


DISCURSIVE PAPER

Recognising and responding to intimate partner violence using telehealth: Practical guidance for nurses and midwives

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Abstract

Aims: To synthesise the current, global evidence-informed guidance that supports nurses and midwives to recognise and respond to intimate partner violence (IPV), and how these practices can be translated from face-to-face encounters to care that is delivered through telehealth.

Background: COVID-19-related social and physical distancing measures increase the risk for individuals who are socially isolated with partners who perpetuate violence. Providing support through telehealth is one strategy that can mitigate the pandemic of IPV, while helping patients and providers stay safe from COVID-19.

Design and Methods: In this discursive paper, we describe how practical guidance for safely recognising and responding to IPV in telehealth encounters was developed. The ADAPT-ITT (Assessment, Decisions, Administration, Production, Topical Experts, Integration, Testing, Training) framework was used to guide the novel identification and adaptation of evidence-informed guidance. We focused on the first six stages of the ADAPT-ITT framework.

Conclusions: This paper fills a gap in available guidance, specifically for IPV recognition and response via telehealth. We present strategies for prioritising safety and promoting privacy while initiating, managing or terminating a telehealth encounter with patients who may be at risk for or experiencing IPV. Strategies for assessment, planning and intervention are also summarised. System-level responses, such as increasing equitable access to telecommunication technology, are also discussed.

Relevance to clinical practice: Integrating innovative IPV-focused practices into telehealth care is an important opportunity for nurses and midwives during the current global COVID-19 pandemic. There are also implications for future secondary outbreaks, natural disasters or other physically isolating events, for improving healthcare

efficiency, and for addressing the needs of vulnerable populations with limited access to health care.

KEYWORDS

guidance, health care, intimate partner violence, mobile health, nursing, quality assurance, referral and consultation, screening, telehealth

1 | AIM

The aim of this paper was to explore how current, global evidence-informed guidelines that support nurses and midwives to recognise and respond to intimate partner violence (IPV) can be translated from face-to-face encounters to care via telehealth. The principles of trauma- and violence-informed care (TVIC) were applied to develop practical guidance on how to prioritise the emotional and physical safety of both patients and providers when initiating contact or delivering care through telehealth. A secondary aim was to explain how the ADAPT-ITT framework was used as a tool to develop the adapted guidance.

2 | BACKGROUND

The coronavirus disease 2019 (COVID-19) pandemic declared by the World Health Organization (WHO) on 11 March 2020 created innumerable challenges for both healthcare providers and patients (WHO, 2020). Efforts to decrease transmission of COVID-19 to prevent overwhelming healthcare system capacity led to social and physical distancing worldwide. Sudden restrictions on movement prompted cancellation of many preventative healthcare visits and accelerated the shift by primary healthcare providers to embrace telehealth options in their practice (Mehotra et al., 2020). Telehealth visits may be appropriate for some primary and public healthcare assessments and interventions provided by nurses and midwives for the foreseeable future, given uncertainty regarding the timeline for development, and level and duration of immunity for a COVID-19 vaccine. As such, many people will remain confined due to the continued threat of the virus, even as governments allow resumption of free movement. Unfortunately, COVID-19 containment and mitigation strategies that restrict movement and interaction inadvertently fuel another global pandemic—that of IPV (Peterman et al., 2020).

Even before the COVID-19 global pandemic, research showed that IPV sometimes escalates during large-scale crises or disasters (Peterman et al., 2020; Serrata & Hurtado Alvarado, 2019), although with mixed results (e.g. Campbell et al., 2016). Regional and global crises, including pandemics, create stressful environments characterised by social isolation, uncertainty about the future, financial hardships and feelings of loss of control, which may contribute to an increased risk for IPV. Social and physical distancing strategies used to mitigate the spread of infection can also increase IPV risk by increasing proximity to individuals who use violence while

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

- During the COVID-19 pandemic, many nurses and midwives were required to rapidly transition to provide care through telehealth. Practical guidance, informed by the principles of trauma- and violence-informed care, has been developed to support providers using telehealth to safely identify and respond to individuals experiencing intimate partner violence.
- System-level adaptations may be required to support nurses and midwives providing care via telehealth to individuals experiencing violence. There is also a need to address potential inequities that may arise during the transition to alternate models of care.

decreasing opportunities for time spent away and access to community resources and support systems. Such isolation can result in fewer options for those seeking safety or needing help. Individuals who perpetuate violence may use fear about the crisis as a scare tactic to further threaten or isolate victims (Sandler, 2020). Additionally, survivors of IPV, who are not currently experiencing violence, may experience re-traumatisation as isolation and lack of control may replicate feelings of past trauma. Bradbury-Jones and Isham (2020) have coined the term *pandemic paradox* to describe this conflicting state in which staying at home is viewed as a critical strategy for maintaining safety, but, in fact, is likely to reduce safety for those affected by IPV.

In many countries, COVID-19 disproportionately affects marginalised populations, underscoring another co-pandemic for people experiencing IPV—that of structural inequity (Schwalbe et al., 2020). Disparities related to healthcare access and outcomes have been fuelled by multi-generational discrimination and barriers related to gender identity, race/ethnicity, geographic location and socioeconomic factors, including limited access to technologies necessary for telehealth (Jennings et al., 2015; Raifman & Raifman, 2020). Acknowledging this intersectionality of multiple pandemics provides a useful lens for examining IPV and highlights the urgent need for structural changes initiated with individuals, communities and healthcare organisations to improve access and outcomes for the most vulnerable populations (Figure 1).

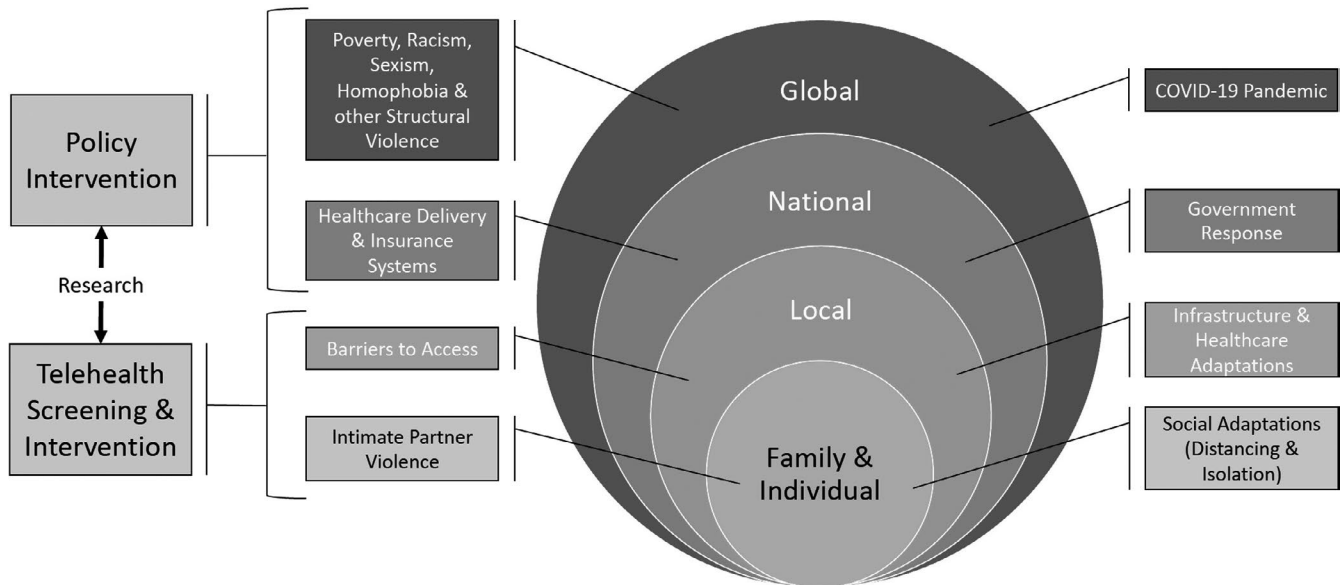


FIGURE 1 Multiple intersecting pandemics

TABLE 1 Operationalisation of the ADAPT-ITT framework

ADAPT-ITT Phase	Sampling	Methods	Outcomes
Assessment	Review of recent media reports for IPV +COVID-19	Broad assessment of recent reports about IPV, primarily from the media	The authors recognised there is a critical need for innovative solutions to support individuals experiencing IPV and to promote their health and safety during the current pandemic
Decisions	GLAD search strategy (use of a clinical practice guideline term +MeSH term) was used to search both SUMSearch 2 and Google Scholar using terms 'guideline' AND 'intimate partner violence' with relevant limits applied.	Review the existing evidence-informed guidelines for IPV screening and response	Based on the existing evidence-informed guidelines for IPV screening and response, the authors made the decision that they could be adapted to the telehealth context
Adaptation	Best practice guidelines for telehealth identified in the USA, Australia, Canada and the UK.	Review of global telehealth guidelines combined with the authors clinical, education and research expertise related to IPV	The authors adapted existing evidence-informed guidelines for IPV screening and response with global telehealth best practice guidelines
Produce		Existing evidence-informed guidelines for IPV screening and response were assimilated with the telehealth guidance and rooted in TVIC principles	Draft of the principles and guidelines related to identifying and responding to IPV via telehealth
Topical Experts	Cadre of global nursing experts in IPV identified to review the draft guidelines (n = 5)	Topical experts had two weeks to review the draft principles and guidance and provide feedback and recommendations based on their expertise	A list of key points to integrate into the final principles and guidance
Integrate		During the integration phase, the authors addressed suggestions from the topical experts	Final version of the principles (Table 3) and guidelines (Table 4) to identify and respond to IPV via telehealth

For many nurses and midwives working in public health, community or primary care settings, the implementation of physical distancing measures meant that their work rapidly transitioned from in-person home visits or appointments to delivering care via telehealth. Telehealth incorporates the use of bidirectional telecommunication technologies as the mode of delivery for communication, health education and interventions between providers and patients (Totten et al., 2016). In this paper, we use the term telehealth to refer to the use of text messages, email, voice calling (telephone) or videoconferencing by a nurse or midwife to provide assessment, screening, diagnostic, education or referral interventions.

An extensive body of research has systematically mapped the effectiveness of different forms of telehealth to deliver a wide range of interventions or healthcare services to different patient populations (Totten et al., 2016). Specific to the integration of telehealth to address women's healthcare, a 2017 evidence map identified 211 references, with 40% ($n = 81$) of articles focused on maternal health interventions, and <3% ($n = 6$) of articles focused on telehealth responses to IPV (Goldstein et al., 2017). Despite the scant amount of telehealth research conducted among women experiencing IPV, evidence suggests that telehealth interventions for IPV provide favourable outcomes with regard to perceived social support, health-related quality of life, adherence to postexposure prophylaxis, violent incidents, safety-promoting behaviours, and healthcare use (Abrahams et al., 2010; Tiwari et al., 2012). Though feasibility and acceptability for IPV-focused telehealth interventions was high in some studies, there is still limited evidence for efficacy and for the effects of content versus modality on the impact of interventions, as shown in a systematic review of mhealth and Web-based interventions (Anderson et al., 2019).

Remote monitoring through telehealth is one strategy that can mitigate the pandemic of IPV while also helping people stay safe from COVID-19. Nurses and midwives have long played a central role in identifying, assessing and responding to IPV within healthcare settings. This role is even more important during the current COVID-19 pandemic, given the potential for escalation of IPV. Additionally, with social distancing measures in place, the most meaningful social connection some individuals have may be with their healthcare providers. Preventative telehealth visits and COVID-19 contact tracing encounters are both opportunities to assess for IPV in the home and to provide strategies to increase overall safety. However, healthcare professionals also need to be aware of the potential risks to privacy, confidentiality and safety that the use of telehealth may introduce when communicating with patients. Thus, the aim of this paper was to develop practical guidance on the safe use of telehealth as a strategy to support individuals experiencing IPV.

3 | DESIGN AND METHODS

The Assessment, Decisions, Administration, Production, Topical Experts, Integration, Testing, Training (ADAPT-ITT) framework

(Wingood & DiClemente, 2008) was used to guide the identification and tailoring of existing evidence-informed guidelines that could be adapted to telehealth. This process was guided by the research question: 'Can pre-existing evidence-informed guidelines for IPV screening and response be adapted to the telehealth context?' The ADAPT-ITT framework has been used primarily to adapt evidence-based interventions to new geographic regions, cultural contexts or populations related to HIV (Latham et al., 2010, 2012; Sullivan et al., 2014; Wingood et al., 2011), and sexual violence prevention (Munro-Kramer et al., 2020). The use of the ADAPT-ITT framework to guide the adaptation of clinical guidelines is a new approach, but one that is important when a rapid uptake of new practices is needed. This methodology offers a systematic process to adapt evidence-based interventions, rather than creating new interventions when there is already a pre-existing evidence base. We focused on the first six stages of the ADAPT-ITT framework in this discursive paper. Table 1 outlines this framework and the steps at each phase in detail.

3.1 | Phase I—Assessment

An increase in IPV, combined with forced isolation, will undoubtedly exacerbate common health effects associated with violence and trauma including injuries, anxiety, depression, post-traumatic stress disorder and substance abuse (Garcia-Moreno et al., 2013). Many regions of the world have reported an increase in IPV since the implementation of social and physical distancing measures, including Africa, Australia, Brazil, Canada, China, Europe and the USA (Allen-Ebrahimian, 2020; Amin, 2020; Chukwueke, 2020; Davies & Batha, 2020; Daya & Azpirir, 2020; Gwinn, 2020; Kelly & Morgan, 2020; Reuters News Agency, 2020; Taub, 2020; The Guardian, 2020). However, these reports have not included systematic comparisons of prevalence and incidence with prior time periods. Therefore, it is not clear whether the increases are related to increased severity of existing IPV or new cases. Early estimates from multiple countries suggest as much as a 20%–50% increase in calls to emergency support lines, IPV-related police reports, need for emergency shelter and Internet searches related to IPV support in the immediate aftermath of various social and physical distancing edicts (Bradbury-Jones & Isham, 2020). Given preliminary findings, it is plausible that at least as many people or more are being abused as before, and that existing IPV cases may be exacerbated by COVID-19-related physical and social distancing measures. Thus, there is a critical need for innovative solutions to support individuals experiencing IPV and to promote their health and safety during the current pandemic.

3.2 | Phase II—Decisions

The authors conducted a rapid review to identify existing evidence-informed best practice guidelines for nurses or midwives recognising and responding to IPV among their patients. The

TABLE 2 Evidence-informed recommendations for recognising and responding to IPV

Evidence-informed guidance document	Privacy assessment	IPV assessment	Clinical actions in response to disclosure
Australian Department of Health (2018)	<ul style="list-style-type: none"> • Ask when alone with patient 	<ul style="list-style-type: none"> • Routine enquiry • Active listening 	<ul style="list-style-type: none"> • Conduct safety assessment • Encourage patient to access specialist support services
Futures Without Violence (2020)	<ul style="list-style-type: none"> • Prioritise confidentiality • Assess privacy 	<ul style="list-style-type: none"> • Provide universal education (e.g. about stress, relationships and connection to health) 	<ul style="list-style-type: none"> • Validate response • Provide support • Warm referral to survivor support agency
National Health Service (2013, 2017)	<ul style="list-style-type: none"> • Facilitate disclosure in private without any third parties present • Ensure it is safe to ask • Be attentive and approachable 	<ul style="list-style-type: none"> • Ask about IPV, frame topic and ask direct questions • Early identification of risk factors, signs, presenting problems or conditions, including patterns of coercive control • Routine enquiry to question observations; determine whether presentation warrants concern • Use approaches of 'sensitive enquiry' 	<ul style="list-style-type: none"> • Acknowledge and validate disclosure • Address presenting concerns • Conduct comprehensive physical/mental health assessment • Assess risk of immediate danger • Refer to local domestic violence services for support • Discuss safety strategies
NICE (2014)	<ul style="list-style-type: none"> • Create an environment for disclosing domestic violence • Prioritise people's safety 	<ul style="list-style-type: none"> • Ask patients routinely about abuse in some specialised settings is good practice; insufficient evidence for screening however. 	<ul style="list-style-type: none"> • Respond with empathy • Assess for immediate safety; conduct risk identification and assessment • Regularly assess services needed; refer to domestic violence specialist if specialised support required • Conduct safety planning
VEGA (2020)	<ul style="list-style-type: none"> • Create safe environments and interactions 	<ul style="list-style-type: none"> • Be alert to potential signs and symptoms of IPV; inquire if indicated (do not recommend universal screening) 	<ul style="list-style-type: none"> • LIVES protocol (Listen, Inquire about needs and concerns, Validate experience, Enhance safety through safety planning, provide/refer to Supports) • Assess immediate risk of danger
WHO (2013, 2014)	<ul style="list-style-type: none"> • Ensure privacy, confidentiality • Never raise issue unless patient alone • Use empathetic, nonjudgemental language relevant to community/culture 	<ul style="list-style-type: none"> • Be aware of risk indicators (do not recommend universal screening) • Assess partner behaviours • Raise topic if there are injuries/conditions that prompt asking 	<ul style="list-style-type: none"> • LIVES protocol • Assess immediate risk

following criteria were applied to locate guidance/guidelines: (a) published by an international- or national-level organisation or working group; at the national level, the search was limited to retrieving guidance documents from organisations within Australia, Canada, Europe, the UK and the USA; (b) developed for healthcare professionals (including nurses/midwives); (c) rigorously developed and informed by the best available evidence at the time of publication; (d) included clinical recommendations across multiple steps of the nursing process (e.g. assessment, diagnosis, planning, implementation or evaluation) specific to addressing IPV experienced by adults; (e) published in English; and (f) published between 2010–2020. A guidance/guideline document was excluded if it: (a) provided only medical recommendations (specific to physicians); or (b) included clinical recommendations for only one phase of the nursing process (e.g. recommendations for screening). The GLAD

search strategy (use of a clinical practice guideline term +MeSH term) (Haase et al., 2007) was used to search both SUMSearch 2 and Google Scholar using terms 'guideline' AND 'intimate partner violence' with relevant limits. All co-authors and topic experts were also asked to identify relevant guidance documents. From this process, we determined that acceptable evidence-based guidelines already existed and could be adapted for telehealth. The following eight resources were included to provide the foundation of evidence from which we developed telehealth guidance for recognising and responding to IPV: (a) the WHO (international) guideline on responding to IPV (2013) and its (b) companion clinical handbook (WHO, 2014); (c) the NICE (2014) public health guideline for domestic violence and abuse; (d) the National Health Service (NHS, the UK) domestic abuse resource for NHS staff and allied healthcare providers (2017); (e) the NHS (2013) Guidance

for health professionals on domestic violence; (f) the Violence, Education, Guidance, Action (VEGA; Canada) IPV guidance (2020); (g) Australian Department of Health recommendations to respond to family violence and pregnancy care guidelines (2018); and (h) the Futures Without Violence (the USA) virtual 'CUES' guidance (2020a). Each guideline was reviewed, and brief summaries of primary recommendations were extracted and summarised (Table 2) related to: (a) privacy assessment; (b) IPV assessment; and (c) interventions in response to disclosure.

3.3 | Phase III—Adaptation

In this paper, we focus on developing practice towards holistic IPV care that is delivered via telehealth. Using the evidence-informed recommendations for recognising and responding to IPV summarised in Table 2, the team developed practical guidance on how to adapt these recommendations when using telehealth. This guidance was informed by: (a) best practice guidelines and standards for telehealth; (b) emerging guidance for safe use of technology with individuals who have experienced violence (e.g. Safety Net Technology, 2020); and (c) the clinical, educational and research expertise of the authors in recognising and responding to IPV in a variety of clinical settings.

Given the potential for telehealth to enhance healthcare infrastructure, improve access to quality, value-based care and mitigate health disparities, best practice guidelines and standards have been developed by multiple national or professional associations such as the: (a) College of Nurses of Ontario (2020) Practice Guideline for Telehealth [Canada]; (b) the American Nurses Association (2019) Core Principles on Connected Health; and (c) The Royal College of Nursing [the UK] eHealth Forum (2020). These guidelines and standards provide foundational information regarding roles and responsibilities, ethical and legal considerations, strategies to ensure consent and promote confidentiality, documentation and considerations for providing care, consultation or education. However, standards at this level do not provide the practical guidance that nurses or midwives need when they are considering 'how' recommendations can be enacted during telehealth encounters, particularly with patients at risk for or experiencing IPV.

The adaptation phase was anchored in the skills and expertise of the cadre of international authors. All authors, members of the Nursing Network for Violence Against Women International (www.nnvawi.org), bring nursing or midwifery practice, research, education, public health and policy expertise in the following areas: (a) IPV screening and assessment (CBJ, DLS, SMJ, JCC, JRW, LJM); (b) IPV curricula for healthcare providers (CBJ, SMJ, DLS, JRW, MMK), (c) TVIC (ERT, SMJ, DLS, JRW), (d) telehealth in public health nursing practice (CBJ, DLS, SMJ, LJM); (e) use of the ADAPT-ITT framework (MMK); and (f) healthcare responses to IPV (all authors). This expertise supported our adaptation of recommendations summarised from the guidance documents

retrieved in Phase II. Given the additional challenges of providing care remotely to individuals experiencing or at risk for IPV, we also ensured that recommendations for individual interactions or organisational responses reflected the four inter-related principles of TVIC, in that: (a) the creation of emotional and physically safe environments was prioritised for all patients and providers; (b) responses reflected an awareness that trauma and violence impacts people's lives and behaviours; (c) they fostered opportunities for choice, collaboration and connection; and (d) the guidance reflected a strengths-based approach built upon existing capacities (Wathen & Varcoe, 2019).

3.4 | Phase IV—Production

Next, we focused on producing a draft of the relevant recommendations for safely recognising and responding to IPV and mapping recommendations to either: (a) specific guidance for creating emotionally and physically safe care environments; or (b) the nursing process. Telehealth guidance was then reviewed to ensure that the principles of TVIC were reflected and augmented with examples of ways nurses or midwives can discuss IPV. The provision of scripts has been identified by nurses as a valuable strategy for increasing confidence and skill on how to introduce the topic of IPV to patients (Jack et al., 2012).

3.5 | Phase V—Topical experts

A group of five internationally recognised experts in IPV recognition and response were identified [Dr. Linda Bullock, USA; Dr. Karen Campbell, Canada; Dr. Sinegugu Duma, South Africa; Dr. Julie McGarry, UK; and Dr. Janet Wong, Hong Kong]. The topical experts received the draft principles and guidance outlined in Tables 3 and 4 and were asked to provide feedback based on the following prompts: (a) Do the adapted recommendations align with existing evidence? and (b) Are there any other recommendations that should be incorporated? Each expert returned recommendations based on their professional expertise as nurses and researchers.

3.6 | Phase VI—Integration

During the integration phase, the authors addressed expert suggestions on the following topics: (a) describing the type of visit (e.g. new patient, returning visit, obstetric visit, patient experiencing IPV) for which guidance was developed; (b) expanding the focus to include more forms of telehealth, particularly SMS text and email; (c) recognising the importance of children in decision-making related to IPV; (d) including informal social support networks as part of safety planning, (e) emphasising the importance of digital safety practices such as techniques to avoid others overhearing a conversation,

TABLE 3 Principles to Prioritise Individuals' Physical and Emotional Safety When Delivering Care Through Telehealth

Strategies	Examples of Questions or Statements to Use
Preparing for a telehealth visit	
<ul style="list-style-type: none"> • Orient self to organisation (or country)-specific guidance around IPV and telehealth [e.g. Safe Lives (UK)] • Practice and be prepared to respond to an IPV disclosure. • Prepare a list of resources that can be shared safely with individuals about local resources/services to support individuals experiencing violence. • Locate a private space to initiate telehealth connection. • Identify and respond to barriers that may limit patient engagement in telehealth (e.g. limited data plan, no access to computer or tablet, lack of headphones or ability to connect them to a device). • Advocate for, or locate, local community agencies who provide cell phones to individuals experiencing social or economic disadvantage or violence. 	
Scheduling and confirming telehealth visit	
<p><i>'This is Emma J, the nurse with (agency), to confirm our 10:00 AM appointment on 01/01/2020. We have a telehealth visit scheduled, however please let me know if you are still available, if we can connect privately and if you prefer to connect by a video call, text, or telephone.'</i></p>	
<ul style="list-style-type: none"> • Ask the patient if there is a time when they have access to a quiet, comfortable and private space where other people cannot overhear the conversation. Be prepared that they may not. • If privacy is an issue, explore or discuss options (e.g. go for a walk, call from an outdoor location such as a park). • If available, and when possible, ask the patient to wear earphones that connect with the device being used (e.g. phone, computer, tablet). • For telephone calls, recommend that the conversation not be broadcast over a speaker phone. • When confirming the visit, send only information about visit logistics. Do not include personal health information. The patient's partner may have access to their phone or passwords. • Provide choices and options for different modes of connecting. This provides the patient with agency to assess their current situation and select other options that may enhance safety. • When possible, plan a videoconference as both visual and audio cues will help to assess whether it is safe to proceed with conversations related to IPV. • Many telehealth visits are being scheduled electronically through text messaging or email. The message language should suggest privacy if possible, but not make the wording such that patients who cannot get privacy are discouraged from making an appointment. 	
Initiating the telehealth visit: Assessment of privacy	
<p><i>'Is this still a good time for us to connect?'</i></p>	
<p><i>'So much has changed with this coronavirus. I'm wondering how all of you are doing with the changes. I haven't met your partner yet. Is _____ home so I can say hi?'</i></p>	
<ul style="list-style-type: none"> • Start by assessing patient readiness to meet. Appreciate that an abusive partner may require the patient to respond positively. Listen and watch for cues that the patient is feeling safe, not editing their comments or (when using videoconferencing) glancing at others before speaking. • If patient is ready to meet, discretely assess if others are present by asking if you can say 'hi'. This provides you with information about the presence of others and thus a precaution about initiating a discussion related to relationships, violence or safety. • When asking about sensitive issues through telehealth, this may be a situation when it is appropriate to ask close-ended questions and to prompt the patient to answer using 'yes' or 'no'. • Discuss confidentiality by noting that healthcare information remains confidential, even in a telehealth setting, and then discuss any region-specific reporting requirements (including mandatory reporting of child exposure to IPV). 	
During the telehealth visit	
<p><i>'Sometimes the cell service/Internet connection in my area is unstable. If we get disconnected, how would you like to safely re-connect?'</i></p>	
<ul style="list-style-type: none"> • Develop a plan on how to respond if the call/video is suddenly disconnected, including if, how and by who the call should be re-initiated by. While calls may be dropped due to poor connections, a patient may abruptly terminate a connection if someone enters their space or their safety is threatened. • Probe if the nurse should text or call back immediately or wait for the patient to initiate the call. • If the patient is currently experiencing IPV and if the call is not reconnected, explore whether nurse can call a friend, family member or neighbour to check on their safety or to call the local emergency number (e.g. North America 911; United Kingdom 999/112) • During visits where you suspect or are aware that the patient is experiencing IPV, discuss having a code word or hand signal (for video) that the patient can use to express that they are in danger or unable to speak privately. 	
Ending the telehealth call	
<p><i>'Once you receive my text message with the phone number for (name of agency), do you have a safe place where you can store that information and it won't be found by your partner?'</i></p>	
<p><i>'Once you use or save the information, would you feel comfortable deleting the text so that my message won't be noticed if someone else picks up your phone?'</i></p>	
<ul style="list-style-type: none"> • If a resource or referral has been suggested or requested (e.g. to access an advocate, seek shelter services), ask how this information can safely be transmitted to the patient. • If the patient requests for the information to be sent via text message, explore strategies for safeguarding the information. • If re-scheduling a follow-up visit, re-assess the safest time/day to connect, the safest mode for connecting and recommendations for actions the patient would like the nurse to take if they cannot reach the patient. 	

TABLE 4 Guidance for using the Nursing Process to Recognise and Respond to IPV during Telehealth

Identification and Assessment (Case Finding)	
<ul style="list-style-type: none"> Normalise the discussion about relationships and health 	<p>'I talk to every patient I see about relationships and how they may be impacting their health'. 'In these unusually difficult times, some patients who previously felt safe at home no longer feel that way'.</p>
<ul style="list-style-type: none"> Provide universal education about how the COVID-19 pandemic is affecting the relationships, stress and health of many individuals globally. 	<p>'We recognize that the COVID-19 pandemic has been a very stressful time for many households. It is causing stress on relationships as well as stress related to finances, food, childcare/education, and other things'.</p>
<ul style="list-style-type: none"> Provide universal resources and note they may be useful for family members or friends. 	<p>'I want to make sure that everyone I work with, and their family and friends, know where they can get free, confidential help if they are experiencing depression or anxiety, or if they feel unsafe in their relationship. You can text/call [add local crisis line information]'.</p>
<ul style="list-style-type: none"> Listen for, observe (if using video), and be sensitive to 'red flags' or known risk indicators, health effects or injuries, or behaviours (e.g. not making eye contact [video], adult voices in the background, prolonged silence) that may indicate the patient is experiencing (or at risk) for IPV. When red flags are present, frame the topic using a general statement and then, if safe, follow up with a more direct question about IPV or use your clinic-specific items or tools. 	<p>Framing and General question: 'I would like to ask you a few questions about your relationship. How are things at home?'</p> <p>Direct follow-up questions: 'Do you feel safe in your current relationship?' 'Are you afraid of your partner?' 'Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?' 'Within the last year, has anyone forced you to take part in sexual activities?' 'Does your partner control or try to control the things you do?'</p>
<ul style="list-style-type: none"> If there is not an IPV disclosure but provider suspects patient is experiencing abuse, acknowledge patient's response, indicate that if they are concerned about their safety, that you (or a colleague) are available to talk, and close conversation by highlighting that the pandemic can be a stressful time for everyone, and share at least one community resource that patient might use in future or share with family and friends. 	<p>'Thank you for talking to me about your relationship. If anything changes in the future and you become worried about your safety or the safety of your children, I am here to help. The COVID-19 pandemic has been stressful for many families too, so would it be okay if I texted you information about (local crisis line, community help number) if you, a friend, or family member needed to talk to someone?'</p>
Diagnosis: Response to a disclosure of IPV	
<ul style="list-style-type: none"> Actively listen and use nonjudgemental statements that validate the individual's experiences. If you are involved in audio communication only, remember that the patient cannot see your body language and it may be necessary to pay particular attention to tone and to use encouraging verbal cues (instead of nonverbal cues like nodding one's head) to allow the patient to continue. 	<p>'It sounds like you have been dealing with this abuse from your partner for quite some time, can you tell me how you have been keeping yourself safe?'</p> <p>'Addressing abuse in a relationship is a complicated process. Thank you for sharing. Talking together is a first step'.</p> <p>'This makes me worried about your safety and your health. I would like to help you however I can'.</p>
Planning and Implementation	
<ul style="list-style-type: none"> Inquire about, and respond, to the needs and concerns identified by the patient as the most critical or immediate priority (e.g. may be related to food, health, safety of children, housing, employment). 	<p>'If I could help you with one thing right now, what is the most important need that you have?'</p>
<ul style="list-style-type: none"> Offer support. Individuals experiencing IPV are often isolated. Social distancing may be increasing their isolation. As a nurse/midwife, you may be one of the few individuals they can connect with. Explore how often, and in what ways (e.g. daily or weekly text message), you can 'check-in' and provide supportive messages. 	<p>'It sounds like you are feeling quite alone right now. Would it be okay if we connected (weekly) by phone? Would it be safe if I occasionally sent you a text message to see how you are doing?'</p> <p>'Do you have a friend or family member that you are able to connect with, who could provide you support if you are feeling unsafe?'</p>
<ul style="list-style-type: none"> Provide a warm referral where the nurse/midwife helps the patient make the first contact with another agency. During a telehealth visit, this may involve setting up a three-way call with the agency and the patient or using screen share to help them access the agency's website. With the patient's permission, it is possible to also send information as a follow-up in an email, through a patient portal in an electronic health record, text message or postal service. 	<p>'I can connect you with someone who works with people who are going through difficult times in their relationship. Would it be ok for me to do that now?'</p> <p>'I can provide you with connections to (list local resources) right now if you would like to stay on the call/videoconference or send you the information. What would work best for you?'</p>

(Continues)

Table 4 (Continued)

Identification and Assessment (Case Finding)	
<ul style="list-style-type: none"> If time or privacy is limited, explain to the patient how they can safely access the MyPlan decision aid tool to independently develop a tailored safety plan. United States: https://www.myplanapp.org/; New Zealand: https://isafe.aut.ac.nz; Canada: https://myplanapp.ca; Australia http://idecide.org.au Assess patient concerns and provide education related to technology-facilitated harassment, stalking, abuse or impersonation (e.g. Tech Safety (US) https://techsafetyapp.org/home or 'Do It Yourself Online Safety' (UK) https://chayn.co/safety/) Offer strategies for reducing stress. Ask the patient what generally helps them when dealing with stress. Brainstorm ways the patient can incorporate these and other stress-reducing activities, into their routine during the pandemic. For example, several free online resources have been created to help individuals exercise, meditate and engage in mindfulness while staying at home. Document referrals and care plans in the medical record. Schedule a follow-up visit. 	<p>'One step we can take together is planning for your safety. That may mean planning ways to stay safe at home/in your relationship or planning a safe way to leave. I am here to help make a plan that will work for you [and your children/family]'</p> <p>'If this is not a good time to talk through a plan, there are some resources I can share with you. Can I text you information about a safety planning app? We can also discuss how you can safely access these tools.'</p> <p>'Due to the increased use of technology during the pandemic, we have been sending patients information about staying safe when using technology. Can I text you information about this?'</p> <p>'This is an unusually stressful time, and relationship stress/violence [use their words] can make things harder. What activities do you use to relax and feel good? Can I share some resources that might help you find new strategies for taking care of yourself at home?'</p>

developing code words for when a patient may be in danger, and using a trustworthy vendor with a robust privacy and security contract; (f) recognising that impersonation could occur during telehealth visits, particularly with new patients; (g) promoting the need for agency-owned devices and parameters around patient contact for the well-being of nurses and midwives; and (h) highlighting the expanded accessibility that telehealth provides to certain vulnerable populations. We reviewed the expert feedback and revised the principles and guidance accordingly.

4 | RESULTS

The ADAPT-ITT framework resulted in two outcomes that addressed the initial research question: (a) principles for prioritising individuals' physical and emotional safety by promoting privacy and confidentiality during telehealth encounters and (b) guidance for screening and responding to IPV via telehealth. Tables 3 and 4 provide practical strategies and scripts for providers to use in their telehealth encounters. This high-level guidance has been developed for (a) initial contacts with new patients or (b) existing patients for whom care is transitioning from in-person to a telehealth environment.

Of primary importance is the awareness that, as compared to in-person interactions, healthcare professionals have fewer options and less control in assessing or managing the patient's safety within the telehealth environment. There is increasing awareness of the extent to which perpetrators of violence use technology to monitor, stalk, harass or impersonate their partners (National Network to End Domestic Violence, 2014). Healthcare professionals therefore need to be extra vigilant and take additional steps to protect a patient's privacy and safety when using telehealth. Practical strategies for prioritising emotional and physical safety when working with

individuals who are experiencing IPV are summarised in Table 3. This guidance may be useful for facilitating agency-specific procedural documents focused on screening for safety during each encounter.

Guidance for IPV assessment and case finding, planning and intervention is summarised in Table 4, while subsections (4.1 to 4.6) summarise telehealth-based IPV assessment and response strategies.

4.1 | Case finding and assessment

One primary role of nurses and midwives is to create an atmosphere where a patient feels safe to disclose and/or discuss violence if they choose. In both in-person and telehealth encounters, it is important to observe or listen for 'red flags' or risk indicators (including heightened stress related to COVID-19), health effects or injuries, or behavioural cues associated with IPV. If 'red flags' are present, the provider can introduce the topic of IPV and then follow up with direct questions related to IPV exposure. The 'CUES' intervention provides helpful guidance for how to incorporate Confidentiality, Universal education and Empowerment, and safer Supports into practice (Futures Without Violence, 2020a). Acknowledging and discussing stresses related to living through a pandemic may be a safe topic to initiate within a telehealth encounter. *Normalising* conversations about relationships and health and providing *universal education* are aligned with TVIC approaches and acknowledges that patients are often doing the best they can in unusual circumstances (Futures Without Violence, 2020a). Offering *universal resources* related to food, shelter, employment and IPV ensures the introduction of these supports regardless of IPV disclosure and normalises that patients and their families or friends may experience increased need for resources during the pandemic.

4.2 | Response to a disclosure

Nurses and midwives have a professional responsibility to respond sensitively to IPV disclosure and provide additional supports in the context of healthcare encounters, regardless of setting. However, telehealth is unique in that providers have limited control over the care environment and must implement novel strategies to mitigate risks associated with patient safety and loss of privacy and confidentiality. For example, during video calls, providers should be aware of the patient not making eye contact or of seeing others listening to or observing the call. In telephone or audio-only encounters, providers should be aware of potential eavesdropping, other adult voices in the background or prolonged silence from the patient. If there is a safety concern for the patient at any time, then the discussion on IPV should be stopped and discreet indicators (e.g. yes/no questions or asking the patient to nod their head) should be used to ensure the patient's safety.

4.3 | Planning and intervention

If a patient discloses IPV, or IPV is suspected, there are several interventions nurses and midwives can provide to help ensure the safety and health of the patient. The WHO (2014) 'LIVES' protocol can also be used in telehealth encounters as a short reminder to guide response: Listen, Inquire about needs and concerns, Validate, Enhance safety and Support. It is essential to convey a nonjudgemental tone, especially when communicating by phone or text when the patient cannot hear or observe nonverbal cues and tone. In the context of COVID-19-induced isolation, connection and support from a nurse or midwife may be one of the most critical and important interventions: reach out often, maintain contact and share positive messages of hope and support (Futures Without Violence, 2020b). During social and physical distancing, it also may be beneficial to encourage the patient to explore their social support networks and identify who may be able to help them in an unsafe situation. Other interventions include active listening, safety planning and connecting the patient with community resources. It is critical that interventions are tailored to the patient's individual situation, including the severity of violence, and their current danger level, cultural background, desires regarding intervention. Interventions should also build upon the patient's existing safety strategies and strengths. Although providers may not agree with the course of action desired by the patient, they should support and align interventions with the patient's wishes. Providers can offer patients the possibility of a warm referral—a connection made while they remain on the call—or to send a list of resources with contact information for crisis lines, local shelters, the police and counselling services. These resources could be sent via a private electronic patient portal or password-protected text message or email. Depending on the patient's telecommunication device, it may be possible to share a contact with them under the provider's name or the clinic name that includes a list of resources in the notes

section. However, options for safe shelter may be more limited due to social and physical distancing guidelines.

Transitioning care to telehealth also creates a natural opportunity to increase patients' awareness about technology-facilitated stalking, harassment or abuse (including impersonation) and to provide education about how to enhance their privacy and security while using technology. Reviewing principles of cell phone, device, location and online (e.g. social media engagement) safety may be a critical component of a tailored safety plan.

4.4 | System responses

During the COVID-19 pandemic, many systems and institutions have quickly adjusted to new ways of functioning, and these system-level changes are important considerations when recognising and responding to IPV via telehealth. For example, if a healthcare system usually uses paper forms or a tablet to screen for IPV prior to a patient visit, it is possible that this information is no longer being captured during telehealth encounters. Electronic health records (EHRs) also offer the ability to screen for IPV before or during the visit, but these questions may not be getting asked or patients' responses may be overlooked. It is also essential that the system for conducting telehealth provide safety and security for the patient and provider. If a new system is introduced, this means ensuring it is from a trustworthy vendor with robust safety and privacy practices.

Many shelters have necessarily modified their policies and services due to COVID-19, including moving counselling sessions online, limiting shelter capacity to ensure physical distancing and eliminating donation drop-offs (clothes, cleaning products, food). Court systems have also reduced proceedings, which may be causing delays in personal protective orders. This has resulted in some regions offering hotel rooms to survivors of IPV, especially those who may need to quarantine (Reuters News Agency, 2020; Taub, 2020). Providers should stay up to date on their local community options and services for patients who are experiencing IPV.

4.5 | Prioritising the emotional and physical safety of the nurse/midwife

For nurses and midwives accustomed to face-to-face care encounters, the transition to telehealth during a global pandemic presents both personal and professional challenges. Prioritising the safety of their patients when assessing and responding to IPV while also maintaining their own physical and emotional well-being are primary examples. When providing telehealth from their homes, this may mean establishing a private space to connect with patients. This may be difficult with children in the home, and even more so in situations where the provider is also sheltering in place with an abusive partner. To protect the privacy of providers, it is further recommended that phone calls and text messages are not sent from personal phones, but from devices distributed by their employer.

The physical, psychological and economic stressors of gender-based violence, structural racism and a pandemic affect both patients and providers. It may feel at least as difficult to assess for, listen to, and respond to descriptions of suffering, abuse and IPV via telehealth, as during an in-person visit. Providers who work with people in emotionally distressing situations often experience substantial psychological, physical and emotional consequences, termed vicarious or secondary trauma (McCann & Pearlman, 1990). Further, providers bring their own unique sociocultural and historical experiences to their work, which may place some at more risk than others for vicarious trauma. Providers who connect strongly with their patients' stories and/or have previous personal experiences with trauma are particularly vulnerable (Figley, 1995). Previous research with telecommunications emergency personnel indicated that bearing auditory witness to another person's distress appears to create the same level of vicarious trauma as physical presence (Jenkins, 1997).

Beyond the potential of bearing witness to IPV, caregiving during this infectious disease pandemic is fatiguing (Sun et al., 2020). Coping with shortages of personal protective equipment, screen fatigue, perceived helplessness and professional isolation are just a few issues that contribute to weariness experienced by providers. It is inherently traumatic to live through a pandemic, and there is a constant, real and pressing threat to providers' health. Vicarious trauma and fatigue may overlap with other cognitive symptoms such as difficulty with problem-solving or concentrating and feeling pessimistic or confused. The emotional experience covers a spectrum from anxiety and anger to hopelessness and worry, while physical symptoms may include sleep disruption, gastrointestinal disturbances and headaches. Many may also experience behavioural changes that may include hypervigilance, withdrawal, avoiding work or extreme irritability (Figley, 1995; Morrissette, 2004).

Nurses and midwives who engage patients in telehealth visits during the COVID-19 pandemic need to prioritise personal safety and self-care. Setting work/life boundaries may be more challenging when working from home; however, walking away from electronic devices at the end of the workday is an act of self-preservation. Establishing clear boundaries with patients around access through telehealth, such as clearly communicating when the provider is available to answer calls or respond to texts/emails, is also critical. Developing routines that support emotional and physical rejuvenation, such as mindfulness exercises, deep breathing, yoga, prayer or meditation, and maintaining strong social connections are forms of primary prevention (Melvin, 2012).

Another important resilience tactic for providers is cognitive reframing (Hart et al., 2014). For example, the provider should ask themselves 'Do I think it is my job to solve my patients' problems?' and may need to consider reframing their perceived role to acknowledge the realistic scope of interventions they can deliver, particularly within the context of telehealth. When working with people in abusive situations, the primary goal is not to fix the problem, but rather to validate the person's experience, to help them find safer ways to be in relationships, and to promote their overall well-being.

Effective prevention and interventions for vicarious trauma acquired during telehealth encounters require both individual and organisational responses. Resilient healthcare organisations need to care for their employees, both proactively and in response to specific crises. A TVIC approach acknowledges that there are structural issues within organisations that can exacerbate or mitigate the effects of vicarious trauma (Befus et al., 2019), yet vicarious trauma can also be the result of the systems themselves. Thus, healthcare organisations must examine their basic operating principles, personnel and policies with an equity lens, acknowledging historical trauma experienced by employees and patients and actively working to embrace healthier, more just approaches to care delivery.

When providers are also required to work remotely, organisational management can use specific strategies to create and maintain an equitable and healthy workplace. Continuing flexible work hours and location arrangements used during the COVID-19 pandemic, even as lockdown restrictions are relaxed, can give employees more autonomy. Creating online opportunities for collegial discussions about patient encounters through individual debriefings or regular group meetings to discuss peer caseloads can mitigate isolation and increase self-efficacy (Ashley-Binge & Cousins, 2019). Another important approach is to promote a culture of ongoing professional development (Nolte et al., 2017). Specifically, in-depth training on IPV assessment and intervention, vicarious trauma, TVIC, engaging with patients via telehealth, and developing healthy coping strategies and relationships may be helpful.

The more people on a nurse or midwife's caseload who are experiencing trauma and violence, the more likely that the provider will experience serious vicarious trauma (Bober & Regehr, 2006; Figley, 1995; Nolte et al., 2017). Thus, organisations must also re-assess how large a caseload can reasonably be managed by any individual provider via telehealth and ensure that workload is fairly distributed. It is part of the supervisory role to monitor the well-being and productivity of staff; this should include evaluating perceived self-efficacy and screening for vicarious trauma in all front-line providers (whether working in-person or via telehealth). Supervisors should also have the knowledge and skill to recognise and respond to providers who may be IPV while working at home and/or isolated with their partner. Further, healthcare organisations should recognise that poor job performance may not be a personality flaw of the employee, but rather a reflection of difficulty coping with vicarious trauma and/or systemic issues that interfere with optimal care delivery. Ensuring that employees feel empowered to critique the structure or nature of the work, point out mistakes and identify problematic processes without fear of retribution is critical to maintaining a healthy work environment (Gates & Gillespie, 2008). For employees who disclose IPV, experience vicarious trauma or suffer a decrease in performance, Employee Assistance Programs and outside counsellors are only one part of a comprehensive intervention. These moments of crisis are opportunities for reflection to examine structural issues that contribute to the situation and to seek feedback from staff and community members so as to prevent similar injury in the future.

4.6 | Equitable access to telehealth-based IPV care

One advantage of telehealth is that patients have a potentially continuous and convenient mode of alternate or supplemental care if in-person care options are limited or pose new dangers and challenges, such as with the COVID-19 pandemic (Jennings et al., 2015; Lopez et al., 2011; WHO, 2011; World Bank, 2012). In addition, nurses, midwives and broader healthcare systems whose revenue (and salaries) is determined by patient volume may favourably view the use of telehealth as a means of fiscal sustainability in the midst of social distancing restrictions. Thus, telehealth models support positive health and economic outcomes.

However, assessing and responding to IPV via telehealth requires that both providers and patients have access to telecommunications technologies, including text messaging, email or videoconferencing equipment, such as cell phones, computers (including laptops), smartphones, or tablets (Denizard-Thompson et al., 2011; Jennings et al., 2015; Newman et al., 2012) as well as requisite cellular, land-line or Internet bandwidth. While access to these technologies has rapidly increased in recent years, substantial inequities based in gender, socioeconomic, household and geographic characteristics remain (Braveman & Gruskin, 2003). Further, people experiencing IPV may have limited tele-connectivity and be less likely to control their personal or household telephone and computing devices (Jennings & Gagliardi, 2013; Jennings et al., 2016). Physical distancing orders may have the unintended effect of widening disparities for the poorest and most vulnerable patients by disrupting access to in-person services without compensatory technological access and support for telehealth-based IPV services (Jennings et al., 2015; Wang & Young, 2013). Questions remain about how unemployed patients who are experiencing IPV cover access costs (e.g. phone bills, Internet service charges, fees for phone, or computer repairs), in addition to their potential loss of employer-based health insurance to cover telehealth costs. This problem is particularly apparent in the USA, where many high-quality nurse-led IPV services for patients are available only through insurance-mandated clinics.

Implementing equitable IPV services via telehealth and avoiding what has been termed the 'digital divide' (Denizard-Thompson et al., 2011; López et al., 2011) requires addressing several key considerations. First, information regarding equity in eligibility, uptake and continuity of telehealth services needs to be collected and analysed among individuals with diverse demographic characteristics. To date, few studies have examined inequities in telehealth access and uptake among individuals experiencing IPV (e.g. Liaw et al., 2020). Second, it is imperative that providers continually problem-solve with individuals experiencing IPV with limited telecommunications access or capacity so as to effectively deliver technological, financial and operational assistance, as well as IPV assessment and care. Solutions to problems of access may look like providing rented or donated earphones or smartphones, vouchers for purchase of cellular airtime, or access to free high-speed Internet. Successful provision of IPV-related care may also require

the use of innovative distancing techniques that do not rely on telecommunications, such as mail or peer referrals. As physical distancing measures are loosened, organisations may begin to examine models of care that blend online and offline interventions as a strategy to promote more equitable access to individuals who were less likely to engage in fully online services (Veinot et al., 2018). Finally, implementing community-based information channels is essential to awareness of telehealth IPV care alternatives that can be accessed during physical and social distancing restrictions. This may be achieved via distributed or mailed flyers, televised public health alerts, social media posts to peers or door-to-door canvassing (without home entry). Addressing structural inequities to telehealth-based IPV care may also entail special provisions to assess and respond to IPV among individuals who do not identify as cisgender and/or heterosexual women (i.e. cisgender men, transgender women/men, and gender nonconforming individuals), who may have lower rates of access and uptake of perceived 'women-focused' IPV services in general, and especially via telehealth.

Equitable access to telehealth-based IPV care also requires equitable institutions and organisations that support nurses, midwives and other healthcare providers. Recommended strategies to address structural inequities for providers of IPV care via telehealth include the following: (a) assessing the extent to which providers have the technological and financial means to confidentially carry-out telehealth IPV services from their home; and (b) covering the costs of or providing employee benefits to subsidise purchases and installation of equipment for telehealth services (e.g. earphones, videoconferencing subscriptions, computers/tablets, or home office space remodelling or reconfiguration for privacy). In countries where access to universal health care is limited, organisations may also need to develop revenue policies that do not differentially compensate providers, including nurses and midwives, for in-person versus telehealth IPV care encounters. Such practices may inadvertently contribute to healthcare inequalities for individuals experiencing IPV who are ineligible for telehealth services and unable to safely attend in-person visits.

5 | CONCLUSIONS

Recognising that there are well-established practices for telehealth and IPV more generally, this paper fills an important gap by outlining specific strategies for nurses/midwives to assess for and respond to IPV via telehealth. The application of TVIC principles required us to also develop considerations for equity-informed telehealth at the system level, whereas most guidance is typically limited to recommendations for front-line care. The importance of addressing the emotional and physical safety of both patients and nurses/midwives engaged in telehealth emerged as an overarching practice priority.

We successfully applied the ADAPT-ITT framework in a non-traditional way, highlighting the potential this framework has in the clinical arena. Our process demonstrates that during a global pandemic, when time is of the essence, ADAPT-ITT can be used to

adapt existing evidence (rather than focusing on new knowledge production) for rapidly changing circumstances. This discursive paper focused on the first six phases of the ADAPT-ITT framework. Additional research is now required to address the remaining aspects of the framework: Training nurses and midwives using telehealth modalities to assess for and respond to IPV and Testing the effectiveness of the guidance provided here. Furthermore, the guidance presented in this paper is focused on the systems and processes currently in place within high-income countries and may not be applicable to low- and middle-income countries. Additional research is warranted to investigate responding to and recognising IPV during the COVID-19 global pandemic in these regions.

Integrating innovative IPV-focused practices into emerging telehealth delivery is an important opportunity for nurses and midwives during the current global pandemic, with implications for future secondary outbreaks, natural disasters or other isolating events. However, while there may be potential benefits and efficiencies associated with using telehealth to provide primary health care, it is not a panacea and providers and organisations must continually evaluate and implement measures for providing equitable access and services, particularly for individuals experiencing digital exclusion because of lack of access or resources.

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CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

AUTHOR CONTRIBUTIONS

Conception and outline, identification, adaptation and integration of evidence resulting in production of guidance, findings, discussion, drafting and final review and revision of the work to be published: all authors; review and extraction of existing evidence to inform guidance and elicitation of feedback from topical experts: SMJ, MMK.

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REFERENCES

- Abrahams, N., Jewkes, R., Lombard, C., Mathews, S., Campbell, J., & Meel, B. (2010). Impact of telephonic psycho-social support on adherence to post-exposure prophylaxis (PEP) after rape. *AIDS Care*, 22(10), 1173–1181. <https://doi.org/10.1080/09540121003692185>
- Allen-Ebrahimian, B. (2020). China's domestic violence epidemic. *Axios*. <https://www.axios.com/china-domestic-violencecoronavirusquarantine-7b00c3ba-35bc-4d16-afdd-b76ecfb28882.html>
- American Nurses Association (2019). ANA core principles on connected health. <https://www.nursingworld.org/~4a9307/globalassets/docs/ana/practice/ana-core-principles-on-connected-health.pdf>
- Amin, F. (2020). Domestic violence calls surge during pandemic. *City News [Toronto]*. <https://toronto.citynews.ca/2020/04/08/domestic-violence-calls-surge-during-coronavirus-pandemic/>
- Anderson, E. J., Krause, K. C., Meyer Krause, C., Welter, A., Jean McClelland, D., Garcia, D. O., Ernst, K., Lopez, E. C., & Koss, M. P. (2019). Web-based and mHealth interventions for intimate partner violence victimization prevention: A systematic review. *Trauma Violence & Abuse*. <https://doi.org/10.1177/1524838019888889>
- Ashley-Binge, S., & Cousins, C. (2019). Individual and organisational practices addressing social workers' experiences of vicarious trauma. *Practice: Social Work in Action*, 32(3), 191–207. <https://doi.org/10.1080/09503153.2019.1620201>
- Australian Government, Department of Health (2018). Family violence: Pregnancy care guidelines. <https://www.health.gov.au/resources/pregnancy-care-guidelines/part-e-social-and-emotional-screening/family-violence>
- Befus, D., Kumodzi, T., Schminkey, D., & St. Ivany, A. (2019). Advancing health equity and social justice in forensic nursing research, education, practice, and policy: Introducing structural violence and trauma- and violence-informed care. *Journal of Forensic Nursing*, 15(4), 199–205. <https://doi.org/10.1097/JFN.00000000000000264>
- Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, 6(1), 1–9. <https://doi.org/10.1093/brief-treatment/mhj001>
- Bradbury-Jones, C., & Isham, L. (2020). The pandemic paradox: The consequences of COVID-19 on domestic violence. *Journal of Clinical Nursing*, 29(13–14), 2047–2049. <https://doi.org/10.1111/jocn.15296>
- Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, 57(4), 254–258.
- Campbell, D. W., Campbell, J. C., Yarandi, H., O'Connor, A. L., Dollar, E., Killion, C., Sloand, E., Callwood, G., Cesar, N., Hassan, M., & Gary, F. (2016). Violence and abuse of internally displaced women survivors of the 2010 Haiti earthquake. *International Journal of Public Health*, 61(8), 981–992. <https://doi.org/10.1007/s00038-016-0895-8>
- Chukwueke, J. (2020). The "shadow pandemic" of gender-based violence. The Atlantic Council. <https://www.atlanticcouncil.org/blogs/africa-source/the-shadow-pandemic-of-gender-based-violence/>
- College of Nurses of Ontario (2020). *Telepractice: Practice guideline*. College of Nurses of Ontario.
- Davies, S., & Batha, E. (2020). Europe braces for domestic abuse 'perfect storm' amid coronavirus lockdown. *Thomas Reuters Foundation News*. <https://news.trust.org/item/20200326160316-710uf>
- Daya, R., & Azpirir, J. (2020). Calls to Vancouver domestic-violence crisis line spike 300% amid COVID-19 pandemic. *Global News*. <https://globalnews.ca/news/6789403/domestic-violence-coronavirus/>
- Denizard-Thompson, N. M., Feiereisel, K. B., Stevens, S. F., Miller, D. P., & Wofford, J. L. (2011). The digital divide at an urban community health center: Implications for quality improvement and health care

- access. *Journal of Community Health*, 36(3), 456–460. <https://doi.org/10.1007/s10900-010-9327-5>
- Figley, C. R. (1995). Compassion fatigue: Towards a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (pp. 3–28). The Sidran Press.
- Futures Without Violence (2020a). Virtual CUES to support survivors of intimate partner violence. <https://www.futureswithoutviolence.org/wp-content/uploads/Home-Visitation-Virtual-CUES-to-support-survivors-FINAL.pdf>
- Futures Without Violence (2020b). Telehealth, COVID-19, intimate partner violence, and human trafficking: Increasing safety for people surviving abuse. National Health Resource Center, Futures Without Violence: San Francisco, CA. https://www.futureswithoutviolence.org/wp-content/uploads/Telehealth-COVID-19-IPV-and-HT_Guide.pdf
- García-Moreno, C., Pallitto, C., Devries, K., Stöckl, H., Watts, C., & Abrahams, N. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization.
- Gates, D., & Gillespie, G. L. (2008). Secondary traumatic stress in nurses who care for traumatized women. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN*, 37(2), 243–249. <https://doi.org/10.1111/j.1552-6909.2008.00228.x>
- Goldstein, K. M., Gierisch, J. M., Zullig, L. L., Alishahi, A., Bready, T., Dedert, E. A., Williams, J. W. (2017). Telehealth services designed for women: An evidence map (VA ESP Project #09-010). Washington (DC): Department of Veterans Affairs (US). <https://www.ncbi.nlm.nih.gov/books/NBK532574>
- Gwinn, C. (2020). *Pandemic shutdowns are leading to more extreme domestic violence. We cannot let it continue*. The San Diego Union Tribune.
- Haase, A., Follmann, M., Skipka, G., & Kirchner, H. (2007). Developing search strategies for clinical practice guidelines in SUMSearch and Google Scholar and assessing their retrieval performance. *BMC Medical Research Methodology*, 7, 28. <https://doi.org/10.1186/1471-2288-7-28>
- Hart, P. L., Brannan, J. D., & De Chesnay, M. (2014). Resilience in nurses: An integrative review. *Journal of Nursing Management*, 22(6), 720–734. <https://doi.org/10.1111/j.1365-2834.2012.01485.x>
- Jack, S. M., Ford-Gilboe, M., Wathen, C. N., Davidov, D. M., McNaughton, D. B., Coben, J. H., Olds, D. L., MacMillan, H. L., & NFP IPV Research Team (2012). Development of a nurse home visitation intervention for intimate partner violence. *BMC Health Services Research*, 12, 50. <https://doi.org/10.1186/1472-6963-12-50>
- Jenkins, S. R. (1997). Coping and social support among emergency dispatchers: Hurricane Andrew. *Journal of Social Behavior & Personality*, 12(1), 201–216.
- Jennings, L., & Gagliardi, L. (2013). Influence of mHealth interventions on gender roles in developing countries: A systematic literature review. *International Journal for Equity in Health*, 12(1), 85. <https://doi.org/10.1186/1475-9276-12-85>
- Jennings, L., Lee, N., Shore, D., Strohminger, N., Burgundi, A., Conserve, D. F., & Cheskin, L. J. (2016). U.S. minority homeless youth's access to and use of mobile phones: Implications for mHealth intervention design. *Journal of Health Communication*, 21(7), 725–733. <https://doi.org/10.1080/10810730.2015.1103331>
- Jennings, L., Omoni, A., Akerele, A., Ibrahim, Y., & Ekanem, E. (2015). Disparities in mobile phone use and maternal health service utilization in Nigeria: A population-based survey. *International Journal of Medical Informatics*, 84(5), 341–348. <https://doi.org/10.1016/j.ijmedinf.2015.01.016>
- Kelly, J., & Morgan, T. (2020). Coronavirus: Domestic abuse calls up 25% since lockdown, charity says. BBC News. <https://www.bbc.com/news/uk-52157620>
- Latham, T. P., Sales, J. M., Boyce, L. S., Renfro, T. L., Wingood, G. M., DiClemente, R. J., & Rose, E. (2010). Application of ADAPT-ITT: Adapting an evidence-based HIV prevention intervention for incarcerated African American adolescent females. *Health Promotion Practice*, 11(Suppl. 3), 53S–60S. <https://doi.org/10.1177/1524839910361433>
- Latham, T. P., Sales, J. M., Renfro, T. L., Boyce, L. S., Rose, E., Murray, C. C., Wingood, G. M., & DiClemente, R. J. (2012). Employing a teen advisory board to adapt an evidence-based HIV/STD intervention for incarcerated African-American adolescent women. *Health Education Research*, 27, 895–903. <https://doi.org/10.1093/her/cyr003>
- Liaw, W. R., Jetty, A., Coffman, M., Petterson, S., Moore, M. A., Sridhar, G., Gordon, A. S., Stephenson, J. J., Adamonson, W., & Bazemore, A. W. (2020). Disconnected: A survey of users and nonusers of telehealth and their use of primary care. *Journal of the American Medical Informatics Association*, 26(5), 420–428.
- López, L., Green, A. R., Tan-McGrory, A., King, R. S., & Betancourt, J. R. (2011). Bridging the digital divide in health care: The role of health information technology in addressing racial and ethnic disparities. *The Joint Commission Journal on Quality and Patient Safety*, 37(10), 437–445. [https://doi.org/10.1016/S1553-7250\(11\)37055-9](https://doi.org/10.1016/S1553-7250(11)37055-9)
- McCann, I., & Pearlmán, L. A. (1990). Vicarious traumatization: a framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 141–149. <https://doi.org/10.1007/BF00975140>
- Mehotra, A., Ray, K., Brockmeyer, D., Barnett, M. L., & Bender, J. A. (2020). Rapidly converting to “virtual practices”: outpatient care in the era of COVID-19. *NEJM Catalyst Innovations in Care Delivery*, 1(2). <https://doi.org/10.1056/CAT.20.0091>
- Melvin, C. (2012). Professional compassion fatigue: What is the true cost of nurses caring for the dying? *International Journal of Palliative Nursing*, 18(12), 606–611. <https://doi.org/10.12968/ijpn.2012.18.12.606>
- Morrisette, P. (2004). *The pain of helping: Psychological injury of helping professionals*. Routledge.
- Munro-Kramer, M., Rominski, S. D., Seidu, A. A., Darteh, E. K. M., Huhman, A., & Stephenson, R. (2020). Adapting a sexual violence primary prevention program to Ghana utilizing the ADAPT-ITT framework. *Violence against Women*, 26(1), 66–88. <https://doi.org/10.1177/1077801219828533>
- National Health Service (NHS) (2013). Domestic violence and abuse—professional guidance. Department of Health and Social Care, United Kingdom Government. <https://www.gov.uk/government/publications/guidance-for-health-professionals-on-domestic-violence>
- National Health Service (NHS) (2017). Responding to domestic abuse: A resource for health professionals. Department of Health and Social Care, United Kingdom Government. <https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals>
- National Institute for Health and Care Excellence (NICE) (2014). Domestic violence and abuse: multi-agency working. Public health guideline [PH50]. <https://www.nice.org.uk/guidance/ph50>
- National Network to End Domestic Violence (2014). A glimpse from the field: How abusers are misusing technology. <https://www.techsafely.org/blog/2015/2/17/a-glimpse-from-the-field-how-abusers-are-misusing-technology>
- Newman, L., Biedrzycki, K., & Baum, F. (2012). Digital technology use among disadvantaged Australians: Implications for equitable consumer participation in digitally-mediated communication and information exchange with health services. *Australian Health Review*, 36, 125–129. <https://doi.org/10.1071/AH11042>
- Nolte, F., Downing, C., Temane, A., & Hastings-Tolsma, M. (2017). Compassion fatigue in nurses: A metasynthesis. *Journal of Clinical Nursing*, 26(53–54), 4364–4378. <https://doi.org/10.1111/jocn.13766>
- Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., Oertelt-Prigione, S., & van Gelder, N. (2020). Pandemics and violence against

- women and children. Center for Global Development Working Paper 528. Washington DC: Center for Global Development. <https://www.cgdev.org/sites/default/files/pandemics-and-vawg.pdf>
- Raifman, M. A., & Raifman, J. R. (2020). Disparities in the population at risk of severe illness from covid-19 by race/ethnicity and income. *American Journal of Preventive Medicine*, 59(1), 137–139.
- Reuters News Agency (2020). As domestic abuse rises in lockdown, France to fund hotel rooms. Aljazeera. <https://www.aljazeera.com/news/2020/03/domestic-abuse-rises-lockdown-france-fundhotel-rooms-200331074110199.html>
- Royal College of Nursing (2020). eHealth Forum. <https://www.rcn.org.uk/get-involved/forums/ehealth-forum>
- Safety Net Technology (2020). Online communication for advocates. <https://www.techsafety.org/online-communication-for-advocates>
- Sandler, R. (2020). Domestic violence hotline reports surge in Coronavirus-related calls as shelter-in-place leads to isolation, abuse. Forbes. <https://www.forbes.com/sites/rachelsandler/2020/04/06/domestic-violence-hotline-reports-surge-in-coronavirus-related-calls-as-shelter-in-place-leads-to-isolation-abuse/#664aef1e793a>
- Schalbe, N., Lehtimäki, S., & Gutiérrez, J. P. (2020). COVID-19: Rethinking risk. *The Lancet Global Health*, 8(8), e974–e975. [https://doi.org/10.1016/S2214-109X\(20\)30276-X](https://doi.org/10.1016/S2214-109X(20)30276-X)
- Serrata, J. V., & Hurtado Alvarado, G. (2019). Understanding the impact of Hurricane Harvey on family violence survivors in Texas and those who serve them. Austin, TX: Texas Council on Family Violence. <https://tcfv.org/wp-content/uploads/2019/08/Hurricane-Harvey-Report-FINAL-and-APPROVED-as-of-060619.pdf>
- Sullivan, P. S., Stephenson, R., Grazer, B., Wingood, G., Diclemente, R., Allen, S., Hoff, C., Salazar, L., Scales, L., Montgomery, J., Schwartz, A., Barnes, J., & Grabbe, K. (2014). Adaptation of the African couples HIV testing and counseling model for men who have sex with men in the United States: An application of the ADAPT-ITT framework. *SpringerPlus*, 3, 249. <https://doi.org/10.1186/2193-1801-3-249>
- Sun, N., Wei, L., Shi, S., Jiao, D., Song, R., Ma, L., Wang, H., Wang, C., Wang, Z., You, Y., Liu, S., & Wang, H. (2020). A qualitative study on the psychological experience of caregivers of COVID-19 patients. *American Journal of Infection Control*, 48(6), 592–598. <https://doi.org/10.1016/j.ajic.2020.03.018>
- Taub, A. (2020). A new COVID-19 crisis: domestic abuse rises worldwide. The New York Times. www.nytimes.com/2020/04/06/world/coronavirus-domestic-violence.html
- The Guardian (2020). Lockdowns around the world bring rise in domestic violence. <https://www.theguardian.com/society/2020/mar/28/lockdowns-world-rise-domestic-violence>
- Tiwari, A., Yuk, H., Pang, P., Fong, D. Y. T., Yuen, F., Humphreys, J., & Bullock, L. (2012). Telephone intervention to improve the mental health of community-dwelling women abused by their intimate partners: a randomised controlled trial. *Hong Kong Medical Journal*, 18(Suppl 6), 14–17.
- Totten, A. M., Womack, D. M., Eden, K. B., McDonagh, M. S., Griffin, J. C., Grusing, S., & Hersh, W. R. (2016, June). Telehealth: Mapping the evidence for patient outcomes from systematic reviews. Technical Brief No. 26. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290–2015–00009–I.) AHRQ Publication No. 16-EHC034-EF. Rockville, MD: Agency for Healthcare Research and Quality (US). <http://www.effectivehealthcare.ahrq.gov/reports/final.cfm>
- VEGA Project (2020). VEGA's Family Violence Handbook: Intimate Partner Violence Section. McMaster University, Hamilton, ON. <https://vegaproject.mcmaster.ca>
- Veinot, T. C., Mitchell, H., & Ancker, J. S. (2018). Good intentions are not enough: How informatics interventions can worsen inequality. *Journal of the American Medical Informatics Association*, 25(8), 1080–1088.
- Wang, S. I., & Young, C. L. (2013). Vertical equity of healthcare in Taiwan: Health services were distributed according to need. *International Journal for Equity in Health*, 12(1), 12. <http://www.equityhealthj.com/content/12/1/12>
- Wathen, C. N., & Varcoe, C. (2019). Trauma- & violence-informed care: Prioritizing safety for survivors of gender-based violence. London, Canada. https://gtvincubator.uwo.ca/wp-content/uploads/sites/22/2020/05/TVIC_Background_Fall2019r.pdf
- Wingood, G. M., & DiClemente, R. J. (2008). The ADAPT-ITT model: A novel method of adapting evidence-based HIV interventions. *Journal of Acquired Immune Deficiency Syndrome*, 47(1), S40–S46. <https://doi.org/10.1097/QAI.0b013e3181605df1>
- Wingood, G. M., Simpson-Robinson, L., Braxton, N. D., & Raiford, J. L. (2011). Design of a faith-based HIV intervention: Successful collaboration between a university and a church. *Health Promotion Practice*, 12, 823–831. <https://doi.org/10.1177/1524839910372039>
- World Bank. (2012). *Information and communications for development 2012: Maximizing mobile*. World Bank. License: Creative Commons Attribution CC BY 3.0.
- World Health Organization (2011). Mhealth: New horizons for health through mobile: Based on findings of the second global survey on eHealth. *Global Observatory for eHealth Series*, 3, 1–122.
- World Health Organization (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO. <http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>
- World Health Organization (2014). *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook*. Geneva: WHO. <https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/>
- World Health Organization. (2020, March 11). WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020. <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19--11-march-2020>

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