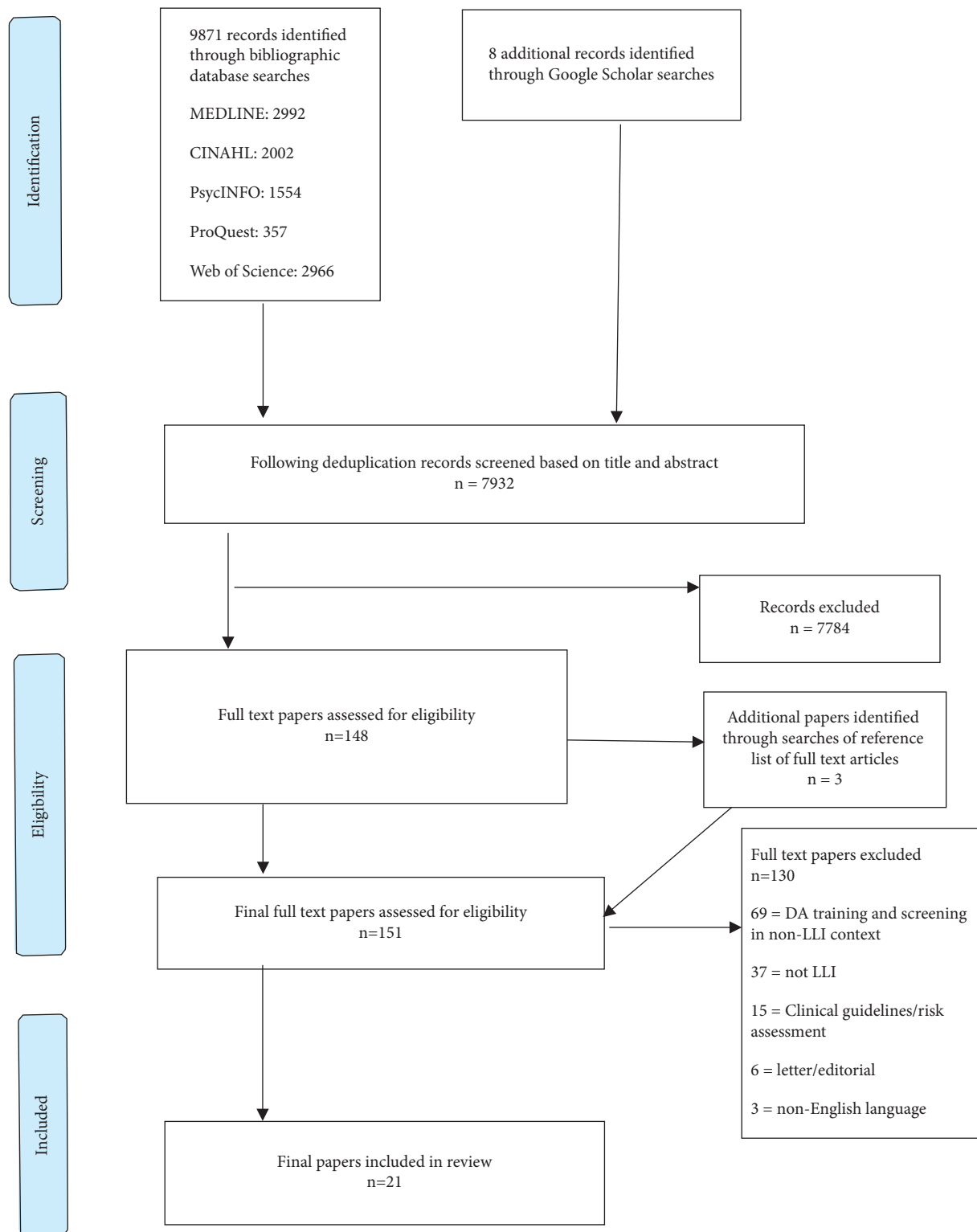


FIGURE 1: PRISMA-ScR flow diagram.

2.8.5. Participants. Sample sizes in the included papers reporting empirical studies ranged from 7–21 participants who had been involved in qualitative interviews (4, 6–7, 10–14, and 16), 206–3,335 who had responded to surveys (1, 3, and 15), 20 in the audit (18), and one in the case study (9).

In the papers reporting mixed method studies, sample sizes ranged from 3 to 204 (8, 17, and 20). Sixteen of the included papers were carried out with patients who were reported as living with life-limiting conditions, which included multiple sclerosis ($n = 1$) (1), but predominately cancer ($n = 12$) (2, 2,

TABLE 3: Characteristics of included studies.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
1	Morrison et al. [29] Abuse and neglect of people with multiple sclerosis: a Survey with the North American Research Committee on Multiple Sclerosis (NARCOMS) Journal paper-Multiple Sclerosis and Related Disorders	USA Community	Adults with multiple sclerosis (MS) requiring caregivers	To estimate the incidence and prevalence of caregiver mistreatment of adults with advanced MS	Anonymous telephone survey Patient reported outcome measures used: (i) Scale to report emotional stress signs-multiple sclerosis (STRESS-MS) (ii) Multiple sclerosis neuropsychological screening questionnaire (MSNQ) outcomes study-social support survey (MOS-SSS)	Quantitative	54.9% participants reported at least one form of mistreatment by caregivers (including psychological abuse (44.2%), financial abuse (25.2%), neglect (16.5%), physical abuse (11.2%), or sexual abuse (8.3%)). Mistreated participants reported less social support, increased alcohol consumption, and higher levels of fatigue and cognitive impairment. Caregivers suffering from mental illness increased the chance of mistreatment 13 times

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
2	Aygin and Bozdemir [30] Exposure to violence in breast cancer patients: Systematic review Journal paper- Breast Cancer	Turkey Hospital Oncology clinics	Female patients who have undergone breast cancer surgery	To systematically review data from studies on breast cancer patients who have been exposed to violence	Systematic review qualitative and descriptive studies	Descriptive narrative review	Nine studies were reviewed, six descriptive and three qualitative, looking at breast cancer patients who were exposed to spouse/partner violence in childhood or during the therapeutic process. Breast cancer patients exposed to violence had higher depression scores, low quality of life, and have their healing adversely affected. A positive correlation was also shown between advanced stage cancer and history of violence. Providing care to these patients can be difficult due to the “taboo” nature of violence
3	Coker et al. [31] Partner interfering behaviours affecting cancer quality of life Journal paper-psycho-oncology	USA Community	Female cancer patients	To understand how destructive, controlling, or interfering partner behaviours impact women's cancer care	Telephone survey Patient reported outcome measures used: (i) Partner interfering behaviours in cancer care (PIB-C) (ii) Functional assessment of cancer therapy (FACT-G) (iii) Functional assessment of chronic illness therapy-spiritual well-being (FACIT-SP)	Quantitative using validated measures and quality of life outcomes	Women who reported any partner interfering behaviour experienced more symptoms of depression and stress and lower functional assessment scores. Specific partner behaviours are more common (14.7%) than intimate partner violence (IPV). (10.7%) with a similar cancer impact. However, interfering partner behaviours do not meet the “violence” threshold so may not be identified in screening

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
4	Johnson [32] Journey of decision-making among a sample of women diagnosed with breast cancer and living with a nonsupportive or abusive partner Thesis-University of California, Los Angeles	USA Hospital and Community	Female breast cancer patients	To explore the decision-making journey in women diagnosed with breast cancer who live with a nonsupportive or abusive partner	Qualitative descriptive study using interviews	Grounded theory	A lack of partner support was shown to be stressful, confusing, and disheartening. Women had an increased need to depend on other sources of support and were resourceful in using strategies that helped them make treatment decisions
5	Johnson and Pieters [33] Intimate partner violence among women diagnosed with cancer Journal paper-cancer nursing	USA Hospital (oncology)	Female cancer patients	To evaluate the presence of intimate partner violence (IPV) in female cancer survivors and to provide oncology nurses with clinical guidelines about IPV	Systematic review Studies included a chart review, case studies, a prospective study, and a phenomenological design	Not reported	The 10 articles selected presented accounts of abusive partner behaviours throughout their cancer journey affecting their treatment decision-making. In many cases, women described how their partners controlled their money, health insurance, and cancer treatments. Cancer survivors from three studies felt that their cancer diagnosis was a direct result of the abuse they had endured. Oncology nurses often have a special bond with their patients that can be used to promote safety and health in cancer patients suffering from IPV

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
6	Wiseman [34] 10 minutes with Anne May Online article-palliative care Australia	Australia Hospital (palliative care)	Palliative care patients	To explore domestic abuse in palliative care settings and highlight that abuse can be mistaken for grief reaction in palliative care settings	Interview	Not reported	Abuse may be mistaken for grief reaction. Caregiver controlling pain relief. Need trauma informed approach to care. Palliative care patients lack energy to advocate for themselves
7	Speakman et al. [35] “I didn’t fight for my life to be treated like this!”: the relationship between the experience of cancer and intimate partner abuse Journal paper-health and social work	USA Hospital and Community	Cancer patients	To understand the high occurrence of intimate partner abuse in cancer patients and experiences of IPV before and after diagnosis, impact of abuse of treatment, effect of treatment on ability to deal with abuse	Qualitative semistructured interviews	Thematic qualitative analysis using grounded theory techniques	Participants described various abusive and unsupportive behaviours by their partners over their cancer journey, which contributed to them reassessing their relationships. Factors that led to relationship changes were a heightened awareness on their own health, discovery of greater inner strength, and enhanced social support. Participants who made relationship changes or left an abusive relationship usually did so after they recovered from cancer treatment. 76% of participants had experienced abuse prior to diagnosis

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
8	Cesario et al. [36] Linking cancer and intimate partner violence Journal paper-clinical journal of oncology nursing	USA Community	Female cancer patients, women who used shelters and justice system	To determine the rates of IPV and the types of cancer reported by women seeking support from IPV services	Survey Telephone interview	Quantitative analysis	Women experienced psychological and physical distress including high levels of pain severity, indicating the physical effects of IPV. Women also remained at higher risk for continued abuse despite living in a safe shelter. Women who left home had higher marginality scores than the women who remained at home with the support of law enforcement and a protection order
9	Culver Wygant et al. [12] Intimate partner violence in an outpatient palliative care setting Journal paper-journal of pain and symptom management	USA Hospital palliative care	Metastatic cancer patients	To describe emotional and verbal abuse in the palliative care setting	Single case study	Not reported	The case study demonstrates how IPV can impact patients' physical and emotional well-being, social support system, and capability to seek health care. Health choices were made against the participants' better judgement. The participant also believed that the stressful relationship worsened her cancer

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
10	Daly et al. [37] Critical care nurses' perspectives on elder abuse Journal paper-nursing in critical care	USA (Hospital) Critical care	Critical care nurses	To explore the perspectives of critical care nurses on elder abuse to gain an understanding of the issues of reporting and develop ideas for improving the process	Qualitative interviews	Thematic analysis	To some extent critical care nurses systematically evaluate for abuse on admission. The nurses recognise the signs and symptoms of abuse and are conscious of why an older person may not want to report abuse. Experience, facts, and personal value affect personally defining abuse, suspicion, and dependence for each nurse. The nurses reported that the reporting process is vague and unknown
11	Manthorpe et al. [38] Responding to the financial abuse of people with dementia: A qualitative study of safeguarding experiences in England Journal paper-international psychogeriatrics	UK Social care adult safeguarding	Adult safeguarding co-ordinators	To explore the experiences and views of professionals responsible for adult safeguarding in local government, focusing on financial abuse	Qualitative interviews	Framework analysis	Themes identified during the interviews included: incidence of financial abuse such as unpaid bills; safeguarding responses; signs of financial abuse; encouraging preventative measures such as advance care plans and lasting power of attorney; and barriers and facilitators in safeguarding

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
12	Sawin [39] “The body gives way, things happen”: older women describe breast cancer with a nonsupportive intimate partner Journal paper-European journal of oncology nursing	USA Community	Female breast cancer patients	To explore the aging-related experiences of older women diagnosed with breast cancer whilst in a nonsupportive, difficult intimate relationship	Semistructured qualitative interviews	Hermeneutic phenomenological analysis	Women's breast cancer experience was complicated by aging-related issues such as changes in sexual relationships, comorbidities, and partner illness. Despite the lack of partner support the women in the study coped effectively with breast cancer by seeking outside support and sometimes distancing themselves from their intimate partner
13	Sawin and Parker [40] “If looks would kill then I would be dead”: Intimate partner abuse and breast cancer in older women Journal paper-journal of gerontological nursing	USA Community	Female breast cancer patients	To describe the experiences of older women with breast cancer while experiencing intimate partner abuse (IPA)	Semistructured qualitative interviews	Hermeneutic phenomenological analysis	Themes that emerged from the interviews included: Cancer and control; negative relationship changes; changes in intimacy; and moving on Some of the participants felt trapped in the relationship due to financial issues such as health insurance from the partner, losing the home, and having few work skills. The women developed coping strategies such as setting boundaries and limiting contact

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
14	Sawin [41] My husband would not help me, so I was driving over there: older rural women experiencing breast cancer with a nonsupportive intimate partner Journal paper-rural and remote health	USA Community	Female breast cancer patients	To explore the experiences of older rural women diagnosed with breast cancer while in a nonsupportive and/or abusive relationship	Semistructured qualitative interviews	Hermeneutic phenomenological analysis	Themes identified during the interviews included: driving; gossip in the local community; rural location as therapeutic; and community support Patients reported an increased difficulty to access treatment due to their partners' refusal to help with transport. The participants emphasised the positive support they found in their communities
15	Csikai and Durkin [42] Perceived educational needs and preparation of adult protective services workers for practice with end-of-life issues Journal paper-gerontology and geriatrics education	USA Social care Adult safeguarding	Adult protective services (APS) professionals	To investigate the extent of end-of-life preparation in APS professionals	Quantitative postal surveys	Quantitative analysis	APS professionals frequently encounter situations involving serious illness and injury, death and bereavement. Less than half were educated about issues of death and dying in their degree, and only half had attended a continuing educational programme on these topics. The participants reported the greatest educational needs in practical resources, the use of advanced directives, and end-of-life decision making

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
16	Sawin et al. [10] Breast cancer in the context of intimate partner violence: a qualitative study Journal paper-oncology nursing forum	USA Community	Breast cancer patients	To describe the experiences of women diagnosed with breast cancer while living with IPV	Semistructured qualitative interviews	Hermeneutic phenomenological analysis	A number of themes emerged including reassessing life; believing that stress from the relationship caused the cancer; valuing support from others; the significance of the breast. All participants reported a change in their intimate relationship as a result of their breast cancer diagnosis. Living with cancer offered the women an opportunity to review their life, and in some cases change their relationship status
17	Owen-Smith et al. [43] Screening for domestic violence in an oncology clinic: barriers and potential solutions Journal paper-oncology nursing society	USA Hospital (gynaecology and oncology clinics)	Gynaecologic oncology or colposcopy patients' medical records Oncology nurses	To evaluate the implementation of a domestic violence screening protocol in an oncology clinic	Medical record review Survey of nurse practitioners	Descriptive analysis of the medical records. Content analysis of the survey	Of the medical records reviewed, 63% had a domestic violence screening record, but only 12% of these had documentation. Patients with domestic violence screening documentation were more likely to have had five or more clinic visits Nursing staff listed forgetting to screen or document domestic violence screening as the most common barrier to implementing the protocol. To overcome this, nurses recommended providing screening reminders and adding domestic violence screening questions to forms

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
18	Payne [44] Safeguarding adults at end of life: Audit and case analysis in a palliative care setting Journal paper-journal of social work in end-of-life and palliative care	UK Hospice	Safeguarding adults' cases	To report the findings of an audit of safeguarding adults' cases over two years from the introduction of an adult protection policy	Case audit	Not reported	Various forms of abuse were identified, involving institutional, physical, verbal, and financial abuse and neglect. Most patients wanted protection, but some did not want to disrupt personal care and relationships despite abuse. Analysis of physical abuse cases found a large proportion of cases where difficulties in family relationships, often associated with alcohol and drug misuse, worsened the stresses in end-of-life care
19	Jayawardena and Liao [45] Elder abuse at end-of-life Journal paper-journal of palliative medicine	USA Community	Older adults at end-of-life	To investigate elder abuse at end-of-life	Literature review	Not reported	Clinical presentation of abuse may overlap with natural dying process. The (multidisciplinary team) MDT most effective intervention for assessment and prevention. Most abuse occurs at home; hospice team may be only outside professionals coming into the home. Caregiver stress and victim dependency increase risk
20	Schmidt [11] Domestic violence against women with cancer: examples and review of the literature Journal paper- the journal of supportive oncology	USA Hospital (oncology clinic)	Female cancer patients experiencing or at risk of domestic abuse who had been referred to psychologist for evaluation of mood	To present case studies and the literature review on domestic abuse and issues of detection and management in a cancer population	Case studies Literature review	Not reported	All husbands of patients had appeared supportive to the oncology team. Cancer patients share dependency, frailty, and other characteristics with other patients at high risk of abuse—cancer may be a risk factor

TABLE 3: Continued.

Paper ID	Author/year/title/publication type	Country and setting	Participants	Aims/objectives	Methodology/data collection methods reported	Method of analysis	Main findings and conclusions
21	Fisher [9] The invisible dimension: abuse in palliative care families Journal paper-journal of palliative medicine	Australia Hospital (palliative care)	Palliative care	To investigate abusive family relationships in palliative care	Literature review	Not reported	Studies in palliative care and families tend to focus on the functional family unit, how illness and dying has affected the family and the needs of family members. The palliative care literature does not explicitly deal with families and patients affected by abusive caregiving relationships

4, 5, 7, 8, 9, 12, 13, 14, 16, and 20), and three papers included patients who were described as palliative or at end-of-life (6, 19, and 21). Of these, 11 papers reported studies with women experiencing abuse (2, 3, 4, 5, 8, 9, 12, 13, 14, 16, and 20) and three included male and female participants affected by domestic abuse (1, 7, and 19). Two studies did not report the gender of participants. Five papers focused specifically on participants who were health or social care professionals, including nurses (10 and 17) and adult safeguarding professionals (11, 15, and 18).

Mapping of the existing literature retrieved little evidence exploring domestic abuse and the coexistence of life-limiting illness in health and care settings. Papers that were included showed that most studies have been conducted in the USA with a dearth of research in the United Kingdom and other countries in Europe. Most of the literature focused on women living with cancer and studies conducted in hospital and community settings. Only one paper reported a study carried out in a hospice. None of the included papers were in third sector organisations. There was a limited range of study designs in the empirical work and evidence synthesis methodologies. While there is representation from relevant participant groups, including patients and health and care professionals, sample sizes of the majority of studies were small. To date, there is a paucity of evidence that explores domestic abuse and life-limiting illness and the factors that shape the experiences of those affected and the health and care professionals who care and support them.

2.9. Objective 2: To Identify and Characterise the Experiences of Adults Living with a Life-Limiting Illness Experiencing or at Risk of Domestic Abuse, Their Support Needs, and Existing Support Mechanisms Provided by Health, Social Care, and Third Sector Organisations

2.9.1. Types of Abuse. Different types of domestic abuse were reported and reflected attempts to specifically target the person's illness (2) and part of a continuum of power and control. Abuse was rarely contained to a one-off incident and often more than one form of abuse was present (5 and 21), with emotional psychological abuse reported as most frequently experienced (21). This manifested as critical behaviour (7), accusing the patient of infidelity (9), or the perpetrator having an affair (4, 5, 7, 12, and 16), minimising the illness or being dismissive of the person who was ill (4 and 7), withholding of attention or emotional detachment (7 and 12), telling the person they were going to die (7) or that they were a burden (12), not dying fast enough to benefit the family (5), and how illness or treatment was affecting the perpetrator (7).

Coercive and controlling behaviour was a dominant type of abuse experienced and characterised by threats, humiliation, and intimidation intended to harm, punish, or frighten the person or make them subordinate or dependent on the abuser and regulating their everyday lives. Examples reported included: preventing or delaying access to essential medical care and treatment (5, 7, 9, 13, and 17) which had led in some cases to the illness progressing to a stage where it was no longer treatable or curable (4, 5, and 9). In one study,

one woman's partner refused to allow her to receive chemotherapy, and another removed his wife who had been diagnosed with cervical cancer against the advice of the clinical team and prevented her from returning for follow-up treatment (5). Other types of coercive and controlling behaviour included controlling access to medical care, for example refusing to drive or accompany patients to hospital appointments; forcing them to drive themselves even when they felt physically or mentally unsafe to do so, which left them feeling exhausted and stressed, and was particularly difficult for those living in rural locations (4 and 14). Fear of abuse also led to people making adverse decisions about their care, including cancelling medical appointments (5, 9, 13, and 17). Threatening behaviour by the perpetrator (13), control over or negative comments about personal appearance (9 and 13), control over relationships including isolation from family and friends, and restricting access to support networks or preventing access to children (9). This controlling behaviour impacted on ability and opportunities to disclose the abuse and where the perpetrator was the caretaker, enabling them to increase their power to manipulate and further increase the person's dependency on them.

Verbal abuse was reported in a number of papers (1, 6, 7, 9, 16, and 18) and included swearing and verbal insults (1), making jokes or insensitive comments about the person's illness (7), using intimidating language or tone (6), and making negative statements to or about the person (13). Incidences of physical abuse were reported which could leave the person with broken bones, bruises as a result of the abuser intentionally bumping into surgical sites (5, 16), being pushed downstairs (5), strangulation (5), and being kicked or shoved (1, 5). While sexual abuse was described less frequently in the papers, there were experiences of rape or forced, unwanted sexual activity (5, 7), and alterations in intimate relationship including rough treatment (12).

Neglect was commonly experienced (5, 7, 9, 10, 11, and 18) and characterised by unmet care needs including: refusal to provide care or call for medical assistance when the person was in pain (5, 9, and 11), withholding food and water which could lead to malnutrition and dehydration (5), dismissing symptoms leading to delays in treatment (7, 9) or refusing to acknowledge levels of fatigue associated with the condition and the need for rest (7). Poor hygiene care and poorly managed continence resulted in patients developing sores and bruises (10). One paper also reported perpetrator abuse of the patients' medication (18).

Financial abuse was reported in seven papers (1, 5, 9, 10, 11, 13, and 18) and ranged from refusing to pay for health insurance (5) and misuse of direct payments such as state benefits (1, 11, and 18). A study in the USA reported an example of a family member wanting to wake a ventilated patient to sign a social security check (10). Other examples of financial abuse included: exerting control over finances, such as limiting access to joint bank accounts (1, 5, and 9) forcing the person to make purchases against their will (1), removing cash and valuables without the person's permission and in some cases selling them, and using credit or debit cards without the person's knowledge (1 and 11).

2.9.2. Impact of Abuse. Domestic abuse was reported to have wide ranging effects for the person living with a life-limiting illness (1, 2, 3, 4, 5, 7, 8, 12, 13, 14, 16, 17, 18, and 21) and some papers reported that participants blamed their illness on the stress resulting from the abuse they experienced (2, 8, 13, and 16). Abusive behaviours led to delays in screening and diagnosis and follow-up of conditions (5 and 7), missed treatment (7). Interfering behaviours during cancer care affected quality of life across multiple domains (3). In one study, a patient's husband was reported to disagree with the diagnosis and treatment plan which led to her cancer advancement before treatment could be initiated (5). Abuse impacted on mental health and wellbeing causing emotional distress (18 and 21), feelings of loss of control, entrapment and powerlessness (1, 5, and 12), and higher depression and stress scores (1, 2, 3, 17, and 21). Effects on physical health and wellbeing included high levels of pain severity as a result of physical abuse and/or interference with medication doses (8) or delayed medications (5 and 19), fatigue and tiredness through lack of sleep or being prevented from taking rest (1, 3, and 18).

Restricted access to family and support networks led to social isolation. This prevented help seeking behaviours due to feelings of powerlessness and led to the person feeling trapped and unable to leave the relationship due to their illness (5 and 7) and consequently dependent on the perpetrator (1, 2, and 5). For some, the prospect of escaping the abusive relationship was one more loss in addition to a terminal diagnosis that they could not contemplate (7). Financial issues could also mean staying in a relationship because of economic dependence on the abuser and concerns about becoming homeless (13). Fear of the repercussions of trying to leave the relationship (5) and not wanting to upset the abuser who was also their caregiver (18) also increased feelings of being trapped and a lack of control (2).

2.9.3. Impact of a Life-Limiting Illness. Existing power imbalances in relationships often became exacerbated when the person became ill or was a catalyst for abuse following diagnosis (4, 5, and 9) leading to a continuation of existing patterns of abuse (18) and worsening relationships (12). Living with a life-limiting illness increased vulnerability to domestic abuse with greater dependency on the perpetrator due to the increased care needs (2, 7, and 9), fear of disclosure leading to placement in institutional care (19), isolation due to the illness (9), reduced protective measures (8), and symptoms resulting from the illness and treatment also meant the person was unable to fight back or had the energy to advocate for themselves (2, 6, 7, 12, and 18). However, some papers reported how diagnosis of an illness could prompt the person to re-evaluate their life and end an abusive relationship (7, 13, and 16). Increased care needs led to changes in family relationship dynamics and complexity in the relationships between other family members resulting in abuse of the person who was ill (18). Caregivers could feel threatened by the attention the person with the life-limiting illness was receiving (12, 13) and resentful of the burden of caring (18, 21).

2.9.4. Support Needs and Coping Mechanisms. There was a paucity of evidence on the support needs of those experiencing domestic abuse, or how they were supported by health and social care professionals, or specialist domestic abuse organisations. Coping mechanisms tended to be derived from both internal sources of support, such as the person's faith or religion (4), increased alcohol consumption (1), and external support systems comprising neighbours, friends, and members of the community (4, 14, and 16) and in some cases included healthcare professionals (4).

2.10. Objective 3: To Identify and Characterise the Views and Experiences of Health and Social Care Professionals and Third Sector Organisations of Identifying, Responding, and Supporting Adults Living with a Life-Limiting Illness Impacted by Domestic Abuse

2.10.1. Identifying and Detecting Abuse. Papers reported the challenges for health and social care professionals of identifying domestic abuse within the context of life-limiting illness (2, 5, 8, 9, 11, 17, 19, 20, and 21). At an individual level, this included the professional's lack of confidence to ask about abuse (2 and 5), forgetting to ask domestic abuse screening questions when seeing the patient (17), or not recognising signs of abuse, particularly when there were no presentations of physical violence (20 and 21), or being unable to differentiate between someone advocating for the patient and controlling behaviour (6). The presence of comorbid conditions, masking signs of abuse or overlapping with the natural dying process also made identifying domestic abuse challenging when coexisting with life-limiting illness (9 and 19). Furthermore, identifying family members as perpetrators of abuse could be difficult as they could put on a supportive appearance in the presence of others (5 and 19) and domestic abuse could be mistaken for, or interpreted as, a grief reaction by professionals (6). Fear about "making things worse" for patients or "opening up a Pandora's Box" also prevented them from enquiring about abuse (19). This could be made more complex by a patient's reluctance to disclose due to fears of the consequences of making a disclosure (5, 9, and 10), particularly if they were dependent on the abuser for their care or finances (2, 10), did not recognise their experiences as abuse (5), or had difficulty answering questions about abuse because of issues with recall or fluctuating or diminishing capacity (11 and 19). Family dynamics and cultural issues could also deter reporting, with patients feeling embarrassed or ashamed about the abuse or considering it to be a private, family problem (2 and 19).

Disclosure was more likely when a professional could provide a safe environment (2 and 10) and ensure privacy and confidentiality (8). This was often difficult as patients were likely to be accompanied by a caregiver (5, 8, 9, 17, and 20). Building a relationship with the perpetrator so they felt confident to leave the patient alone could be a key to facilitating a disclosure (10). When disclosures were made, patients were more likely to tell a nurse who provided continuity of care (20) and where rapport and a trusted, non-judgemental relationship was established (5 and 10).

However, it was recognised that domestic abuse requires a multidisciplinary team (MDT) approach (2 and 20).

Several papers outlined ways professionals could address the challenges of identifying domestic abuse and encourage disclosure. These included asking open questions (20) as part of routine history taking (2, 3, 14, and 19) and maximising opportunities to do so such as during admission to hospital (10), at a home visit (21), or on discharge (10). Asking about abuse on repeated occasions provided opportunities for patients to disclose when they felt ready (5, 9, 15, and 19). It was important for questions to be phrased in a non-judgemental and empathetic way to put patients at ease (2, 5, and 9). Being vigilant for signs of abuse such as controlling behaviours in consultations (3, 5, 10, and 20), suspicious physical injuries (10), financial abuse (11), and using “gut instinct” or intuition (10) also helped to alert professionals to domestic abuse.

2.10.2. Risk Factors for Domestic Abuse. Living with a life-limiting illness can increase the risk of domestic abuse as it places additional burdens on relationships that are already strained (18), increasing the vulnerability of the person with the illness (18). Papers identified a number of “victim” risk factors such as: a history of domestic abuse in the relationship prior to diagnosis (1, 9, 18, and 21), increased dependency on the perpetrator for daily care (1, 9, and 18), poor social support (19) and exhibiting provocative or abusive behaviour themselves (19). Other health-related patient risk factors include cognitive (19) and physical impairments (9 and 19), mental health issues (18), advancing age (21), and substance misuse (1). Perpetrator risk factors were reported as caregiver stress (9, 15, 18, 19, and 20), substance misuse (1, 18, and 19), financial difficulties and dependency on the person for money (9, 19), existing family disagreements (1 and 18) and mental health issues (1 and 9). Codependency between “victim” and perpetrator could also be a trigger for abuse (10 and 21).

2.10.3. Responding to Disclosures of Abuse. Responding to a disclosure of domestic abuse experienced by a patient could be challenging for professionals and papers identified a number of barriers to managing abuse and providing appropriate support. These included: insufficient training (17), lacking confidence (17) or awareness of abuse (17 and 19) or understanding of the cultural context (5). Professionals could feel intimidated if discussions needed to be carried out with the perpetrator (21) and where there were child protection issues (20). Organisational factors such as lack of policies and processes (19 and 21), time constraints for clinical contact (5 and 17), and availability of a private space in the clinical setting (17 and 20) also inhibited the response to a disclosure.

When a disclosure of domestic abuse was made supporting the patient was as a key. Providing support to empower the person and make the best decision for them (9) was a priority regardless of whether that was accepting appropriate support or referral (5, 8, and 19), remaining in the relationship (9) or refusing abuse interventions (9, 18,

and 20). In cases where a patient stayed in the relationship developing an individualised strategy in the form of a safety plan was paramount (5). Documenting the abuse using the patient’s language as much as possible was considered to be good clinical practice (5 and 17). Conducting a holistic assessment with the patient, including family dynamics (5 and 6) and taking into account their concerns about disrupting the relationship with the abuser when they were also their caregiver, whilst dealing with abuse in a way that was sympathetic to the perpetrator’s needs, was deemed essential (18 and 19).

An MDT approach involving the police, social services, and safeguarding practitioners (11) was viewed as the most effective way of responding to and managing abuse (2, 5, 8, 11, 18, 19, and 21), and achieving a resolution before the end of the patient’s life (8). Different roles within the team complemented each other to best assess patient needs and provided relevant resources (5). Across the team, core skills were recognised as essential to effectively respond to domestic abuse including: empathetic communication (5), establishing rapport with a patient (17), and validating the patient’s experience (5 and 17). Referring on and signposting to sources of support, when this was the patient’s wish, was identified as part of care (5, 9, and 18). However, it was reported that practitioners were often unaware of the outcome of a case once it has been referred to safeguarding. Also, improving the feedback loop from safeguarding was considered important (10).

A number of papers focused on how practitioners might reduce the risk of abuse (11). Such measures included educating caregivers on the illness trajectory and what to expect during the approach to end-of-life and their role and responsibilities as caregivers (15, 18, and 19), establishing care plans (11) and helping to manage caregiver stress (18 and 19).

2.10.4. Improving Identification and Response to Abuse. The majority of papers provided suggestions for improving screening and management of abuse in practice (1, 2, 5, 10, 11, 12, 13, 14, 15, 17, 18, 19, and 21). Suggestions included asking about domestic abuse by including screening questions when asking about social support (12, 13, and 14), amending existing clinical forms and questionnaires to enquire about abuse (17), and developing culturally sensitive screening tools and in different languages (2). Similarly, when enquiring about domestic abuse, a trauma-informed approach to care was needed (6). It was also important for health and care professionals to recognise signs and symptoms of abuse, such as interfering behaviours, which may go undetected during screening (3).

Educational programmes for both undergraduate and postgraduate healthcare professionals was seen as key, with a focus on screening (1, 2, 5, 9, 10, 13, and 20), building rapport (5), counselling and supporting survivors of abuse (5, 9, 15, 18, and 19), understanding the coexistence of domestic abuse and life-limiting illness (5, 12, and 15), and documenting abuse and legal responsibilities (10). Academic curriculums also needed to address: follow-up care for

patients (9), supporting vulnerable rural patients (14), family dynamics and relationships (18, 21), and speaking to perpetrators of abuse (21). For greatest effectiveness, ongoing training and development for healthcare professionals on domestic abuse is needed (15).

3. Discussion

A scoping review was conducted to identify factors that shape and characterise the experiences of adults living with a life-limiting illness and domestic abuse, and those of the health, social care, and third sector practitioners who support them. To our knowledge, this is the first scoping review to focus on domestic abuse and the coexistence of life-limiting illness and it intends to increase the understanding of the topic and identify gaps in knowledge that warrant further investigation. Findings revealed a paucity of evidence, resulting in significant shortcomings in the literature, with most papers reporting on women living with cancer and omissions in regard to the support needs of those experiencing or at risk of domestic abuse. Similarly, there was limited evidence on the experiences, support, and development needs of professionals outside of the health sector, in adult social care and the third sector. Given that successful management of domestic abuse relies on a complex and multi-layered interagency approach [19], and findings in this review showed MDTs are considered an effective mechanism for managing abuse in the life-limiting illness context, developing the evidence base on the experiences and needs of all sectors is imperative.

People living with a life-limiting illness experienced a range of abusive behaviours, but some forms were reported as more frequently perpetrated: coercive and controlling behaviour, emotional and psychological abuse, and neglect and financial abuse. Domestic abuse had specific impact for people living with a life-limiting illness. It had a detrimental impact on mental health and wellbeing, but an important and disturbing finding was that for some, abuse could result in delays in screening leading to late diagnosis, the illness advancing and palliative rather than curable treatments being available. Progression of the illness often increased care needs and dependency on the caregiver and further intensified the person's vulnerability to domestic abuse, and reluctance to disclose the abuse for fear of being placed in institutional care. Coercive and controlling behaviour, which restricted access to family and other support networks, led to social isolation and prevented help-seeking, and the person being trapped in the relationship and unable to leave, even if they were able or wanted to.

The diagnosis and progression of a life-limiting illness can change relationship dynamics for both the person and caregiver. As the person with a life-limiting illness becomes less able to look after themselves and more reliant on their caregivers, caregiver stress may develop. Caregiver stress is often the result of exhaustion, stress, and anxiety [47] and should not be mistaken for domestic abuse, which is rooted in issues of power and control. In the context of life-limiting illness, domestic abuse often reflects existing abuse prior to the person becoming ill, which may be exacerbated following diagnosis. Many of the participants in the studies included

here had experienced domestic abuse throughout their partnership or marriage. The blurring of boundaries between caregiver stress and domestic abuse may be a result of the abused person's perceptions of themselves, and what constitutes abusive behaviours, as well as presumptions by health and care providers. The failure to draw a clear distinction between the two is likely to result in the needs of those with a life-limiting illness not being met and poorly defined by services or the complexity of the nature of relationships at all stages of the lifecycle being acknowledged [48–51]. The literature provided little evidence on the support needs of this population which requires further research and investigation.

Papers reported the challenge for healthcare professionals of identifying and responding to domestic abuse in the context of a life-limiting illness and related to lacking confidence, and skills and knowledge of other support services and referral pathways. This highlights the need for increased training, education, and continuing professional development (CPD) in this area. Evidence suggests that nurses and other healthcare professionals are often ill-prepared to respond and manage incidences of domestic abuse effectively [52, 53] and highlights the need for improved training, resources, and support for them to be able to do so [54]. Training and education are essential to help practitioners understand the complexities of the disclosure process and potential enablers and facilitators to a patient disclosing. In the UK, domestic abuse is a national and local policy priority driver for healthcare, with a focus on the development of strategies and training to support the effective recognition and management of domestic abuse by health and social care professionals [55]. There are legislative frameworks to support healthcare services identify, manage, and respond to disclosures of domestic abuse [56–59]. However, while training and education programmes are available, there is no specific training for responding to domestic abuse where it coexists with life-limiting illness. Where training is provided, it tends to be in the context of adult safeguarding. Given the specific and complex needs of people living with a life-limiting illness, regular training for practitioners that addresses all aspects of domestic abuse and life-limiting illness is both essential and overdue.

Disclosure was more likely to occur when a trusted relationship with the practitioner was established and privacy and confidentiality could be provided. Responding to a disclosure could be as challenging as identifying the abuse and was exacerbated by healthcare professionals feeling underprepared. While this relates to upskilling practitioners, it extends to ensuring they feel emotionally ready for the work required to manage domestic abuse [19]. While those working in hospice and palliative care are experienced in having “difficult” and “sensitive” conversations about end-of-life, this does not necessarily translate to other topics, including abuse, often because of concerns about offending patients, making the situation worse, or jeopardising their relationship with them [60]. This is despite evidence showing that patients want to be asked directly about abuse by supportive practitioners [61] and look to them to provide practical support [62].

Contributory factors to practitioners feeling unprepared to address domestic abuse include lack of organisational and system level support, which restricts time permitted for clinical contact and does not allow for carrying out sensitive work with patients, and absence of protocols and policies for managing domestic abuse [63]. Research in other healthcare settings suggests that support from managers, opportunities for reflexive feedback and monitoring, feedback loops, and clear and visible organisation guidelines, protocols and policies provide legitimacy to practitioners that this is part of their role and increases their confidence and competence to respond appropriately to disclosures of domestic abuse [64–66].

3.1. Implications for Policy and Practice. From our review, we conclude that for health and care professionals to provide adequate and appropriate support to patients/clients with a life-limiting illness who disclose domestic abuse, education, training, and continuing professional development are essential. Education and training on domestic abuse in the context of life-limiting illness need to be included in undergraduate and postgraduate curriculums for health and care professionals and continue into practice. This is important for understanding the complexities of domestic abuse where it coexists with life-limiting illness, and how to manage disclosures. Training not only improves understanding but also increases confidence to ask about and respond to abuse, including what, how, when, and where to ask. Topics should include as a minimum: types of abuse, indicators of abuse, enquiring about abuse, dealing with disclosure, conversations with perpetrators, risk assessment, and referral options. Research has shown that patients are more likely to confide in practitioners who they perceive as knowledgeable and capable of handling a disclosure, offer an empathetic response and validate their disclosure [16, 67, 68]. Organisations should consider who is best placed to deliver training, whether this can be provided in-house or by an external specialist domestic abuse service, and different modes for delivery. Evidence shows that health and care professionals can be trained successfully to intervene and respond to domestic abuse [69] and is more effective when it is interactive and involves participation and experiential learning [70].

Training should not be limited to health and social care professionals and should be accessible by all members of staff in hospice and palliative care organisations. Patients may choose to confide in someone without a healthcare background, including volunteers, catering, housekeeping, or administrative staff. Non-healthcare staff should receive training that increases confidence and awareness of domestic abuse, addresses issues of confidentiality, and who within their organisation they report disclosures to.

Along with increasing awareness and knowledge, equipping those working in hospice and palliative care with the confidence and skills to identify and respond to abuse is key. Training should address issues related to practitioners' own safety, especially when undertaking home visits, and emotional aspects of dealing with domestic abuse. Training needs to ensure staff are emotionally ready to manage the

work of domestic abuse, otherwise it is setting them up to fail [19]. Appointing domestic abuse champions within an organisation can help act as a point of reference for staff and provide advice and emotional support to them when needed. Although a relatively new concept, evidence suggests domestic abuse champions in healthcare settings have a positive impact and act as change agents through their support and mentorship, enabling colleagues to effectively alter their practice and engage in the complex and challenging work of detecting and responding to abuse [71]. Champions need to be trained to an enhanced level, but not delegated sole responsibility for managing domestic abuse within the organisation, rather supporting fellow practitioners through the process. While all staff should be given the opportunity to take on the champion role, they should be those who are approached for problem solving or have line management responsibilities, to operate as part of a network of champions within the setting [72].

Creating a private and safe environment within the clinical setting where confidentiality is assured is more likely to facilitate a disclosure. Where these do not exist, organisations may need to make structural changes to provide these spaces. Ensuring patients are aware of resources available to them by having posters and information displayed may also give them confidence to disclose [73].

Finally, practitioners should be adopting an advocacy approach to addressing domestic abuse, which moves away from the traditional medical model of “fixing” patients' problems, to one of the support and empowerment to allow them to make the best decision for them and that recognises patients as experts in their own lives. This is important regardless of whether a patient wants support or further action to be taken or to remain in the abusive relationship. However, wherever possible, a safety plan that the patient is comfortable with should be developed and put in place, especially for those at high risk.

3.2. Limitations. As with all reviews, there are some limitations here. A focus on healthcare systems similar to that of the UK was intended to increase transferability of findings. However, differences between these systems and exclusion of healthcare systems those were not comparable to that of the UK may limit transferability. There were limitations in terms of data obtained. This includes a lack of male participants in included studies, with only three papers including males. Studies reporting on the experiences of people living with a life-limiting illness in the context of abuse focused on those living with cancer, including four papers derived from one study (12, 13, 14, and 16), and as such there was little evidence relating to those with other terminal conditions. While the type of condition may not be a predominant factor pertaining to experience, further research may be needed to establish the generalisability of findings to other life-limiting illnesses and to men's experience of domestic abuse. In addition, there was limited evidence on the experiences, support, and developmental needs of professionals outside of the health sector, in adult social care and third sector organisations.

4. Conclusion

This review has strengthened the evidence based on domestic abuse in the context of life-limiting illness, bringing together research on the experiences of people living with an incurable condition experiencing domestic abuse, and identifying and characterising the experiences, support, and training needs of those who care for them. However, significant gaps in knowledge remain with regard to the support needs of those experiencing or at risk of abuse and the support mechanisms outside of healthcare, particularly in social care and specialist services in the third sector. Addressing these gaps is an important goal for future research in order to inform policy and practice to identify and manage domestic abuse where it coexists with life-limiting illness.

Data Availability

Data sharing is not applicable as no datasets were generated and/or analysed during the study. No additional data are available.

Additional Points

What is known about this topic? (i) Domestic abuse is a global public health issue. (ii) People living with a life-limiting illness are at increased risk of domestic abuse because their condition may make them vulnerable, frail, and dependent on others who may also be the perpetrator of the abuse. (iii) Those experiencing domestic abuse are more likely to disclose to a healthcare professional than any other professional. *What this paper adds.* (i) People living with a life-limiting illness experience a range of domestic abuse types which can result in social isolation and impacts on their health and wellbeing. (ii) The findings from the paper have important implications for policy and practice in regard to recognition of domestic abuse in people with a life-limiting illness, how to approach questioning, maintain clinical trust, respond, and overcome barriers to disclosure. (iii) Training and education for health and social care practitioners, which increases knowledge and confidence in managing and supporting disclosures of domestic abuse is essential to adequately support patients with a life-limiting illness and ensure their specific and complex needs are addressed.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Supplementary Materials

Appendix 1. Stage 1 MEDLINE (EBSCO). Appendix 2. Stage 2 MEDLINE Search Strategy. Appendix 3. CINAHL (EBSCO).

Appendix 4. PsycINFO (OvidSP). Appendix 5. Social Sciences Citation Index (web of Science). Appendix 6. ProQuest Theses and Dissertations Global. (*Supplementary Materials*)

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