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## Identification and assessment of intimate partner violence in nurse home visitation

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### Abstract

**Aims and objectives**—To develop strategies for the identification and assessment of intimate partner violence in a nurse home visitation programme.

**Background**—Nurse home visitation programmes have been identified as an intervention for preventing child abuse and neglect. Recently, there is an increased focus on the role these programmes have in addressing intimate partner violence. Given the unique context of the home environment, strategies for assessments are required that maintain the therapeutic alliance and minimise client attrition.

**Design**—A qualitative case study.

**Methods**—A total of four Nurse–Family Partnership agencies were engaged in this study. Purposeful samples of nurses ( $n = 32$ ), pregnant or parenting mothers who had self-disclosed experiences of abuse ( $n = 26$ ) and supervisors ( $n = 5$ ) participated in this study. A total of 10 focus groups were completed with nurses: 42 interviews with clients and 10 interviews with supervisors. The principles of conventional content analysis guided data analysis. Data were categorised using the practice–problem–needs analysis model for integrating qualitative findings in the development of nursing interventions.

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**Contributions:** Study design: SMJ; data collection, analysis and data interpretation: SMJ, MFG, DD, HLM; NFP IPV intervention: SMJ, MFG. drafting and revising: SMJ, MFG, DD, HLM.

**Results**—Multiple opportunities to ask about intimate partner violence are valued. The use of structured screening tools at enrolment does not promote disclosure or in-depth exploration of women's experiences of abuse. Women are more likely to discuss experiences of violence when nurses initiate nonstructured discussions focused on parenting, safety or healthy relationships. Nurses require knowledge and skills to initiate indicator-based assessments when exposure to abuse is suspected as well as strategies for responding to client-initiated disclosures.

**Conclusion**—A tailored approach to intimate partner violence assessment in home visiting is required.

**Relevance to clinical practice**—Multiple opportunities for exploring women's experiences of violence are required. A clinical pathway outlining a three-pronged approach to identification and assessment was developed.

### Keywords

assessment; home visits; intimate partner violence; nurse; public health nursing; qualitative study

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### Introduction

The major impact of intimate partner violence (IPV) on women's physical and mental health has been increasingly recognised over the past 40 years. Findings from a multicountry study conducted by the World Health Organization identified significant associations between women's lifetime experiences of IPV and self-reported poor health and a broad range of specific health problems including difficulty walking, pain, difficulty with daily activities, emotional distress, suicidal thoughts and attempts, among others (Ellsberg *et al.* 2008). A recent systematic review that included data from 66 countries concluded that one in seven homicides are committed by an intimate partner – a figure that is six times higher for female compared with male homicides (Stoöckl *et al.* 2013). Exposure of women to IPV during pregnancy is also a major concern because it can threaten the health of both the mother and the foetus; abuse may lead to poor pregnancy outcomes and perinatal death (Shah & Shah 2010).

Despite the morbidity and mortality associated with IPV, relatively little attention has been given to the development and evaluation of strategies for healthcare providers to respond to women exposed to IPV. During the 1980s, Campbell and Humphreys (1984) identified that nurses were ideally positioned to assist women who had experienced family violence, but subsequently, the emphasis on screening appeared to overshadow a broader consideration of ways in which nurses could support women who are experiencing IPV. Of note, although nurses have a long tradition of involvement in home visiting, and such programmes have been operating in many countries for decades with an emphasis on the perinatal period (Kamerma n & Kahn 1993), it is only recently that this type of intervention was conceptualised as an approach to reducing IPV. Home visiting programmes have generally focused on providing services to promote child development and/or improve parenting skills (Powell 1993). The role of home visitation in preventing family violence has emphasised reduction of child abuse and neglect over the years (Donelan-McCall *et al.* 2009) rather than IPV. With increased knowledge about the association between child maltreatment and

partner violence between caregivers, as well as better understanding about the importance of reducing children's exposure to IPV, home visitation as an approach to reducing IPV has become a recent focus of investigation. Many young women living in poverty with children at risk for poor developmental outcomes – one of the groups for whom home visitation has been shown beneficial – are also those at increased risk of IPV (MacMillan & Wathen 2014).

The Nurse–Family Partnership (NFP), an intensive programme of nurse home visitation for low-income first-time mothers, is an intervention shown in US trials to improve maternal and child outcomes, including exposure to child maltreatment (Olds *et al.* 2007). The NFP programme of home visitation is currently being implemented or evaluated internationally, in countries including the USA, Canada, Australia, England, Scotland, Northern Ireland, the Netherlands and Norway. The context of the NFP, a programme for women at high risk of IPV, provides a unique opportunity for nurses to respond to women experiencing IPV (Jack *et al.* 2012). The overall purpose of this programme of research was to develop a complex intervention to identify and respond to IPV within the context of NFP (Jack *et al.* 2012). In this article, we present the results from a practice, problem and needs analysis using data from the broader project exploring how nurse home visitors identify and assess for IPV exposure and what conditions foster the safe disclosure and discussion of experiences of abuse.

## Background

Historically home visitation programmes have addressed IPV through routine screening and referrals to outside agencies after a disclosure or signs of IPV became evident to the home visitor (Sharps *et al.* 2008). Home visitors report a high likelihood of interacting with clients experiencing IPV in their caseloads (Jack *et al.* 2012), and most believe that routine assessment of IPV is within their professional role (Dickson & Tutty 1996, Shepard *et al.* 1999), yet, significant barriers exist that may prevent effective identification, assessment and disclosure of IPV in this unique setting. The therapeutic home visitor–client relationship that develops over time has been described as a one of the most important facilitators of home visitors' assessment of IPV (Jack *et al.* 2008, Burton & Carlyle 2015). However, many home visitation programmes are structured so that IPV screenings occur early in the visitation schedule or at every visit, which may not be conducive to initiating conversations about IPV or eliciting accurate responses from clients (Burton & Carlyle 2015). Home visitors have reported reluctance to screen for IPV out of fear of jeopardising established rapport and trust with their clients (Frost 1999, Sharps *et al.* 2013). Without established therapeutic relationships between nurses and clients, there is an increased risk of high levels of client attrition from the home visiting programmes.

Identifying and responding to IPV is a time and resource-intensive activity. For example in postpartum home visits, public health nurses report difficulty finding adequate time to address IPV within the context of a content-rich home visit (Jack *et al.* 2008). Furthermore, balancing IPV assessment with other complex, pressing needs that clients and their families may be facing (e.g. lack of housing, mental health and substance abuse issues) is particularly challenging for home visitors (Jack *et al.* 2008, Tandon *et al.* 2008). Other studies have described home visitors' feelings of discomfort when taking focus off of the child to discuss

parental concerns (Hebbeler & Gerlach-Downie 2002, Taft *et al.* 2012). An additional concern is the presence of partners, family members and children in the home – a common scenario that may preclude safe and private discussions about IPV between the client and home visitor (Shepard *et al.* 1999, Jack *et al.* 2008, Taft *et al.* 2012). While clients enrolled in home visitation programmes report their own set of barriers to disclosing their experiences of abuse to their HV (e.g. embarrassment, fear of child protective services, and fear of partner finding out), most believe a focus on parental psychosocial well-being is appropriate (Hebbeler & Gerlach-Downie 2002).

Finally, perhaps the most salient barrier to assessing IPV in home visitation has been inadequate education and resulting lack of knowledge and skills reported by home visitors to address IPV with their clients (Dickson & Tutty 1996, Peckover 2003, Tandon *et al.* 2005, Jack *et al.* 2008, Sharps *et al.* 2008). Furthermore, studies indicate that even when clients in home visitation programmes are screened for IPV, only a small proportion are referred to and receive needed services (Shepard *et al.* 1999, Tandon *et al.* 2005, 2008). Fortunately, there is evidence to indicate that IPV education that goes beyond providing knowledge and includes skills-based strategies (e.g. role playing with guided practice, supervision with direct feedback) can increase home visitor confidence in asking about IPV screening (Sharps *et al.* 2013).

In a review of the literature on perinatal home visitation and IPV published in 2008, Sharps *et al.* (2008) found that although many home visitation programmes included protocols to screen clients for IPV and refer them to outside agencies, no programme had specific content related to IPV as a formal part of the curriculum. Given this finding, the aforementioned barriers to screening and assessment in these settings are concerning, yet unsurprising. Fortunately, since this review, increased attention has been focused on home visitation programmes as a potential mechanism for improving health and well-being of abused women (Sharps *et al.* 2008), and several rigorous randomised controlled trials have been developed to test the effects of integrating enhanced IPV assessment within home visits, such as the Domestic Violence Enhanced Home Visitation trial (Bhandari *et al.* 2011, Sharps *et al.* 2013) and the NFP IPV trial (Jack *et al.* 2012). What has emerged from the formative research (Jack *et al.* 2012, Sharps *et al.* 2013) of these larger trials is a better understanding of what is needed to develop ‘best practices’ for home visitors to effectively identify and respond to IPV.

While it is well-recognised that addressing IPV in home visitation should include processes for identifying IPV in a private, sensitive, nonjudgmental manner within the context of a solidly established provider–client relationship, a more nuanced description of the specific strategies for incorporating assessments into the home visitation schedule and practical techniques for initiating conversations with clients is needed. This contextual information is important for improving assessment and supportive nursing practices related to IPV (Hooker *et al.* 2015).

### **Nurse–Family Partnership: a programme of nurse home visitation**

Home visiting programmes, particularly for the most vulnerable pregnant women and young families, have demonstrated significant benefits in improving prenatal, child health and

development, and maternal outcomes (Howard & Brooks-Gunn 2009). Although the goals of many home visitation programmes are similar, programme model elements may vary by frequency of home visits, length of programme tenure and the qualifications of the home visitor. NFP is a targeted home visiting programme delivered to young, low-income first-time pregnant women and mothers. The home visits, delivered by registered nurses, begin early in pregnancy (before the end of the 28th week of pregnancy) and continue until the child's second birthday. The establishment of a therapeutic relationship is central, and during home visits, nurses and clients discuss content from across six broad domains: personal health, environmental health, friends and family, the maternal role, the use of healthcare and human services and maternal life course development (Dawley *et al.* 2007). NFP has been evaluated in three US-based randomised controlled trials and has demonstrated consistent effects in improving a range of maternal and child health outcomes (Olds *et al.* 2007). However, findings from the first study conducted in Elmira, New York, indicated that in households where women reported moderate to severe levels of IPV exposure, the positive effect of the NFP in reducing rates of child abuse and neglect was not found (Eckenrode *et al.* 2000). This finding indicated the need to enhance the strategies nurses use to identify and respond to IPV in NFP.

## Methods

### Design

An exploratory multiple-case study design (Yin 2003) informed the qualitative work that was conducted to develop and pilot test the NFP IPV intervention. The results presented here draw on data from (1) four US-based NFP sites that informed intervention development; and (2) one of these US-NFP sites where the NFP IPV intervention was piloted for feasibility, for acceptability and to identify any necessary changes to the intervention. An in-depth description of the research design, sample and methods used to develop the NFP IPV intervention has been detailed in a previous publication (Jack *et al.* 2012). Permission to conduct this study was obtained from the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board and the Institutional Review Boards of West Virginia University and the University of Colorado. The research protocol was also reviewed and approved at the NFP National Service Office and at each local NFP site by the appropriate committee or affiliated IRB. Informed consent to participate in the study was obtained from each study participant.

### Data collection and analysis

Triangulation of data sources is a characteristic of case study research (Yin 2003). To increase our understanding of how IPV is identified and explored in NFP home visits, data collected from a purposeful sample of NFP supervisors, nurse home visitors and clients (who had self-reported current or past IPV) were included in this analysis (Table 1). From the intervention development sites, data from 27 nurse home visitors, four NFP supervisors and 20 NFP clients were analysed. Additional data from the pilot study (i.e. qualitative interviews with an additional five nurses, one supervisor and six NFP clients) were also used in this analysis. Nurse home visitors each participated in two focus groups and supervisors each independently completed two face-to-face semistructured interviews. Among the 26

participating NFP clients, all completed one interview, while 16 of those participants completed a second interview. Therefore, a total of 62 transcripts from the focus groups and individual interviews were included in this analysis.

In this case study, all interview guides contained a range of questions framed by phases of the nursing process, to guide the development of a context-relevant NFP IPV intervention. For this analysis, responses to questions focused on IPV identification, assessment or disclosure were extracted from the selected transcripts (see Table 2 for sample questions). All interviews were first audio-recorded and transcribed verbatim with identifying information removed. The principles of conventional content analysis and constant comparison guided all coding and synthesis of the data. Multiple authors (SJ, MFG and DD) participated in coding, synthesising and summarising the data. Data were categorised using the practice–problem–needs analysis model for integrating qualitative findings in the development of complex nursing interventions (van Meijel *et al.* 2004).

## Results

A comprehensive description of how nurse home visitors ask about IPV and the conditions in which NFP programme clients disclose information about their experiences of abuse is presented in this section. The results are categorised as follows: (1) an analysis of existing NFP nurse home visitor *practices* specific to asking about IPV and client responses to those practices; (2) identification of the *problems* or challenges that limit a thorough assessment of IPV experiences; and finally, (3) an analysis of what *needs* to be changed to improve current practice. A summary of findings from the practice, problem and needs analysis is provided in Table 3.

### Practice analysis

**Assessment procedures**—The clinical protocol in place at the beginning of this study involved nurses asking clients to complete a *relationship assessment questionnaire*, a modified version of the Abuse Assessment Screen (McFarlane *et al.* 1992) at three time points: intake (generally on or before the fourth prenatal visit), at 36 weeks of pregnancy and when the infant is 12 months. In the focus groups, nurse home visitors reported that using this protocol to ask questions about IPV early in the programme helped heighten clients' awareness that IPV is a topic that can be discussed safely with their home visitor, even if women did not feel safe to disclose exposure to IPV at that time. As one nurse explained, 'even if they are not honest with you in the beginning, you plant a seed about what this programme [NFP] does'. Repeating the assessment so that clients had multiple opportunities to disclose abuse over time was seen by nurses as important because: (1) the nature of the client's relationship with her partner may change during pregnancy or following the birth of the child; (2) the client may enter into a relationship with a new partner necessitating a new baseline to be established; and (3) clients may be more likely to disclose abuse later in the programme once a certain level of trust and rapport with their nurse has been established.

The NFP clients who participated in this study had all experienced IPV, yet 35% indicated that they purposefully did not disclose the abuse when completing the intake relationship assessment, 10% provided a partial disclosure (e.g. admission of emotional abuse but not



physical abuse) and 5% reported that their home visitor did not completed this assessment with them. Clients explained that they did not disclose abuse during the administration of this assessment tool because the questions ‘came out of nowhere’ with minimal introduction provided to help them understand why the information was being sought. Importantly, they were fearful that the information would be shared with others, that child protection services (CPS) would become involved, that the nurse would not understand the complexity of her situation or that violence would escalate if her partner learned of her disclosure. Finally, some believed that there was ‘nothing [the nurses] can do’, except provide support following a disclosure.

**Informal opportunities for learning about IPV**—Both nurses and clients reported that discussions about personal experiences of IPV were more likely to occur during general conversations about other topics, such as personal safety, their relationships, their partner's role in parenting and their experiences in childhood. As one mother explained, ‘I don't actually remember when I told [my nurse]. We've had lots of conversations.... She'd always ask how things were going and how he was partaking in [my daughter's] life. Then it would kind of lead back to talking about him ...’. Some participants also observed that working on a side-by-side activity (such as a craft or parenting skill activity) with their nurse was less threatening than answering questions and helped them open up about their lives and relationships.

In practice, many nurses only learned about a client's exposure to abuse when a crisis was emerging, brought on by escalating violence, that prompted the client to reach out to the nurse. Similarly, some clients reported that they only told their nurse about the abuse when they reached a point of feeling overwhelmed with multiple stressors, lacked substantial family supports or were changing their place of residence due to escalating violence. As one nurse explained, ‘it is not until something huge happens, that then they feel like they've got to call you’. Many nurses also shared that they first became aware of violence within the family when the client experienced an injury that could not be hidden or when the nurse arrived for a visit and observed obvious signs of violence such as damage in the home. One nurse shared, ‘It's when you get there and something has happened and they're still very upset about it. They'll most easily open up then’.

Furthermore, the nature of home visiting provides a unique opportunity for nurses to observe the interactions of clients and family members in their own ‘natural’ home settings. The nurses described initiating conversations about relationships with clients by sharing their observations of what they had seen during the home visits. One nurse shared:

The other way for me [to learn about their IPV] is when the guy is very disrespectful to her while I'm there because usually people are on their best behaviour in front of the nurse, so when they're already disrespectful. Come on. I'm like, ‘even in front of me?’ I'm sitting right here, so I know it is much worse when I'm not there.

Some clients reported that their nurses observed their partners being emotionally abusive during a home visit or would question them about apparent physical injuries. Client-initiated disclosures of abuse were also prompted by questions about recent moves or transitions

within the relationship. It was at such times that clients disclosed that the reason for the move was to escape from or end the violence.

**Attributes of NFP programme**—The nurses described many unique characteristics of the NFP programme model and attributes of skilled nurse home visitors that they believed created a safe context for clients to discuss their IPV experiences. According to the nurses and supervisors, the goals, structure and content of NFP home visits create a foundation where a strong nurse-client therapeutic alliance can be established and nurtured; once that relationship is created, opportunities exist for exploration of issues, such as family violence. Nurses identified that the NFP programme includes a core focus on maternal health goals and needs. When compared to older models of public health nursing, the focus of NFP is on providing support rather than surveillance, and not ‘telling clients what to do’ but instead ‘helping them figure out what to do’. In this context, the nurses identified many clinical strategies used to lay a foundation for conversations about family violence. For example, many nurses spoke about the value of conducting a life history and creating a family tree with clients as a way of understanding the nature of different relationships in the client’s life (past and present), identifying potential risk indicators for current IPV and exploring how past relationships influence how clients parent their own children. While completing the life history, nurses shared that it was common for clients to discuss their experiences of past abuse (often during childhood) but perceived that it was difficult for many clients to talk about current abuse, particularly sexual abuse or coercion.

**Establishment of a therapeutic nurse-client relationship**—Regardless of when or how a disclosure occurs, nurse home visitors explained that establishing a therapeutic nurse-client relationship that is characterised by trust is the most essential factor that supports clients speaking about their experiences of IPV. Clients, in turn, spoke of being able to speak honestly about their experiences of violence and trauma once they felt ‘comfortable’ or had ‘built a system of trust’ with their nurses. While nurses identified that some clients are ‘very verbal at the beginning’ and talk about the abuse as early as intake, many clients wait until later in the programme. As one nurse shared, ‘Once you’ve got a relationship, most of them will sit and talk’. Unique to NFP home visiting is the number of home visits and the overall amount of time over 2.5 years that a nurse spends with each client. Many nurses identified that it takes a significant amount of time to establish the type of relationship where clients feel safe: ‘They [clients] don’t come forth with information right away. It takes time’. One supervisor validated the nurses’ perceptions by summarising, ‘I think it’s a period of time and the development of that therapeutic relationship where they feel comfortable’.

Nurse–Family Partnership nurses develop and apply effective communication strategies that actively engage clients actively in dialogue about their lives and the care and parenting of their infants. Specific communication strategies used by nurses to facilitate discussions about family violence included use of open-ended questions, active listening, and validating client experiences and narratives. The nurses emphasised the importance of conversing with clients rather than a traditional approach of ‘telling’ or ‘educating’ clients about what to do. The nurses perceived that this approach to communication facilitates disclosures. One nurse explained that in a NFP home visit:

Your conversation is two-way, not just one-way where you [the nurse] are spouting off information and they [the clients] are just, 'uh-huh, whatever'. You know you can tell the ones that are actually engaging and listening and offering. I mean they're actually talking with you instead of just listening. I think those are the ones that are going to tell you sooner than the other ones.

### Problem analysis

Nurse–Family Partnership nurse home visitors, clients and supervisors identified several problems that influence nurses' capacity to identify and assess client exposure to IPV.

**False negatives following IPV assessment**—For nurses, it was problematic that the relationship assessment (the current assessment tool for identifying IPV) resulted in a number of false negatives, particularly when administered during programme enrolment. Nurses expressed shock and guilt that although they had inquired about IPV exposure, they often did not learn about it until later in the programme. One nurse recalls:

I sat there with my mouth open. I was at her intake.... and the abuse that she had experienced, I didn't know about it in that whole year. [I was thinking], 'what do you mean? I was here and we talked and is everything okay?' So we don't have the tools to pull out that information.

**Violence perceived as a normative experience**—Some nurses perceived that many clients responded negatively to questions about violence in their relationships because they did not *define* their experiences as abusive. Both nurses and clients explained that for many women enrolled in NFP, violence in relationships is a normative experience; often their mothers were abused, they had been exposed to violence in multiple family relationships and in their communities. At times, nurses expressed frustration that these perceptions created barriers to change for their clients. One nurse explained, 'she [client] would not pursue that or even identify that as an interpersonal violent event, to her that's just everyday stuff. I know he's got a violent temper... but it's still very, very concerning that she doesn't see it as anything abnormal'.

**Client relationship with nurse home visitor**—Nurse–Family Partnership clients identified some unique challenges not acknowledged by the nurses. Some clients did not recall ever being asked any questions about past or current IPV. Others acknowledged that while the nurse may have asked some questions as part of a 'survey,' some nurses were hesitant to ask the questions and certainly did not explore the issue in any depth. A few clients perceived that the NFP nurse prioritised infant health and development issues and was not there to address maternal concerns. One young pregnant NFP client shared both of these concerns:

She [the nurse] will ask me, 'How are you and him doing?' and I'm like, 'Ok, I guess' and she'd be like, 'ok'. She won't ask anything else about it. I guess really don't want to get into it whatever....So I probably didn't tell her [about the abuse] because I thought she was just there for baby.

Ironically, for some clients, the strong nurse–client relationship that had been established actually became somewhat of a barrier to sharing their experiences of abuse. In the NFP programme, clients establish both short- and long-term goals and nurse home visitors collaborate with clients to identify solutions; as clients progress towards their goals, nurses continually acknowledge their progress, celebrate their accomplishments and encourage them to continue to build on their strengths. Some clients perceived that by continuing to stay in an abusive relationship, they were failing to progress and achieve their goals. Therefore, to not ‘let her [the nurse] down’, some clients made a decision to not open up about the violence in her relationship.

### Needs analysis

A needs analysis was conducted to identify what changes in practice were required to improve nurses' capacity to identify and assess client exposure to IPV and to support clients in talking about their experiences safely within the context of a home visit.

**Knowledge and tools required for assessment**—Nurses and clients were emphatic that the most natural approach for introducing the topic of IPV is to do so within the context of a discussion about relationships and safety in different situations and that home visit materials were needed to support these discussions. Nurses identified that tools are required to support clients in reframing their understanding of a healthy relationship. Several nurses recommended that tools such as the Power and Control Wheel and Equality Wheel (Domestic Abuse Intervention Project 1984) be used for this purpose in a home visit. Given the cumulative exposure to different forms of violence across the lifespan and the clients' subsequent framing of violence as a normative experience, many nurses indicated that there is a strong need to support clients in coming to understand that intimate relationships can exist free from abuse.

All client participants spoke about the need to learn about the characteristics of a healthy relationship and the importance of increasing programme content on how to effectively communicate in relationships. NFP clients were also open to talking with nurses about their experiences of child maltreatment, and some identified a need to explore strategies with their nurse home visitors that would help them not repeat the cycle of abuse that they were exposed to in childhood. What emerged was a need, or desire, to raise their infant in environments free of violence and to break the intergenerational cycle of abuse. As one mother shared, ‘My father used to hit us a lot for doing something, for just being loud, for anything. And I saw that so much growing up that I don't want it for my daughter’.

**Qualities of a ‘good’ nurse home visitor**—Nurse–Family Partnership clients' descriptions about what was needed from their nurse home visitors to feel safe in disclosing IPV was remarkably consistent across interviews. Clients found it most helpful when nurse home visitors exhibited respect and were nonjudgmental. Clients were most likely to disclose when they felt they could trust their nurse or were ‘comfortable’ with her. Many clients valued having a nurse who was genuine, ‘easy to talk to’ and who actively listened to their experiences. NFP clients also expressed that in order to disclose their abuse to a nurse, it was essential to feel ‘safe’ with the nurse. This was achieved through holding discussions

in private and reassurance from the nurse that the information would remain confidential. In summarising what was helpful about her work with the NFP nurse, one participant shared:

It felt really safe talking to [the nurse] about [my abusive experiences]. She let me know everything that I tell her will be confidential. Once I got it out there too it felt good to actually talk about it... She just listened, listened really well and asked me a couple of questions, you know, if I feel safe? So that was really nice.

**Professional development and changing protocols**—One of the most pressing needs identified by nurse home visitors was to receive guidance on how to understand, and then respond, to their ‘gut instinct’ or ‘gut feeling’ that a client may be experiencing abuse in her relationship with her partner. This ‘gut instinct’ was illustrated through nurses and supervisors giving examples of observing client or partner behaviours in home visits that suggested attempts by the partner to control the NFP client, by changes in the client’s health status or appearance or by knowing about a history of abuse. One supervisor shared that this is the type of issue that may be raised in reflective supervision sessions with nurses:

It’s the nurse coming to me with this gut feeling of, ‘this is what happened in the visit today and I’m just not... there’s something else that’s going on and I just can’t put my finger on it...’. Most of the time it’s that something is just not quite right. Either [the client] is acting real different around [the nurse] or if the partner is in the home and he is not saying anything or makes you think this just isn’t quite right today.

Nurses and supervisors expressed the need for additional knowledge about additional ‘clues’ that could indicate a client is experiencing abuse or at-risk of IPV. One supervisor further addressed this need about what is required:

Probably things, you know, real common things to look for or clues that might alert you that something is going on. Like phrases that people might say, physical signs to look for, behaviours – what are some common behaviours that clients exhibit. And then maybe some dad traits if there are some commonalities you know of abusers, what that might look like.

Nurses found it challenging to know what to do when they suspected a client was experiencing abuse, but the client had not disclosed any exposure to IPV during previous structured assessments. As the long-term relationship with the client continues, nurses identified that they specifically needed guidance about when and how to take the initiative in raising the issue of abuse again with clients.

Interviews with nurse home visitors and supervisors concluded with discussions about their recommendations for when discussions of IPV should be introduced into the home visit schedule, as well as what tools are required to support them in identifying and assessing IPV in a home visit. There was consensus that conversations about healthy relationships, including a client’s exposure to IPV, should be included multiple times in the NFP programme and should be initiated early in the visit schedule (but not during the first visit) in pregnancy. To organise their assessments and subsequent plan of care, nurses requested a clinical pathway or at least detailed instructions on ‘what to do next’ or how to respond to

IPV disclosures. Some nurses indicated that seeing examples of ‘scripts’ or examples of what would be appropriate ways to ask about IPV, recommendations for how to integrate the questions into a conversation, and exemplar language that they could craft into their own words. Finally, in working with this population of young pregnant women and first-time mothers, the nurses emphasised the value of having interactive, visual materials to use with their clients on home visits. Additionally, nurses emphasised that they also require further instruction on how to integrate the tools into a home visit.

## Discussion

This in-depth problem, practice and needs analysis provides insight and guidance to inform the development of IPV identification and assessment strategies, specifically for the home visitation context, that reflect both nurse home visitor competencies and the preferences of pregnant women and first-time mothers enrolled in the NFP. In recent years, there has been a significant focus on recommending and introducing routine screening for IPV across all healthcare settings (Ghandour *et al.* 2015). However, findings of this study suggest that integration of questions within the context of ongoing discussions as trust develops is more appropriate for nurse home visiting programmes. Our findings also highlight the fundamental need to shift nurse home visiting practice from using short, structured IPV screening tools routinely administered during initial home visits to a more comprehensive, less structured assessment process that engages clients through discussions of healthy relationships, parenting and safety.

Contextually, the delivery of nursing care where a family resides is fundamentally different compared to health service delivery within an institution. As a guest in the client's home, the nurse must navigate the setting in a manner that is respectful of client norms and boundaries (Jansson *et al.* 2002). The development and nurturing of a therapeutic nurse–client relationship is a cornerstone of the NFP programme; it is the process through which the nurse learns about the client and her family (Kitzman *et al.* 1997) and is a strategy to engage vulnerable clients in the programme (Jack *et al.* 2005, Kurtz Landy *et al.* 2012). While our findings are rooted in the home visiting context, they also provide important insights about high-quality nursing care for women experiencing IPV regardless of the type of healthcare setting (Ford-Gilboe *et al.* 2011a).

Reflecting on their experiences of using a structured tool administered at or near the first home visit, nurses expressed the view that asking multiple times about IPV exposure, even without a disclosure, were often beneficial. According to nurses, the main benefit of asking about IPV multiple times was repeated opportunities to increase client awareness that it is safe for her to discuss experiences of abuse with the nurse at anytime in the future. Within health settings when working with a woman who has not disclosed IPV exposure, this benefit is often cited as a strong rationale for repeat inquiry (Hathaway *et al.* 2002, McCloskey & Grigsby 2005, Campbell & Lewis-O'Connor 2008). For some women, repeated inquiry about their exposure to violence may be difficult to manage and has the potential to decrease their use of a health service (World Health Organization 2013). This contradiction between perceived benefit and possible risk is explained by Feder *et al.* (2006) who conducted a meta-analysis of 25 studies exploring abused women's expectations of

healthcare professionals. The authors explain that repeat inquiry is more likely to be preferred by women who are actively planning or seeking to make changes, whereas women who do not define their partner's actions as abusive may find the repeated screens as offensive (Feder *et al.* 2006). Findings from this study indicated that neither clients nor nurses perceived the use of the structured screening tool as beneficial, particularly at or around the time of enrolment. Home visitors have reported reluctance to screen for IPV out of fear of jeopardising established rapport and trust with their clients (Frost 1999, Sharps *et al.* 2013), which may then impact client retention. Overall, the programme instructions for administering the screen were not amenable to facilitating a disclosure so early in the home visiting process.

A recurring theme in our study was the opportunities created for women to speak about experiences of violence, trauma and abuse during conversations with the nurse on topics such as relationships or parenting. The disclosures emerged, not in response to direct questioning initiated by the nurse, but instead at a time under the client's control. These conversations occurred once a trusting therapeutic relationship was established, a relationship in the NFP that is developed and maintained for up to 2.5 years. Feder *et al.* (2006) explain that when women who have experienced abuse have frequent contacts with their healthcare provider, indirect questioning is preferred. Therefore, what may be required in a home visiting context is to provide nurse home visitors with the knowledge and skills to identify and respond to a client's verbal and nonverbal cues and then to explore a client's sense of safety in her relationships, using an open and reflective style of assessment to promote a disclosure. Disclosure of current or past IPV then creates an opportunity for the nurse to conduct a more in-depth, structured clinical assessment, asking about types and frequency of IPV experienced.

While NFP clients were not opposed to explicitly discussing violence and abuse, they did express a preferential need to learn about healthy relationships and safety in relationships. Engaging clients in discussions about the characteristics of healthy or unhealthy intimate relationships is one strategy for creating a foundation upon which future conversations about trauma or violence can then be discussed. Active listening and validation of clients' experiences of surviving abuse along with exploration of the impact of these experiences on health and well-being, rather than in-depth probing for the specific details about violent incidents, is a less intrusive and more empathic approach to assessment (Ford-Gilboe *et al.* 2011b).

These findings also indicate that there is no single approach to identifying and asking about women's experiences of abuse. Instead, nurse home visitors require knowledge and skills to tailor their approach depending on the nature of their developing relationship with the client as well as the context. In this study, NFP nurses and supervisors spoke frequently about having a 'gut feeling' that a woman enrolled in the NFP was experiencing abuse or violence in her relationship and feeling challenged on knowing how to raise the issue with the client during a home visit. The first step to address this challenge is to support nurses to understand that what they refer to as a 'gut feeling' is actually a reflection of a skilled nursing assessment, where over time they have observed clinical symptoms, risk indicators (Wathen *et al.* 2007) or patterns of the client's or her partner's behaviour that may be

associated with IPV exposure. The second step is then to provide nurses with the skills to explore the possibility that the client is experiencing abuse. This approach to identification, based on symptoms or signs, is commonly referred to as 'case finding'. The World Health Organization (2013) has made a strong recommendation for case finding – that 'healthcare providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence... in order to improve diagnosis/identification and subsequent care' (p. 19). By focusing on healthy relationships within the NFP, it provides an opportunity for nurse home visitors to be alert to indicators of IPV, as well as other types of violence, such as a history of maltreatment in the client's childhood.

Finally, NFP clients clearly articulated the contextual conditions under which they are more likely to disclose their abuse status to a nurse home visitor, as well as their expectations for how their nurse will engage with them. Clients emphasised the importance of having conversations about violence and abuse in a private location. Ensuring privacy during a home visit may present as a challenge at times, given that many clients live with multiple family members who may also be present in the home during a visit. Nurse home visitors, therefore, must always first ascertain that no-one else is present prior to initiating an IPV assessment. If the home setting does not allow for privacy, then the nurse home visitor has a responsibility to consider other options for discussion of sensitive issues such as IPV. This may require creative solutions – for example, arranging a clinic visit, accompanying the client and her infant on a walk, or finding a public location that permits private conversation.

Nurse–Family Partnership clients also shared that they were more likely to discuss their IPV exposure with their nurse home visitor if they could be guaranteed that the information would remain confidential. While respecting a woman's right to confidentiality, as mandated reporters, nurse home visitors have a legal and ethical responsibility to report suspected or observed child maltreatment to CPS. In many jurisdictions, child witnessing or exposure to IPV within a household is considered a form of child maltreatment and thus reportable. In the NFP programme, clients' have previously expressed fear that if their involvement in an abusive relationship is reported to CPS, they will subsequently lose custody of their children (Davidov *et al.* 2012). Therefore, prior to initiating any assessment of IPV exposure, nurse home visitors have a responsibility to explain their role as a mandated reporter to the client and also to provide the client with information about any supportive services or programmes that CPS may be able to provide to women and children experiencing abuse (Davidov *et al.* 2012).

## Limitations and strengths

Study strengths included data source and type triangulation and member checking during second interviews with both clients and nurses to strengthen data credibility. Data dependability was strengthened by researcher triangulation and code–recode procedures. However, the findings may be limited in transferability to home visitation programmes employing registered nurses and providing services to the most socially and economically disadvantaged families, comparable to those enrolled in NFP.



## Conclusion

The use of qualitative methods to develop a deep understanding of nurses', supervisors' and clients' experiences of discussing IPV has facilitated the development of clinical practices that are relevant to the unique context of the NFP home visitation programme. Attention to context allows for the development of tailored nursing practices. In NFP, by engaging women in discussions about their IPV experiences, either in conversations framed around safety, parenting or healthy relationships or through indicator-based assessments, nurse home visitors have the opportunity to continue to develop the therapeutic alliance with the client. Given the challenges of engaging young, socially and economically disadvantaged mothers in home visiting programmes, it is anticipated that a tailored approach to assessment and identification will limit client attrition. The lessons learned from this study have informed the development of a three-pronged approach to IPV identification and assessment within the NFP context (Jack *et al.* 2012).

## Relevance to clinical practice

The findings from this case study were used to develop a three-pronged approach to IPV identification and assessment within the context of the NFP home visitation programme (Jack *et al.* 2012). In the clinical pathway developed for nurse home visitors, the three identification strategies outlined to promote a client IPV disclosure are (1) the universal assessment of safety, (2) an indicator-based assessment and (3) a client-initiated disclosure. The universal assessment of safety is a less structured interview that allows the nurse and client to engage in a discussion about safety, social supports and the characteristics of healthy relationships. The universal assessment is initiated four to eight weeks after enrolment while the client is still pregnant. If there is no IPV disclosure, the universal assessment of safety is repeated during the postpartum period and again when the child is 16 months old.

The second strategy for identification and assessment follows the principles of a case-finding approach. In the NFP IPV education that NFP nurse home visitors complete, opportunities to increase their knowledge about risk indicators and clinical presentations associated with IPV exposure are reviewed. Nurses are provided with opportunities to practise developing scripts on how to initiate the indicator-based assessment in a home visit. Unlike other types of assessments that can be scheduled, the initiation of an indicator-based assessment must rely on the nurse's capacity to identify risk indicators or clinical symptoms and her confidence to raise the topic during any home visit as appropriate.

The third approach to identification and assessment provides nurses with guidelines on how to respond appropriately and empathically to a client disclosing abuse, even when this is unexpected – for example, in a crisis situation. Such disclosures can occur at challenging times during home visits, but the guidelines outline how to respond in a way that is supportive and safe, yet still practical and feasible.

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**What does this paper contribute to the wider global clinical community?**

- A tailored approach to the identification and assessment of intimate partner violence in nurse home visitation programmes is required to support young pregnant women and mothers to safely discuss their experiences of violence.
- The integration of unstructured discussions about parenting, safety and healthy relationships provides women with opportunities to share their experiences of survival in a safe and nonintrusive manner.
- Nurse home visitors require the knowledge and skills to use multiple strategies for identification and assessment, including unstructured discussion and case-finding approaches.

**Table 1**  
**Data sources used in this analysis**

	<b>Intervention development NFP sites (n = 4 sites)</b>	<b>Pilot site for NFP IPV intervention (n = 1 site)</b>	<b>Total transcripts</b>
Nurse home visitors			
Sample size	27	5	32
#Focus groups conducted	8	2	10
NFP clients			
#First interviews completed	20	6	26
#Second interviews completed	16	n/a	16
Nurse supervisors			
Sample size	4	1	5
# First interviews completed	4	1	5
# Second interviews completed	4	1	5

**Table 2**  
**Summary of interview questions focused on IPV identification, assessment and disclosure**

Data source	Questions used in intervention development sites	Questions used in NFP IPV pilot site
Nurse home visitors	<ul style="list-style-type: none"> <li>• What is the role of the NFP nurse in identifying and working with women exposed to IPV?</li> <li>• Under what conditions do women generally disclose their experiences of IPV?</li> <li>• When a woman discloses IPV, please describe your usual response</li> <li>• What resources or supports are required for NFP nurses working with women exposed to IPV?</li> </ul>	<ul style="list-style-type: none"> <li>• What recommendations do you have for changing or improving: (a) the universal assessment of safety; (b) the clinical IPV assessment; (c) the indicator-based assessment and (d) the response to client-initiated disclosures?</li> </ul>
NFP clients	<ul style="list-style-type: none"> <li>• Please describe your experiences of working with your NFP nurse</li> <li>• Have you shared with your nurse your experiences of abuse from your partner? If no, probe for reasons why this information not disclosed</li> <li>• If disclosure has occurred - probe for reasons why information was shared and the conditions under which it was disclosed</li> <li>• What were your perceptions of the nurse's response to your disclosure?</li> </ul>	<ul style="list-style-type: none"> <li>• What types of discussions have you had with your nurse about your relationships and protecting yourself and your child? How helpful were these discussions? What was not helpful?</li> <li>• How did you decide that it would be safe to share with the nurse that you had experienced some form of violence in your relationship?</li> </ul>
Nurse supervisor	<ul style="list-style-type: none"> <li>• What do you see as the role of the NFP nurse home visitor in identifying and addressing IPV?</li> <li>• What types of supports do NFP nurses and clients require in order for your agency to better respond to the issue of IPV?</li> </ul>	<ul style="list-style-type: none"> <li>• As a supervisor, you have had the opportunity to observe and support nurses implement the new NFP IPV intervention. What has been your overall experience? What recommended changes would you suggest?</li> </ul>

**Table 3**  
**Summary of findings from the practice, problem and needs analysis**

Nurse home visitors' and supervisors' experiences	NFP clients' experiences
<p>1. Practice analysis</p> <ul style="list-style-type: none"> <li>• Nurses screen for IPV exposure at enrolment, 36 weeks' gestation and 12 months postpartum using a 'relationship assessment' tool.</li> <li>• Asking clients about IPV at enrolment identifies it as a topic that can be discussed</li> <li>• Asking about IPV exposure at different points in time is valued</li> <li>• In-depth disclosure of client exposure to IPV often revealed during discussions about relationships, family history and parenting</li> <li>• Disclosures may occur while engaged in a side-by-side learning activity with the nurse</li> <li>• For some clients, nurses may only learn of IPV exposure during a period of crisis or escalating violence</li> <li>• The home visiting context allows for in-depth observation and assessment of client relationships and interactions with family members</li> <li>• Establishment of a therapeutic nurse-client relationship facilitates discussions related to IPV</li> <li>• NFP programme principles, goals and materials create a foundation upon which they can discuss client exposure to violence</li> </ul>	<ul style="list-style-type: none"> <li>• Some clients do not disclose or make only a partial disclosure when screened for IPV at enrolment</li> <li>• Clients initiate disclosure of IPV exposure during conversations about personal safety, relationships, parenting and childhood experiences</li> <li>• For some, disclosure comes through nurse observation of direct IPV or IPV-associated injuries rather than a verbal disclosure</li> <li>• Will discuss experiences of violence or trauma once trust is established with nurse</li> </ul>
<p>2. Problem analysis</p> <ul style="list-style-type: none"> <li>• At enrolment, use of relationship tool results in false negatives</li> <li>• Nurses experience guilt if they do not learn about a client's IPV exposure until late in the programme</li> <li>• Clients' belief that violence is a normal experience limits their awareness about possibilities for change</li> <li>• Difficult for some clients to define or acknowledge their experiences as abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Some clients identified that nurses were not asking about IPV exposure or did not explore the issue in-depth</li> <li>• Exposure to violence and trauma across the lifespan is a normative experience for many clients</li> <li>• For some clients, the establishment of a therapeutic relationship may be a barrier to disclosure when the client does not want to disappoint the nurse</li> </ul>
<p>3. Needs assessment</p> <ul style="list-style-type: none"> <li>• Require home visit materials that focus on healthy relationships</li> <li>• Need tools to help clients develop a vision of a future free of violence</li> <li>• Need knowledge related to risk indicators for IPV and how to raise the issue of potential exposure to violence among clients who have not disclosed</li> <li>• Need IPV assessment tools that can be administered multiple times in programme, initiated early - but not in the first visit</li> <li>• To support skill development, need scripts on how to communicate about IPV with clients</li> </ul>	<ul style="list-style-type: none"> <li>• Desire to learn about healthy and unhealthy relationships and how to promote safety</li> <li>• Require strategies to not repeat cycles of abuse with their own children and in their relationships</li> <li>• Need to be visited by nurses who are respectful, nonjudgmental and who they feel safe with</li> <li>• Need private spaces to discuss IPV exposure</li> </ul>