Recognizing and Responding to Intimate Partner Violence using Telehealth: Practical Guidance for Nurses and Midwives

Running Title: Intimate Partner Violence and Telehealth

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Author Contributions

All authors: 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. Two authors (SMJ, MMK): review and extraction of existing evidence to inform guidance; elicitation of feedback from topical experts.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

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Article type   : Discursive Paper

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Abstract

Aims: This paper synthesizes current, global evidence-informed guidance that supports nurses and midwives to recognize 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 recognizing and responding to IPV in telehealth encounters was developed. The ADAPT-ITT (**A**ssessment, **D**ecisions, **A**dministration, **P**roduction, **T**opical Experts**, I**ntegration, **T**esting, **T**raining**)** framework was used to guide the novel identification and adaptation of evidence-informed. 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 prioritizing 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 summarized. 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 healthcare.

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

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.

1.

1. Aim

The aim of this paper is to explore how current, global evidence-informed guidelines that support nurses and midwives to recognize 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 prioritize the emotional and physical safety of both patients and providers when initiating contact or

delivering care through telehealth. A secondary aim is to explain how the ADAPT-ITT framework was utilized 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 March 11, 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, Ray, Brockmeyer, Barnett, & Bender, 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 characterized 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 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-traumatization 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, Lehtimaki & Gutierrez, 2020). Disparities related to healthcare access and outcomes have been fueled 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 organizations to improve access and outcomes for the most vulnerable populations (Figure 1).

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 bi-directional 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 video conferencing 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 less than 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 favorable outcomes with regard to perceived social support, health-related quality of

life, adherence to post-exposure prophylaxis, violent incidents, safety-promoting behaviors, and healthcare utilization (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 is to develop practical guidance on the safe use of telehealth as a strategy to support individuals experiencing IPV.

3. Design and Methods

The **A**ssessment, **D**ecisions, **A**dministration, **P**roduction, **T**opical Experts**, I**ntegration, **T**esting, **T**raining (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; Latham et al., 2012; Sullivan et al., 2014; Wingood, Simpson-Robinson, Braxton & Raiford, 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 1outlines 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 United States (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 to 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 recognizing and responding to IPV among their patients. The following criteria were applied to locate guidance/guidelines: 1) published by an international or national level organization or working group; at the national level, the search was limited to retrieving guidance documents from organizations within Australia, Canada, Europe, the United

Kingdom, and the United States; 2) developed for healthcare professionals (including nurses/midwives); 3) rigorously developed and informed by the best available evidence at the time of publication; 4) 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; 5) published in English; and 6) published between 2010-2020. A guidance/guideline document was excluded if it: 1) provided only medical recommendations (specific to physicians); or 2) 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, Follmann, Skipka & Kirchner, 2007) was used to search both SUMSearch 2 and Google Scholar using terms "guideline" AND "intimate partner violence" with relevant limits were applied. 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 recognizing and responding to IPV: 1) the WHO (international) guideline on responding to IPV (2013) and its 2) companion clinical handbook (WHO, 2014); 3) the NICE (2014) public health guideline for domestic violence and abuse; 4) the National Health Service (NHS; United Kingdom) domestic abuse resource for NHS staff and allied healthcare providers (2017); 5) the NHS (2013) Guidance for health professionals on domestic violence; 6) the Violence, Education, Guidance, Action (VEGA; Canada) IPV guidance (2020); 7) Australian Department of Health recommendations to respond to family violence and pregnancy care guidelines (2018); and 8) the Futures Without Violence (United States) virtual "CUES" guidance (2020a). Each guideline was reviewed and brief summaries of primary recommendations were extracted and summarized (Table 2) related to: 1) privacy assessment; 2) IPV assessment; and 3) 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 recognizing and responding to IPV summarized in Table 2, the team developed practical guidance on how to adapt these recommendations when using telehealth. This guidance was informed by: 1) best practice

guidelines and standards for telehealth; 2) emerging guidance for safe use of technology with individuals who have experienced violence (e.g., Safety Net Technology, 2020); and 3) the clinical, educational, and research expertise of the authors in recognizing 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: 1) College of Nurses of Ontario (2020) Practice Guideline for Telehealth [Canada]; 2) the American Nurses Association (2019) Core Principles on Connected Health; and 3)The Royal College of Nursing [United Kingdom] 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: 1) IPV screening and assessment (CBJ, DLS, SMJ, JCC, JRW, LJMW); 2) IPV curricula for healthcare providers (CBJ, SMJ, DLS, JRW, MMK), 3) TVIC (ERT, SMJ, DLS, JRW), 4) telehealth in public health nursing practice (CBJ, DLS, SMJ, LJMW); 5) use of the ADAPT-ITT framework (MMK); and 6) healthcare responses to IPV (all authors). This expertise supported our adaptation of recommendations summarized 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 organizational responses reflected the four inter-related principles of TVIC, in that: 1) the creation of emotional and physically safe environments were prioritized for all patients and providers; 2) responses reflected an awareness that trauma

and violence impacts people's lives and behaviours; 3) they fostered opportunities for choice, collaboration and connection; and 4) 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 recognizing and responding to IPV and mapping recommendations to either: 1) specific guidance for creating emotionally and physically safe care environments; or 2) 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 recognized experts in IPV recognition and response were identified [Dr. Linda Bullock, United States; Dr. Karen Campbell, Canada; Dr. Sinegugu Duma, South Africa; Dr. Julie McGarry, United Kingdom; 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: 1) Do the adapted recommendations align with existing evidence? and 2) 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: 1) describing the type of visit (e.g., new patient, returning visit, obstetric visit, patient experiencing IPV) for which guidance was developed; 2) expanding the focus to include more forms of telehealth, particularly SMS text and email; 3) recognizing the importance of children in decision-making related to IPV; 4) including informal social support networks as part of safety planning, 5) emphasizing the importance of digital safety practices such as techniques to avoid others overhearing a conversation, developing code words for when a patient may be in danger,

and utilizing a trustworthy vendor with a robust privacy and security contract; 6) recognizing that impersonation could occur during telehealth visits, particularly with new patients; 7) promoting the need for agency-owned devices and parameters around patient contact for the well-being of nurses and midwives; and 8) 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: 1) principles for prioritizing individuals' physical and emotional safety by promoting privacy and confidentiality during telehealth encounters and 2) 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 1) initial contacts with new patients or 2) 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 prioritizing emotional and physical safety when working with individuals who are experiencing IPV are summarized 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 are summarized in Table 4, while sub-sections (4.1 to 4.6) summarize 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 **C**onfidentiality, **U**niversal education and **E**mpowerment; and safer **S**upports 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. Normalizing conversations about relationships and health and providing universal education is aligned with TVIC approaches and acknowledges that patients are often doing the best they can in unusual circumstances (Futures Without Violence, 2020a). Offer universal resources related to food, shelter, employment, and IPV ensures the introduction of these supports regardless of IPV disclosure and normalizes 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: **L**isten, **I**nquire about needs and concerns, **V**alidate, **E**nhance safety and **S**upport. It is essential to convey a non-judgmental 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 counseling 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 recognizing 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 counseling 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 that 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 Prioritizing 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. Prioritizing 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 (Morrissette, 2004; Figley, 1995).

Nurses and midwives who engage patients in telehealth visits during the COVID-19 pandemic need to prioritize 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, Brannan, & De Chesnay, 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 organizational responses. Resilient healthcare organizations need to care for their employees, both proactively and in response to specific crises. A TVIC approach acknowledges that there are structural issues within organizations that can exacerbate or mitigate the effects of vicarious trauma (Befus, Kumodzi, Schminkey, & St. Ivany, 2019), yet vicarious trauma can also be the result of the systems themselves. Thus, healthcare organizations 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, organizational management can utilize specific strategies to create and maintain an equitable and healthy workplace. Continuing flexible work hours and location arrangements utilized 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, Downing, Temane, & Hastings-Tolsma, 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, organizations 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 recognize and respond to providers who may be IPV while working at home and/or isolated with their partner. Further, healthcare organizations should recognize 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 counselors 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) are determined by patient volume may favorably 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 video conferencing equipment, such as cell phones, computers (including laptops), smart phones, or tablets (Denizard-Thompson et al., 2011; Jennings et al., 2015; Newman et al., 2012) as well as requisite cellular, landline, 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 & Yaung, 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 United States, 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 analyzed 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, organizations 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, Mitchell, & Ancker, 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 canvasing (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 non-conforming 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 organizations that support nurses, midwives, and other healthcare providers. Recommended strategies to address structural inequities for providers of IPV care via telehealth include: 1) assessing the extent to which providers have the technological and financial means to confidentially carry-out telehealth IPV services from their home; and 2) covering the costs of or providing employee benefits to subsidize purchases and installation of equipment for telehealth services (e.g., earphones, video-conferencing subscriptions, computers/tablets, or home office space remodeling or reconfiguration for privacy). In countries where access to universal healthcare is limited, organizations 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 IPV patients who are ineligible for telehealth services and unable to safely attend in-person visits.

5. Conclusions

Recognizing 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 or similar frameworks 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: **T**raining nurses and midwives using telehealth modalities to assess for and respond to IPV and **T**esting 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 recognizing 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 healthcare, it is not a panacea and providers and organizations 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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Table 1. Operationalization 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 recognized 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 United States, Canada, and the United Kingdom.	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	Draft of the principles and guidelines related to identifying and responding to IPV via telehealth

		telehealth guidance and rooted in TVIC principles	
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

Table 2. Evidence-informed recommendations for recognizing and responding to IPV

Evidence-informed guidance document	Privacy Assessment	IPV Assessment	Clinical Actions in Response to Disclosure
Australian Department of Health (2018)	• Ask when alone with patient	• Routine enquiry • Active listening	• Conduct safety assessment • Encourage patient to access specialist support services
Futures Without Violence (2020)	• Prioritize confidentiality • Assess privacy	• Provide universal education (e.g., about stress, relationships and connection to health)	• Validate response • Provide support • Warm referral to survivor support agency
National Health Service (2013; 2017)	• Facilitate disclosure in private without any third parties present • Ensure it is safe to ask • Be attentive and approachable	• Ask about IPV, frame topic and ask direct questions • Early identification of risk factors, signs, presenting problems or conditions, including patterns of coercive	• Acknowledge and validate disclosure • Address presenting concerns • Conduct comprehensive physical/mental health assessment • Assess risk of immediate danger

		• control • Routine enquiry to question observations; determine if presentation warrants concern • Use approaches of "sensitive enquiry"	• Refer to local domestic violence services for support • Discuss safety strategies
NICE (2014)	• Create an environment for disclosing domestic violence • Prioritise people's safety	• Ask patients routinely about abuse in some specialized settings is good practice; insufficient evidence for screening however.	• Respond with empathy • Assess for immediate safety; conduct risk identification and assessment • Regularly assess services needed; refer to domestic violence specialist if specialized support required • Conduct safety planning
VEGA (2020)	• Create safe environments and interactions	• Be alert to potential signs and symptoms of IPV; inquire if	• LIVES protocol • Assess immediate risk of danger

		indicated (do not recommend universal screening)	
WHO (2013, 2014)	• Ensure privacy, confidentiality • Never raise issue unless patient alone • Use empathetic, non-judgmental language relevant to community/culture	• Be aware of risk indicators (do not recommend universal screening) • Assess partner behaviours • Raise topic if there are injuries/conditions that prompt asking	• LIVES protocol (Listen, Inquire about needs and concerns, Validate experience, Enhance safety through safety planning, provide/refer to Supports) • Assess immediate risk

Table 3. Principles to Prioritize Individuals' Physical and Emotional Safety When Delivering Care Through Telehealth

Strategies	Examples of Questions or Statements to Use
Preparing for a telehealth visit	
• Orient self to organization (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

"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."

- 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 video conference as both visual and audio cues will help to assess if 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

"Is this still a good time for us to connect?"

"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 _____ h*ome so I can say hi?"*

- 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

"Sometimes the cell service/Internet connection in my area is unstable. If we get disconnected, how would you like to safely re-*connect?"*

- 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 if

nurse can call a friend, family member or neighbor 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 *"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?"* *"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?"*
• 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 Recognize and Respond to IPV during Telehealth

Identification and Assessment (Case Finding)	
• Normalize the discussion about relationships and health	*"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.*"*

• Provide universal education about how the COVID-19 pandemic is affecting the relationships, stress, and health of many individuals globally.	*"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."*
• Provide universal resources and note they may be useful for family members or friends.	*"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].*"*
• 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.	**Framing and General question:** *"I would like to ask you a few questions about* your relationship. How are things at home? **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?"*
• If there is not an IPV disclosure but provider suspects patient is experiencing abuse, acknowledge patient's response,	"Thank you for talking to me about your relationship. If anything changes in the future and you become worried about your safety or

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.	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?"*
Diagnosis: Response to a disclosure of IPV	
• Actively listen and use non-judgmental 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 non-verbal cues like nodding one's head) to allow the patient to continue.	*"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?"* *"Addressing abuse in a relationship is a* complicated process. Thank you for sharing. *Talking together is a first step."* *"This makes me worried about your safety* and your health. I would like to help you *however I can."*
Planning and Implementation	
• 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).	*"If I could help you with one thing right now,* what is the most important need that you *have?"*
• 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	*"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

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.	*how you are doing?"* *"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?"*
• 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.	*"I can connect you with some*one who works with people who are going through difficult times in their relationship. Would it be ok for *me to do that now?"* *"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?"*
• 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	*"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]."* *"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."*

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.	*"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?"* *"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?"*

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