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Assessment and Response to Intimate Partner Violence in Home Visitation: A Qualitative Needs Assessment With Home Visitors in a Statewide Program

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Abstract

There is growing recognition that home visitation programs serving at-risk families may be an appropriate mechanism for detecting and reducing intimate partner violence (IPV). More research is needed about how home visitors assess and respond to IPV, especially in rural and underserved areas with unique social and geographic challenges. This study describes the qualitative, needs assessment phase of a larger mixed-methods evaluation of IPV assessment, referral processes, and safety planning with clients within a statewide home visitation program. Three focus groups were conducted with home visitors ($n = 16$) in West Virginia's Home Visitation Program in May 2015. Home visitors represented four separate home visitation models and provided services across 12 of West Virginia's 55 counties. Guiding questions focused on home visitors' current protocol, experiences, barriers, and facilitators to (a) screening and assessment for IPV, (b) making referrals after disclosures of IPV, and (c) developing safety plans with IPV-exposed clients. Barriers identified by home visitors included the nature of assessment tools, issues with service availability and access in rural areas, and lack of education and training surrounding safety planning. Facilitators included building relationships and trust with clients, providing anticipatory guidance when making referrals, and tailoring safety plans to clients' unique situations. Participants also expressed a critical need to develop procedures for assuring home visitor safety when supporting IPV-exposed clients. These qualitative data highlight issues surrounding the management of IPV in home visitation and have the potential to inform future enhancements to programs that are specifically tailored to the needs of rural, disadvantaged communities.

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Supplemental Material

Supplementary material is available online.

Keywords

home visitation; intimate partner violence; rural; West Virginia; assessment; screening; referral; safety plan

Over the past 30 years, home visitation programs have emerged as a successful early childhood intervention for addressing a wide array of society's most complex social and health problems. High rates of intimate partner violence (IPV)—physical, sexual, or psychological harm by a current or former partner or spouse (Breiding, Basile, Smith, Black, & Mahendra, 2015)—have been found among families receiving home visitation services, and research has demonstrated that IPV may attenuate the benefits of home visitation services (Eckenrode et al., 2000). Thus, there has been an increased emphasis on exploring and improving how IPV is addressed within context of home visitation programs. Home visitors in rural or underserved areas may face distinct challenges when supporting clients exposed to IPV. In this study, we explore how home visitors in West Virginia's Home Visitation Program address and respond to IPV with clients, with a specific emphasis on assessment, making IPV-related referrals, and safety planning.

Home visitation typically involves nurses or paraprofessionals working with disadvantaged families during the prenatal and early postnatal period to enhance parental knowledge and skills to foster child development, promote growth and healthy development of children, and connect families to community resources and services (Family Strengthening Policy Center, 2007). Using home visits as a delivery vehicle, these programs work to promote critical health practices, demonstrate appropriate infant caregiving, and provide professional and social support with the goal of positively altering the physical and social environments for at-risk families, in turn improving maternal and infant outcomes (Logsdon & Davis, 2003). Families enrolled in home visiting programs have been shown to experience lower rates of child maltreatment and child unintentional injuries, increases in child-school readiness, significant improvements in maternal employment and educational attainment, increased rates of breastfeeding, and multiple long-term benefits for children compared with nonenrolled families (Gomby, 2005). Given the clear benefits of home visitation for individual families and society as a whole, US\$1.5 billion in funding was set aside in the Patient Protection and Affordable Care Act in 2010 to establish the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and expand existing programs throughout the United States for at-risk pregnant women and children from birth to age 5 years.

It has been noted that families receiving home visitation services experience high rates of IPV (Eckenrode et al., 2000; Sharps, Campbell, Baty, Walker, & Bair-Merritt, 2008). This is likely attributable to socioeconomic disadvantage—a well-established risk factor for IPV—which often serves as an eligibility criteria for enrollment in most home visitation programs in the United States. The presence of IPV has been shown to limit the positive impact of home visitation. Eckenrode and colleagues (2000) found significant reductions in child maltreatment reports for home-visited families in the Nurse–Family Partnership program over a 15-year period; however, this treatment effect was not observed in families with a

history of 28 or more incidents of IPV. Given these findings, there is growing recognition that home visitation programs that serve at-risk families may be an appropriate mechanism for detecting and reducing IPV. Unique aspects of the home visitation experience include delivery of in-home services, long-term engagement with families, and the development of therapeutic relationships between home visitors and clients (Jack et al., 2012; Jack, Jamieson, Wathen, & MacMillan, 2008). These characteristics allow for a more holistic picture of family dynamics to be captured as well as more frequent opportunities for IPV assessment. Thus, in recent years, there has been an increased focus on creating more IPV-training opportunities for home visitors and engaging in research to develop and test interventions for IPV within the context of home visitation. “Happy Moms, Healthy Babies” is a research-based training curriculum focused on addressing IPV and reproductive coercion in home visitation that was developed by the large nonprofit organization, Futures Without Violence. It is currently in its second edition and has been utilized by numerous public health agencies in the United States (Futures Without Violence, 2016). In addition, a number of randomized trials, such as the Nurse–Family Partnership IPV study (Jack et al., 2012) and the Domestic Violence Enhanced Home Visitation (DOVE) trial (Sharps et al., 2013), are underway to test IPV enhancements to home visitation programs.

These efforts have provided new information on how IPV is currently addressed as well as strategies for optimal IPV assessment, but much of this work has been carried out with programs in urban or suburban geographic areas. A small but growing literature suggests differences in IPV experiences and consequences in rural and nonrural areas (Edwards, 2015; Logan, Walker, Cole, Ratliff, & Leukefeld, 2003; Peek-Asa et al., 2011; Shannon, Logan, Cole, & Medley, 2006). Poverty, lack of resources, transportation issues, and geographic isolation have been noted in the literature as serious challenges for both pregnant and nonpregnant women experiencing IPV in rural locales (Bailey & Daugherty, 2007; Bloom, Bullock, & Parsons, 2012; Eddy et al., 2008; Edwards, 2015; Shannon, Nash, & Jackson, 2016). Eddy and colleagues conducted focus groups with home visitors implementing an IPV intervention in a Midwestern state, and described multiple challenges with implementation in rural areas, including slow response by law enforcement when responding to reports of IPV, transportation issues, fewer shelters, and women’s greater reluctance to utilize shelters due to fears of losing anonymity (Eddy et al., 2008). As high rates of psychological and physical abuse among pregnant women have been found in rural, Appalachian samples, especially among low-income and substance-dependent populations (Bailey & Daugherty, 2007; Shannon et al., 2016), there is a need to further explore how IPV is addressed and managed with pregnant women and families enrolled in rural home visitation settings, including those in underserved regions of Appalachia.

The highly rural, Appalachian state of West Virginia faces significant health and socioeconomic disparities, including lower levels of income and educational attainment, high rates of chronic disease and substance abuse, and poor mental health status (Halverson, Ma, & Harner, 2004; West Virginia Department of Health and Human Resources [WV DHHR], 2012a; Zhang et al., 2008). Very few studies examining rural IPV have focused on West Virginia, but crime data reveal one third of all homicides in the state are IPV-related (Smithers & Tomblin, 2012). Home visitation services are currently being implemented using seven distinct home visiting models—Healthy Families America, Maternal Infant

Health Outreach Worker, Parents as Teachers, Early Head Start, Healthy Start/Helping Appalachian Parents and Infants (HAPI), Right From the Start, and Save the Children—and more than 120 home visitors to support thousands of families in all 55 West Virginia counties. Although diverse and geographically spread, all agencies providing home visitation services are administered and managed by the Office of Maternal, Child, and Family Health in the WV DHHR. In 2013, West Virginia was selected to receive funds through the MIECHV initiative to expand evidence-based programs in counties with a high concentration of at-risk indicators. This funding requires programs to demonstrate improvements in a variety of social and health-related benchmark areas among eligible families. After choosing “reductions in crime and domestic violence” as one benchmark, West Virginia’s program has since focused on strengthening home visitors’ identification and response to IPV. Specific areas identified for improvement included increasing (a) the number of pregnant women and mothers screened for IPV, (b) referrals made to IPV-related resources and services, and (c) knowledge and implementation of safety plans for women experiencing IPV (WV DHHR, 2012b).

The purpose of this study was to address the gap in knowledge about addressing IPV via home visitation in rural, underserved areas by exploring home visitors’ experiences with IPV assessment, making referrals to IPV-related resources and services, and safety planning with clients in West Virginia’s statewide home visitation program. The current study is part of a larger mixed-methods project designed to evaluate these efforts. Here, we report qualitative data from the needs assessment phase of this study in which we explored home visitors’ current practices, barriers, and facilitators in each of these key areas.

Method

We approached this study within the realm of a pragmatic interpretive framework (Smith, Bekker, & Cheater, 2011)—that is, we utilized a design that would best achieve our aims instead of fitting our research question to a particular philosophical stance. Specifically, we employed a fundamental qualitative description (QD) design to explore home visitors’ experiences supporting clients in West Virginia’s home visitation program. QD is a useful approach when a rich, straight description of perspectives is desired using participants’ own words, as opposed to a highly theoretical and interpretive rendering of the data (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000). Qualitative descriptive studies do not require that researchers move as far into or beyond the data as interpretive studies, instead offering comprehensive summaries of events through a “surface-level” content analysis that “is oriented toward summarizing the informational contents of that data” (Sandelowski, 2000, p. 338). QD is particularly appropriate for conducting needs assessments and is useful for answering questions that are of relevance to practitioners and policymakers, yielding important data for tailoring clinical interventions (Sandelowski, 2000; Neergaard et al., 2009). The study protocol described here was approved by our institution’s Institutional Review Board (IRB).

Participants

Home visitors employed within the Healthy Families America, Maternal Infant Health Outreach Worker, Parents as Teachers, and Early Head Start program models were included in the larger evaluation. Approximately 61% of home visitors working within these programs hold an undergraduate or graduate degree—typically a Bachelor’s in Social Work or Nursing degree, whereas 36% have a high school diploma or some college experience. Those home visitors that do not hold an educational degree beyond a high school diploma often obtain a Child Development Associate (CDA) credential and have experience in early childhood education. All home visitors from the aforementioned program models ($N = 125$) were invited via email to participate in a focus group session to discuss current perspectives and practices surrounding “screening, referrals and safety planning for domestic violence.” Interested home visitors were able to respond by contacting a member of our study team by email or telephone to sign up to participate in a focus group session. To reduce the burden of scheduling and travel on participants, focus groups were held immediately prior to a daylong training on IPV conducted in four locations around the state on five different dates that home visitors were required to attend. Focus groups were advertised as an “optional focus group breakfast” where home visitors could share their experiences and perspectives with assessing and responding to IPV with clients before attending the training.

Three focus groups were conducted with groups comprised of six, seven, and three participants, respectively ($n = 16$). Three quarters were White and 25% identified as Black or mixed race. Most participants ($n = 11$) had less than 5 years of experience working in home visitation, and three (19%) reported 11 or more years of experience. Their ages ranged from 25 to 65 years, and the majority ($n = 10$) of participants were between 25 and 45 years. Most ($n = 14$) home visitors held at least a bachelor’s degree. There are only five male home visitors employed in West Virginia’s Home Visitation Program; thus, pursuant to the terms of our IRB approval which requires us to maximize participant confidentiality to every extent possible, we are not permitted to report on the breakdown of participant gender for this study. Participants provided home visitation services across 12 of West Virginia’s 55 counties and worked in urban, suburban, and rural locations. Most participants worked multiple counties, and approximately half worked in areas that are considered predominately rural according to 2010 U.S. Census definitions.

Data Collection

Focus groups were chosen as the method of data collection as they are ideal for capturing information about group norms and experiences (Morgan, 1996). At least two members of our research team attended each focus group, either as a moderator or notetaker. To ensure consistency across each focus group, our team met prior to the sessions to establish standardized data collection procedures. Moderators and notetakers kept detailed notes during and immediately after each session, which were subsequently shared with all members of the study team as a way to reflect and debrief about preliminary findings. Each session was held in a private room at the designated training site. At the start of each focus group, participants received a cover letter and were given the opportunity to ask questions about the research study. The moderator obtained verbal informed consent and permission to audiotape the session. Focus groups were facilitated using a semistructured interview guide

with key questions related to screening, making referrals, and creating safety plans with clients experiencing IPV. We asked probing questions about general experiences, current protocols, barriers, and facilitators for each key question. Discussions with home visitors revealed that they typically use the term “domestic violence” when referring to IPV, and thus we used this language. Moderators aimed to maximize interaction among participants and solicited contributions from each participant during the focus groups. We ensured that each participant had an opportunity to speak by calling on participants by name if they did not initially contribute to a discussion. After one participant shared their experience or perspective, moderators asked if other participants agreed, disagreed, or had similar or different experiences with what was previously shared. Focus-group sessions lasted 42 to 58min. One home visitor wished to expand on some of the issues that emerged during focus group, and an additional 30-min interview was conducted with this participant and these data were combined with the focus group data. Participants were provided breakfast and compensated with a US\$20 gift card.

Data Analysis

Audiotapes were transcribed verbatim by a professional transcriptionist. The analysis process began with a thorough reading of each transcript and the creation of memos to generate preliminary ideas. Data were then coded independently by two coders (D.M.D. and J.C.) using both open and directed content analysis (Hsieh & Shannon, 2005) directed by our guiding research questions—home visitors’ current practices, barriers, and facilitators to (a) IPV assessment, (b) making referrals, and (c) safety planning. Directed content analysis was used as we decided a priori to analyze the data for themes related specifically to screening, referral, and safety planning. However, to maintain an iterative and reflexive approach, we began analysis with open coding to ensure that we captured ideas and themes that were unexpected or did not fit within our a priori coding structure. After an initial round of coding, both coders met to discuss the coding structure and process. A revised set of codes and categories was agreed upon, and each coder independently recoded the data. For each category, a kappa coefficient was calculated to assess the level of agreement between the coders. According to Cohen (1960), kappa statistics $>.79$ indicate strong reliability. Both coders met to discuss and revise the coding for categories with less than acceptable agreement until strong agreement (indicated by kappa coefficients $\geq .80$) was obtained for all categories. Both coders worked collaboratively to sort and split or combine categories into emergent themes which were paired with illustrative quotes. NVivo 10.0 was used to facilitate data management and coding.

Trustworthiness

Peer and external member checks were undertaken to enhance our study’s validity. Preliminary results were presented back to home visitors during subsequent IPV-training sessions and at a statewide meeting for home visitation supervisors. Through this process, we obtained feedback from home visitors who attended the focus group sessions to determine if our interpretations “rang true.” Supervisors and home visitors not included in the study (i.e., members of the target population) also shared their reactions to the data, lending further credibility to our findings. All feedback was incorporated in subsequent data

analysis and interpretation. External member checking was carried out with a member of our team with experience as a home visitation training specialist in a neighboring state.

Findings

In line with the principles of QD, we have structured our findings to mirror our guiding research questions, which focused primarily on barriers and facilitators surrounding how home visitors assess for IPV, make referrals to IPV-related resources and services, and create safety plans with clients. This information is also summarized in Table 1.

IPV Assessment

Two major themes emerged related to IPV assessment: (a) issues with the screening tool, including timing and mode of administration (barrier), and (b) the importance of building trust and rapport (facilitator). Home visitors typically assess for IPV during the first visit with new clients and conduct repeat assessments every 3 to 6 months. At the time of data collection, each of the home visitation models in West Virginia use a paper-based version of the Hurt–Insult–Threaten–Scream (HITS) screening tool developed by Sherin, Sinacore, Li, Zitter, and Shakil (1998). Some models primarily screen pregnant women and mothers, whereas others screen both partners.

Barrier: The IPV screening tool—Participants revealed that the HITS screening tool was one of several required assessments, and described the initial visit with new clients as a “mountain of paperwork.” They perceived that new clients are often reluctant to discuss IPV at the first visit, and many cited the acronym “HITS” across the top of the tool as problematic. One home visitor called it “a bad choice of name.” Some reassured clients by stating that all families are asked to complete the paperwork, and their family is not being specifically targeted. Rather than taking up time during the home visit explaining the purpose and value of the IPV assessment, many home visitors reported framing the tool as “just another intake form” and encouraged clients to complete it quickly, both to avoid client discomfort and ensure completion of other required forms. One home visitor stated,

When I do bring up the HITS screening they just kind of look at me like what’s this for? You know and I just explain to them that this is part of the initial package of the paperwork that we have to do and you know we’re not in any way pinpointing your family out. We do this with all families. (FG3)

Home visitors use discretion as to whether they should ask questions on the screening tool verbally versus having the clients complete the form themselves. Some home visitors found value in inquiring about IPV verbally, whereas others noted verbal assessment can be awkward or even dangerous if the client’s partner is at home:

Before when we were verbally asking it made it very awkward to ask in front of the other person, ’cause you don’t know if there is or there isn’t [IPV]. But the form you can kind of slip in and say oh here’s another form the state makes us do along with you know all these others. And then it’s not quite as apparent that you’re screening for that. (FG1)

Home visitors described how protocol dictates that IPV assessments should not be carried out if they sense tension during a home visit. Under such circumstances, home visitors can note in their client's record that screening was "not appropriate." Participants described ways to privately and safely assess IPV in these situations, such as purposefully scheduling visits outside of the home or when the client's partner was at work.

Facilitator: Building trust and rapport—The importance of building trust and rapport emerged as a major facilitator for effective IPV assessment. Home visitors discussed how forming a relationship with clients was critical and several described instances where clients screened negative for IPV using the HITS tool but eventually disclosed IPV in a later conversation, emphasizing that the tool did not accurately reflect clients' relationship experiences. One home visitor stated, "I don't think it's accurate, you know, what they answer on the form ... in all my years I've only had one mom that answered and got a high score on her form" (FG2). This discrepancy was attributed to the timing of the screening:

Usually at the first visit they won't give you as much information because they don't know you. They don't know if they can trust you yet. And so they will typically answer all negatives so that their score comes out to where there's no issues in the home ... So as the clients are getting to know you and start to feel a little bit more comfortable with you then they'll start to give you more information. (FG1)

Another stated, "True disclosure is going to come through a relationship and not from a screening tool" (FG2). Thus, participants were supportive of a flexible assessment schedule with repeat assessments, which allows time to develop rapport and trust. Home visitors described how disclosures of IPV may be more likely to occur during informal discussions instead of with the screening tool:

A lot of times I've noticed like they'll fill out the first time it's all nevers, nevers, nevers, and then maybe six months down the road they may say oh well he sometimes will scream or curse at me but it's never anything more than that until they possibly leave the relationship and then it comes out well there was more—I just didn't want to tell you. (FG3)

Still, even after verbal disclosures of IPV occurred, some clients were still reluctant to divulge information on the screening tool during repeat assessments: "I've had moms tell me what's going on and then when I give them the screen they mark never, never, never, never ... they just say well I trust you to tell you this" (FG2). Home visitors acknowledged that building trusting, therapeutic relationships with clients take time, but felt strongly that it was critical for optimal IPV assessment. A number of participants felt that demonstrating their commitment to improving the health and well-being of the entire family can facilitate this process:

And as we build a rapport there are more things that we do find out from the family. It takes a while to build the rapport with the family honestly I mean with any client it's going to take a long time. But because they think we're there just to play with their child—that we're there to make sure that they're hitting their developmental

milestones. But we have to show them that we're there to actually make sure that they're okay and to make sure that the family is okay. (FG3)

Referrals

Home visitors were asked about their experiences providing information and referring clients to IPV-related services after positive screens or disclosures. The two themes resulting from these discussions included (a) anticipatory guidance helps as a facilitator of navigating referral systems (facilitator) and (b) difficulties with access and availability of services, particularly in rural areas (barrier).

Facilitator: Providing anticipatory guidance for navigating referral systems—

Anticipatory guidance, described by one home visitor as “putting a hand on the shoulder” to help clients navigate social service and criminal justice systems, can facilitate trusting relationships between clients experiencing IPV and referral systems. Home visitors in our study were comfortable with being considered “community navigators” for their clients and were knowledgeable about a variety of available resources, including brochures, pocket-sized safety plans, national hotlines, local telephone numbers, and shelter services. They were cognizant of being discreet in how this information was transmitted to clients: “You can give those things [pamphlets and safety cards], but to leave that in the house or to leave phone numbers laying around is very dangerous and you set them up for you know some other issues altogether” (FG2).

Participants described a wide range of experiences connecting clients to IPV-related services. Several home visitors discussed positive experiences referring to shelter services and mentioned being impressed by the variety of resources offered to clients. In addition to linking clients with advocates at local shelters and information centers, home visitors recommended that clients in abusive situations work with law enforcement:

It's very important to call the police. That's one of the things where a lot of times they don't want to do, and trying to encourage them to call the police is sometimes difficult because they don't want to get involved in the court process and with the police. But it's important for their safety and for future events that they have a record. (FG1)

On the contrary, a number of home visitors encountered difficulties when working with IPV service agencies, listing high turnover, compassion fatigue, lack of training, and poor intra-agency communication as specific barriers to the referral process. These challenges underscored the importance of building and maintaining trusting relationships to facilitate effective referrals. Many self-identified as advocates and felt it was within their responsibility to provide anticipatory guidance about what clients should expect as they “navigate the system.” A home visitor stated,

I think our families, with that trust, they expect you to advocate for them, and I think that's one of the biggest things that I do tell my families ... “Don't worry this is what's going to go on.” (FG2)

They described making themselves available after hours and meeting clients at shelters, magistrate court, and legal agencies to guide them through unfamiliar processes:

I've had to refer several people and I've had a client who asked me to go with them because they were really nervous and the worker there was open to letting her, it was her privacy, so she respected that and let her you know have whatever comfort she needed in having me sit through that. (FG1)

Another home visitor stated,

And we literally go with them from point A to point Z. We take them, go to court with them. We help prepare them for court, whatever they need. If they need a safety [plan], whatever they need is what we provide. (FG2)

Barrier: Difficulties with access and availability of services in rural areas—

Although West Virginia has a central office and 14 licensed IPV programs throughout the state, clients experiencing IPV in more isolated, rural areas face a particular disadvantage. Fear of removing children from school, long travel times, unreliable cellular phone service, and lack of transportation were cited by home visitors as prohibiting victims from securing their safety and protection, especially in emergent situations. Those working in rural locations reported issues finding appropriate referral resources altogether. One participant explained,

Just in the four years I've been working in this field we've seen agencies come and go. So you'll have an agency—oh we can refer to this agency, and we have a contact person—and by the time a situation comes up where you have someone to refer you know they've folded and moved on. (FG2)

Persistent transportation issues hindered clients' access to services. Home visitors described arranging transportation for clients as a struggle as taxis and public transport are not available in many regions. Clients often have to rely on friends, family, or law enforcement for transportation. The following discussion centered on access and transportation issues:

Participant: There's definitely a transportation barrier. Long miles. It's a long way. Sometimes people in the county can't even get to the county [shelter].

Moderator: And so there's one shelter that serves multiple [counties]?

Participant: I think we do 5 or 6 counties. We're talking for some of these people an hour-and-a-half to get to a shelter, and that's if they're close to the main roads. (FG1)

One home visitor explained how having to uproot their children to travel to a shelter in another county was a significant barrier to leaving an abusive partner for many clients:

It's not where they need, you know, close. And that's actually a hang-up with a lot of people I'm sure because they don't want to leave, you know if they do have kids they don't want to take their kids outside of [County] or take them out of the school system and put them into a new school system or something. (FG3)

While most discussions centered on women exposed to IPV, home visitors in all focus groups described how these issues may be exacerbated for men experiencing IPV as well as clients in same-sex relationships, mentioning that halfway houses or homeless shelters may

be the only options for men leaving abusive relationships and this may discourage reporting of IPV to home visitors. One participant stated,

If a woman were to go into shelter nobody would know she was there. If a man had to go and he'd have to go into the homeless shelter and you know everybody knows where the homeless shelter is. So we just don't have any protectors, and so they say that most men aren't going to come out and report. We don't have anything there to protect them or to give them in order for them to report. (FG1)

Safety Planning

Emergent themes related to home visitors' experiences creating safety plans with clients included the following: (a) the lack of education and training surrounding safety planning, including using appropriate terminology (barrier), and (b) the importance of tailoring safety plans to clients' unique situations (facilitator). Home visitors also expressed the need for formal safety procedures for home visitors.

Barrier: Lack of education and training surrounding safety planning—While there was consensus that safety plans are critical for clients in abusive and potentially dangerous situations, many participants expressed uncertainty about how to develop an IPV-specific plan with clients, and several indicated they “wouldn't even know where to begin.” A few participants hoped the regional IPV trainings held after the focus groups would help them learn how to discuss and create safety plans with clients. One home visitor stated, “When I've got to that question and asked them if they have a safety plan they always tell me yes. And I'm like okay. I don't want to blurt out and say can I see it?” (FG3).

Some participants felt clients may be resistant to the phrase safety plan and found value in “dancing around” the term by not specifically mentioning IPV. This was cited as useful when clients were reluctant to disclose IPV:

I try to like dance around it a little bit and be like “What are some things that you guys can do to calm down a situation?” Like try to give them things without like saying safety plan, 'cause a lot of times then they're like okay now she's going to have this in her notes, and we've done a safety plan, and people are going to know, and they get really resistant. (FG1)

Other participants discussed safety plans as procedures families should follow during a fire, tornado, or burglary, as “Most people perceive a safety plan as being like a fire drill, fire safety or something to that effect. They don't think domestic violence safety plan” (FG3). Conversely, some home visitors had no issues using the phrase “safety plan”: “I haven't had an issue with bringing up the term safety plan. It's on all of the brochures—that's what they're entitled is safety plan” (FG1). It was discussed how not being explicit that safety plans are for IPV can be problematic, as clients might not utilize the plan if a dangerous situation were to arise involving their partner. Still, most home visitors felt conversations about relationship safety were most easily discussed within the context of *safety for the entire family*. They described how broader discussions of overall safety (e.g., from fire, natural disasters, emergencies) allowed for a natural transition into conversations about

relationship safety and IPV, and that a comprehensive safety planning tool may facilitate these discussions:

I think it would be amazing if we were able to have a separate screening tool that we could be able to say you know we want to know all elements of safety, like if there was a domestic violence situation you know. Or if there was fire. If a burglar came into the home, like anything, to be able to talk to them about it ... A safety plan for everybody involved, I guess. (FG1)

Facilitator: The importance of tailoring safety plans to clients' unique situations—Home visitors with experience creating IPV-specific safety plans discussed the importance of preparation for clients to leave the home safely. They encouraged their clients to pack and hide diaper bags as well as have phone numbers for the police and the local shelter on hand. They mentioned other important elements of safety plans, including setting money aside for emergencies as well arranging transportation; however, home visitors expressed concern that these steps may not be feasible for their clients with limited financial resources. Therefore, they felt it was paramount to keep in mind where the client lives and the specific resources at his or her disposal during safety planning. In addition, clients in rural and remote areas may not have reliable cell phone service to facilitate leaving an unsafe situation. One home visitor discussed working with a client to address this issue as part of her safety planning process:

They do have the safe link phones if you live in an area where they do not have good cell service ... I have a client who that was one of the things that we did with her. She signed up for the phone and she hid it in her closet in a safe place to where nobody else would know that it was there. (FG1)

Importantly, home visitors acknowledged that safety plans are especially important for clients that may have restraining orders against their partners or have taken advantage of other referral resources. They discussed how leaving an abusive partner is not always the best course of action and may actually place the client in greater danger:

That doesn't mean they're [abusive partners] not going to come to wherever you are because that piece of paper [restraining order] says that. As long as they're keeping that other person happy in the house and hanging out there with them and settling things down you have some control. And we're trying to say oh you've got to get out of this, we've got to do all of these things and life's going to be wonderful? Sometimes they feel that's more of a dangerous situation when they finally do go to one of those referral sources or they do go to press charges then what do you do? You know how do you keep them safe? (FG2)

Another home visitor in this focus group added to the discussion:

I think in that instance [when restraining orders are involved] that's kind of where you teach them, that's kind of like where your safety plan actually comes alive. That's not just on a piece of paper anymore. You know actually teaching them the tools of keeping them safe, because if somebody really wants to kill you that piece of paper don't mean anything. (FG2)

Home Visitor Safety

An unexpected but pervasive theme throughout our focus groups included home visitors' needs for safety planning when supporting families experiencing IPV. Discussions surrounding this topic may have been influenced by the homicide of a social worker who was sexually assaulted and murdered during a routine home visit in southern West Virginia in 2008. Home visitors cited this case as a basis for safety concerns when conducting home visits alone in remote, rural locations. Home visitors expressed the need for more training on how to protect themselves and what the appropriate course of action would be "in the event that it's [IPV] actually occurring in front of my face" (FG3). A few participants were unsure of how to respond to tense and escalating situations when they observe an argument between their clients during a home visit. Home visitors discussed the importance of constant communication with supervisors and coworkers before and after home visits, especially in remote areas, to ensure home visitor safety when working with families experiencing IPV:

We also have to protect ourselves when we're dealing with these situations and being sure we're having conversations with our supervisor saying you know what this one is kind of a little bit difficult and here's why. And sometimes you can even have somebody go with you on those visits if you need to. (FG1)

During the individual interview that took place after one of the focus groups, a home visitor described a situation where she witnessed physical IPV between her clients which resulted in her calling the police. She said, "I really did not know what to expect and was not expecting domestic violence to take place. In fact I was there with gifts to see a brand new baby and was very thrown off by the whole event." After she shared her story, she explained,

I guess it's just something you don't think about and you hope to never have to experience, but when it happens, unfortunately it's an afterthought. And so hopefully we could do something to prevent situations where a home visitor would be put into a compromising situation. (Interview)

Discussion

Our study revealed unique barriers to and facilitators of addressing IPV via home visitation programs in West Virginia, including those in rural and underserved areas. The HITS screening tool itself, as well as issues with the timing and administration of the tool, and the importance of building trust and rapport before screening were important themes that surfaced during discussions of IPV assessment. Anticipatory guidance and challenges finding and accessing IPV-related resources and services emerged as key themes related to referrals. Finally, themes related to safety planning included the lack of education and training about creating safety plans, the importance of considering clients' individual situations, and developing safety procedures for home visitors. While most literature in this area focuses on IPV screening or assessment, there is a dearth of evidence on barriers and facilitators to effective referral practices (Kirst et al., 2012; McFarlane, Groff, O'Brien, & Watson, 2006) as well as information about safety planning procedures (Taft et al., 2015), especially within the context of home visiting programs. Our work extends knowledge on this topic by providing rich descriptions of home visitors' experiences with these complex processes.

Home visitor discomfort with initiating conversations surrounding IPV, especially with new clients, has been reported in previous studies. While prior research has reported that home visitors are knowledgeable about signs, symptoms, and risk factors for abuse, many feel ill-equipped to ask about IPV without embarrassing or isolating clients (Eddy et al., 2008; Jack et al., 2008; Sharps et al., 2008; Tandon, Mercer, Saylor, & Duggan, 2008). Flexibility with the timing of IPV assessments can facilitate discussions about IPV. Jack, Ford-Gilboe, Davidov, MacMillan, and the Nurse Family Partnership (NFP) IPV Research Team (2017) found that relationship assessment tools administered during the first visit with home visitation clients yield high rates of false negatives. They also reported that IPV disclosures were more likely to emerge later in the home visitation schedule and through informal discussion versus utilization of a formal screening tool. The development of trusting, therapeutic relationships between home visitors and clients has been identified as an important facilitator of IPV assessment and disclosure (Dickson & Tutty, 1996; Eddy et al., 2008; Jack et al., 2008; Sharps et al., 2008). This reinforces the importance of ongoing, repeat IPV assessment regardless of clients' scores on formal assessment tools.

Many home visitors in our study attributed false negatives during IPV assessment to the nature of the HITS screening tool. After our focus groups, West Virginia's Home Visitation Program replaced the HITS with the Relationship Assessment Tool developed by Futures Without Violence (Chamberlain & Levenson, 2011). Based on our findings, home visitors may benefit from training on when clients should be asked questions about IPV verbally versus when to use self-administration. Additional guidance on how to administer or delay the assessment when others are present during the home visit is warranted. Furthermore, ensuring there is adequate time to introduce the purpose of IPV assessments, ask questions, and discuss clients' responses sends a message that asking about relationships is an important part of the home visitors' role that deserves special attention. In addition, framing home visiting as a resource for the entire family as opposed to a service primarily geared toward improving child health and well-being can also help establish rapport and facilitate discussions of relationship safety.

The provision of safe and comprehensive referrals and services to individuals and families experiencing IPV is a recognized challenge in health care and social service sectors (Tandon et al., 2008). Home visitors in our study were cognizant of the importance of safe transmission of referral information. While they reported an appropriate working knowledge of available IPV resources and felt comfortable referring clients, home visitors perceived that few clients utilize available resources, such as shelters or hotlines, to manage the IPV in their lives. Home visitors' needs for additional training and skills to promote follow through on client referrals have been described previously (Kirst et al., 2012; Tandon et al., 2008). Many barriers to clients' utilization of IPV-related resources may result from challenges inherent with service provision in rural areas (Farmer, Munoz, & Threlkeld, 2012). Several of the rural home visitation issues outlined by Eddy and colleagues (2008; for example, lack of transportation and shelters, reluctance to utilize available resources) were echoed by the home visitors in our study. Home visitors described how these issues may be exacerbated for men experiencing IPV as well as clients in same-sex relationships. It is possible that Appalachian families exposed to IPV and home visitors that support them experience the challenges of rurality differently than those residing and working in rural areas outside of

Appalachia. More research is needed in these areas from the client, home visitor, and community stakeholder perspective.

Home visitors in this study discussed the importance of contacting law enforcement for protection, documentation, and transportation involving cases of IPV. Concerns over police involvement, including reluctance to call police out of privacy concerns, slow response times (Eddy et al., 2008), “good ol’ boys” networks (Edwards, 2015), and fear of retribution by the perpetrators (Kirst et al., 2012), have been noted in previous studies. Anticipatory guidance when connecting clients with law enforcement and other social service agencies emerged as a critical facilitator of making effective referrals. The completion of Memoranda of Understanding (MOU) between home visitation and IPV programs can enhance intra-agency connections and support “warm” referrals (examples available at <http://www.futureswithoutviolence.org>). While there is temptation to use rates of referrals to external agencies to measure the success of IPV interventions in research and practice, some have cautioned against using referrals as an end goal for clients experiencing IPV (Kirst et al., 2012; Reisenhofer et al., 2016; Taft et al., 2015). Those in the precontemplation and contemplation stages of the cycle of abuse may not view help-seeking or leaving their relationships as a desired outcome. More intermediate goals, such as initiation of safety planning behaviors, have been proposed as appropriate outcomes for improving care of pregnant and postpartum women in home visitation programs (O’Doherty et al., 2014; Taft et al., 2015).

Home visitors requested strategies for using appropriate language, and how and when to initiate conversations about safety plans with clients. Distribution of safety planning information is often utilized as standard of care in clinical settings and in IPV intervention studies, but little is known about how this information is presented and if and how it is utilized by patients and clients. Furthermore, it is unclear whether initiating safety planning behaviors reduces exposure to IPV or improves health and quality of life (Reisenhofer et al., 2016; Taft et al., 2015). Discussions of safety planning being framed as a discussion about safety for everyone or for the entire family that emerged in this study have been reported in other studies and have guided recent research in this area, such as the *universal assessment of safety* developed as part of the Nurse Family Partnership IPV intervention program (Jack et al., 2012).

Finally, concerns of home visitors’ safety have emerged in previous research (Eddy et al., 2008; Sharps et al., 2008). Safety procedures, including de-escalation tactics and protocols for removing themselves from potentially unsafe situations, should be operationalized and integrated into policies and training efforts for all home visitors. We learned through our focus groups that West Virginia’s program is in the process of developing self-care and safety toolkits to address these issues. It is clear that the aforementioned barriers faced by IPV victims in rural areas may also extend to providers working in home-based settings in remote regions; ensuring their protection and safety is an important endeavor that should be addressed in research, practice, and policy arenas (Reisenhofer et al., 2016; Sharps et al., 2008).

Strengths and Limitations

This study is not without limitations. We report data from a small, convenience sample of home visitors who opted to attend a focus group breakfast before a series of mandatory trainings. It is possible that those with an interest in the topic chose to participate; thus, the perspectives we report here may not represent those of West Virginia's home visitors. Data triangulation, which consists of using multiple methods and sources to enhance the validity of study findings, was limited. Integrating the perspectives of clients and community stakeholders who work to address IPV would provide a more comprehensive understanding of the topic. Despite these limitations, there are several attributes of this work that enhance its credibility and trustworthiness. Although our final sample consisted of 16 home visitors, we employed comprehensive member checking that allowed participants and members of the target population who were not included in the study to confirm or refute our conclusions and feel confident that each of our themes reached saturation. In addition, we used two independent coders, which increases validity of study findings. All home visitation models in West Virginia operate under and are managed by one large umbrella program (the West Virginia Home Visitation Program). While each model has unique elements and distinct eligibility criteria, they follow the same general procedures related to IPV assessment. Thus, we accessed and sampled from the population of West Virginia's home visitors, resulting in a diverse sample with a wide range of experience from rural, urban, and suburban areas in West Virginia—the only state entirely within the highly rural Appalachian region. Most research on this topic is conducted in urban areas outside of Appalachia; research surrounding how rural and underserved families who are at risk for IPV can be best supported by social service programs like home visitation is critical. This study adds to the research base by expanding knowledge on this important topic to include populations (i.e., Appalachian) that have historically not received much attention in the research literature.

Conclusion

Home visitors believe IPV assessment, referrals, and safety planning are integral pieces of home visitation practice but need additional strategies for initiating IPV-related conversations with clients and using assessment tools. Characteristics associated with rurality, such as isolation, lack of transportation, and loss of anonymity, may hinder IPV-exposed clients from accessing critical services in West Virginia. Established relationships and trust between clients and home visitors can facilitate the provision of referrals and creation of safety plans, which may need to be tailored based on the client's unique situation, individual priorities, and geographic and social constraints. Safety planning for home visitors is critical to ensure sustainable and safe home visitation practice.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Barriers and Facilitators to IPV Assessment, Referrals, and Safety Planning Identified by Home Visitors.

Focus Area	Barriers	Facilitators
IPV assessment (i.e., screening)	<p>Issues with the screening tool</p> <ul style="list-style-type: none"> Name of the tool (i.e., HTTS) is problematic Administering the tool on the first visit with new clients often results in false negatives Prioritizing IPV screening is difficult given other required health and social assessments and screening tools There are drawbacks to both administering the tool verbally and having clients complete the paper-based version 	<p>Building trust and rapport</p> <ul style="list-style-type: none"> A flexible assessment schedule with repeat assessments may facilitate disclosure of IPV Taking adequate time to allow therapeutic, trusting home visitor–client relationships to develop may facilitate disclosure of IPV Conversations and informal discussions (vs. the use of a screening tool) are more likely to elicit disclosures of IPV Framing home visiting as a resource for the entire family can establish trust and rapport, and facilitate IPV-related discussions
Making IPV-related referrals	<p>Difficulties with access and availability of services in rural areas</p> <ul style="list-style-type: none"> In rural areas, there is a lack of IPV-related resources for clients to contact or access Transportation issues and long travel times to shelters are barriers to accessing IPV-related resources There is a perceived lack of resources for men experiencing IPV 	<p>Providing anticipatory guidance for navigating referral systems</p> <ul style="list-style-type: none"> Serving as a liaison between the client and referral resource is important for navigating and accessing services Home visitors should be knowledgeable of available resources and discreetly transmit this information to clients Home visitors encourage clients experiencing IPV to work with law enforcement
Safety planning	<p>Lack of education and training surrounding safety planning</p> <ul style="list-style-type: none"> Despite safety plans being required for each client, home visitors are unsure how to broach this topic Lack of consensus about whether safety plans should be IPV-specific or discussed in terms of universal safety More education, training, and formal guidelines are needed surrounding safety procedures for home visitors 	<p>Tailoring safety plans to clients' unique situations</p> <ul style="list-style-type: none"> Clients who have restraining orders against their partners or who have taken advantage of referral resources should have a safety plan in place Home visitors recognize that leaving a relationship is not feasible for some clients Home visitors should ensure safety plans are realistic and feasible given clients' geographical, financial, and social situations

Note. IPV = intimate partner violence; HTTS = Hurt–Insult–Threaten–Scream.