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REVIEW

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An integrative review of community nurse-led interventions to identify and respond to domestic abuse in the postnatal period

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Abstract

Aim: To critically review community nurse-led domestic abuse interventions aimed at identifying and responding to domestic abuse in the postnatal period.

Background: Domestic abuse is a global problem resulting in dire consequences for women and children. Public Health Nurses (PHNs) are ideally placed to give women the opportunity to disclose in a safe and confidential manner; however, community settings present complex challenges.

Design: An integrative review and narrative summary.

Data Sources: Five electronic databases: CINAHL, MEDLINE, PsycINFO, EMBASE and Scopus, and peer-reviewed journals were searched for research papers published between 01 January 2005 and 01 March 2019. Fifteen papers met the inclusion criteria.

Review Methods: An integrative review where qualitative and quantitative data were extracted. Following quality appraisal, data were collated, analysed and themes were identified.

Results: Quantitative outcomes from short-term interventions include an increase in routine enquiry, documentation of alone status and safety planning, however, referrals remained low. There was a reduction in victimization seen in intensive home visiting interventions. One study reported potential harm to mothers experiencing domestic abuse prior to the intervention. Thematic analysis generated three themes: (1) benefits to women and nurses, (2) approaches to domestic abuse identification and response and (3) implementation of community nurse-led interventions.

Conclusion: Community nurse-led domestic abuse interventions have shown to have positive outcomes for women, provided the appropriate supports are in place such as: interagency training; guidelines, referral pathways and safety protocols; collaborative working with domestic abuse services and organizational support.

Impact: Professionals such as PHNs are challenged to respond appropriately and compassionately to domestic abuse disclosures, while ensuring the safety of women and children is central to service delivery. This integrative review will inform further development, implementation and the sustainability of community nurse-led domestic abuse initiatives worldwide.

KEYWORDS
abused women, community nursing, domestic abuse, domestic violence, integrative review, intimate partner violence, literature review, nurse/nursing, public health nursing, systematic review

1 | INTRODUCTION

Domestic abuse is a global problem, with dire consequences and can result in death. The World Health Organization (WHO, 2013a) reports between 15% and 70% of women experience domestic abuse worldwide. In 2017, a global study reported that 30,000 women were victims of intimate partner femicide, that is, 82 women were killed by an intimate partner every day (United Nations Office of Drugs and Crime [UNODC], 2019). The physical, emotional and social impacts of domestic abuse are serious (Devaney et al., 2021, pg. 785–789), with women of child-bearing age greatly affected (Baird et al., 2013) having long-term consequences on their children's physical and psychological well-being (Kitzmann et al., 2003; Naughton et al., 2017; Taylor, 2019). Public health nurses (PHNs) have a mandate to visit all mothers after discharge from midwifery services (Giltenane et al., 2021a) and are ideally placed to offer women opportunities to disclose, and signpost women experiencing abuse to supportive services in a safe and confidential manner (Leahy-Warren, 2007; Bradbury-Jones & Broadhurst, 2015, Bradbury-Jones & Nikupeteri, 2021). PHN's approach to identifying and responding to domestic abuse can greatly affect a mother's ability to disclose and seek help for herself and her children. This integrative review examines international research on community nurse-led interventions to identify and respond to domestic abuse, in order that outcomes for women and nurses are understood from an implementation and sustainability perspective.

2 | BACKGROUND

Domestic abuse, a term used interchangeably with domestic violence (DV), intimate partner violence (IPV) and family violence (FV) are defined 'as a pattern of behaviour involving the threat or use of physical, sexual, emotional and/or psychological abuse in close adult relationships' (Health Service Executive [HSE], 2019). However, definitions vary internationally. The UK includes 'honour'-based violence, female genital mutilation in its definition (Home Office, 2012). Coercive control is recognized as a feature of DV and is treated as a crime in some countries. It is acknowledged that men can be victims of DV and less likely to seek help than women (Taylor et al., 2021), however, this review focuses on DV towards women.

Figures differ worldwide as definitions, data collection methods and contexts vary (Henriksen et al., 2017). Recent reports show prevalence rates of 17% in Australia, UK 24.9% and USA 36.3% (Australian Bureau of Statistics, 2016; Office for National Statistics, 2018; Smith et al., 2017). Figures are likely to be underestimated, as DV is underreported to health, social and policing services (National Institute for Health and Care Excellence [NICE], 2016), so accurate data are required to provide effective responses. Healthcare providers must endeavour to identify DV so women can be signposted to routes of safety and support (O'Brien Green, 2020).

Domestic abuse results in physical harm, injury, psychological trauma, depressive disorders, loss of reproductive control and death (Beydoun et al., 2012; Devaney et al., 2021; Devries et al., 2011; Ellsberg et al., 2008; Pallitto et al., 2013; Smith et al., 2017; WHO, 2013b). The social impacts of DV are immense, that is, poverty, homelessness, poor productivity and absenteeism from the workplace, with inter-generational cycles of violence observed (Parveen & McGarry, 2020, Devaney et al., 2021). Pregnancy and early motherhood is a time of increased risk, often with DV beginning or escalating in pregnancy or postnatally (Baird et al., 2013; Finnbogadóttir & Dykes, 2016, O'Brien Green, 2020).

Children are affected by DV which includes witnessing acts of violence and hearing or seeing abusive behaviour and experiencing inadequate parenting (Royal College General Practitioners/National Society Prevention of Cruelty to Children, 2011). Exposure to psychological abuse can have a greater impact on children than witnessing physical violence (Devaney, 2015; Naughton et al., 2017; Taylor, 2019). McGavock and Spratt (2017) report exposure to DV is one of the most common predictors of high adverse childhood experiences scores (ACEs) among students. Mothers' descriptions of DV exposure for children include insecure maternal–infant attachment, neglect, a child's sense of responsibility to protect their mother, delinquency, truancy and physical aggression resulting from learned aggressive behaviours (Ghani, 2018; Izaguirre & Calvete, 2015) due to maternal unavailability and exposure to hostility (Holt & Devaney, 2015).

Screening aims to identify women who are experiencing/have experienced DV with a view to offering supportive interventions, for example, information, safety planning and referral. Universal screening remains controversial. The WHO (2013b) does not recommend 'Universal Screening' or 'routine enquiry' for women attending healthcare services but recognizes antenatal care as an opportunistic time for routine enquiry. O'Doherty et al. (2015) and Ramsay et al. (2002) conclude that although screening increases identification of DV, there is a lack of evidence of the impact of screening on other outcomes such as referral, re-exposure to violence, health impacts or harm arising from screening. Despite a lack of consensus on the best approach to identifying DV, many health sector policies and guidelines recommend DV screening (HSE, 2010; NICE, 2016; Niolon et al., 2017; US Preventive Services Task Force, 2018). NICE (2016) recommends routine questioning about domestic abuse by 'trained' staff in the antenatal and postnatal period supported by guidelines and referral pathways. However, many HCPs report feeling unprepared and lack training to deal with DV (Goff et al., 2003; Henriksen et al., 2017; Jack et al., 2012; Lauti & Miller, 2008; Lazenbatt et al., 2009; Taylor et al., 2013).

Most women do not object to DV enquiry (Bacchus et al., 2003; Parveen & McGarry, 2020; Usta et al., 2012) and HCPs who feel ill equipped to discuss abuse, avoid the issue (Ramsay et al., 2002; Taylor et al., 2013). Häggblom and Möller (2007) and Pratt-Eriksson et al. (2014) report mixed experiences of women seeking help depending on the individual they met; some nurses understood, while others were non-responsive, devoted more attention to physical ailments or even justifying the abuse, leaving women feeling ashamed. Most women find screening an acceptable part of routine history

taking at antenatal clinics (Salmon et al., 2015; Webster et al., 2001). Salmon et al. (2015) note that, although women may choose not to disclose, asking the question indicates to her that she can disclose during another contact. Barriers to disclosure, include feelings of discomfort, fear of perpetrator finding out and not recognizing the abuse as DV (Spangaro et al., 2010). Giltenane et al. (2021a, 2021b) noted trust, relationship building and fostering coping resources are key aspects of postnatal visits. Safety of women, children and healthcare staff is paramount when dealing with DV. Evidence shows strong links between domestic abuse and child abuse (Antle et al., 2007; Holt et al., 2008). Some women, despite having a good relationship with their health visitor are reluctant to disclose DV for fear of losing their children to social services (Peckover, 2003).

PHNs, like health visitors, are ideally placed to give women opportunities to disclose safely and confidentially (Bacchus et al., 2003; Bradbury-Jones & Broadhurst, 2015; Leahy-Warren, 2007). PHNs have opportunities of establishing trusting relationships with women, through home visiting, continuity of care and providing advice for self-care (Begley et al., 2004; Giltenane et al., 2021a, 2021b). In two UK studies, women report that Health Visitors (comparable role to PHNs) are better placed than General Practitioners to routinely ask about DV, as they may have more time, are less formal and are able to provide continued support (Bacchus et al., 2003; Bateman & Whitehead, 2004).

Community settings present different challenges to acute and maternity services. When identifying and responding to DV and safety issues for women and children, PHNs can be considered as a means of establishing universal support mechanisms for mothers postnatally (Giltenane et al., 2021a, 2021b). This integrative review aims to identify the best approach for PHNs to identify and respond to DV, and to support the development and implementation of training, clinical guidelines and referral pathways.

3 | THE REVIEW

3.1 | Aim

The aim of this integrative review is to summarize and synthesize empirical literature on community nurse-led domestic abuse interventions aimed at identifying and responding to domestic abuse postnatally.

3.2 | Design

This study is an integrative review, appraising empirical literature, which involves specific steps of integration and synthesis of quantitative, qualitative and mixed-method research findings (Whittemore & Knafl, 2005, LoBiondo-Wood & Haber, 2016). This review aims to:

- Identify direct outcomes of the intervention(s) used by community health nurses to identify and respond to domestic abuse;
- Identify how interventions have impacted community nursing practice in relation to domestic abuse identification;
- Identify what supported PHNs in implementing and sustaining interventions and
- Make recommendations for PHN practice in identifying and responding to domestic abuse postnatally.

TABLE 1 PICOC—Logic grid

P	Population, patient and problem	Women who experience domestic abuse
I	Intervention	Community nurse-led intervention
C	Comparison	Usual care
O	Outcome	Outcomes of identification and response interventions
Co	Context	Postnatal period (up to 2 years postnatal)

Abbreviation: PICOC, population, intervention, comparison, outcome and context.

3.3 | Search methods

A logic grid aligned with the population, intervention, comparison, outcome and context (Higgins et al., 2008; Table 1) enabled the researchers to refine the research question. Six electronic bibliographic databases were searched; CINAHL, MEDLINE, PsycINFO, EMBASE, Scopus, Cochrane Library and Google Scholar. Initial searches included keywords such as #1 Domestic abuse, #2 Community Nurse, #3 Identify and #4 Postnatal. Further scoping searches and review of titles and abstracts enabled the identification of more keywords and terms from relevant literature. The search results were limited by applying Title/Abstract limiters to each component of the PICO (Co). All searches were tested on several databases. Limiting the context component (#4 Postnatal) to Title/Abstract narrowed the findings significantly, therefore the search for these terms were broadened to all text. The search strategy was performed in accordance with PRIMSA recommendations.

3.4 | Search outcome

The PRISMA Flow diagram (Moher et al., 2009) summarizes the search strategy and results. The results of the searches are presented in the PRISMA format (Moher et al., 2009; Figure 1). A total of 149 records were reduced to 50 through title and abstract review. Twenty six full-text articles were assessed for eligibility. Articles were reviewed for inclusion and exclusion criteria (Table 2). A further 11 studies were excluded for reasons including the postnatal period not being specified, GP practice base or no specified domestic abuse intervention identified. Fifteen studies met the inclusion criteria for this integrative review. Various models of community health nursing

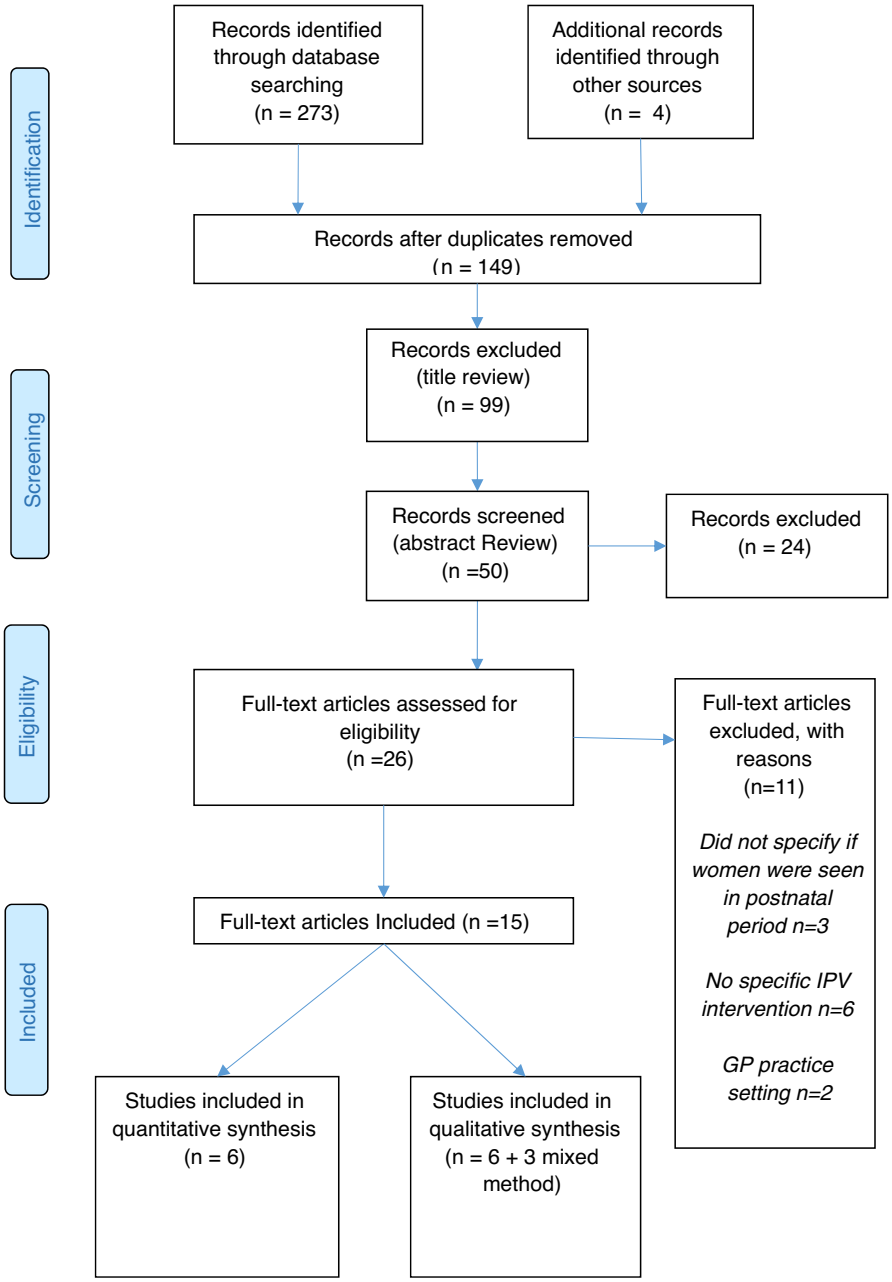

FIGURE 1 PRISMA 2009 flow diagram

exist internationally, this review focussed on PHNs who provide care in home and clinic settings. Practice Nurses were excluded from the review as home visits are not part of their role.

3.5 | Quality appraisal

Given the heterogeneity of the methodologies in this integrative review, appraising the quality of the evidence was complex. Fifteen studies were included in the review and data extracted were assessed for quality, using the critical appraisal tool—CCAT (Crowe & Sheppard, 2011). Papers were appraised in eight categories: preliminaries, introduction, design, sampling, data collection, ethical matters, results and discussion. Scores are marked on a six-point scale of 0 (no evidence) to 5 (highest evidence) based on objective and subjective assessment of each category. The scores are calculated out of a total of 40 and an overall percentage is then applied; however, the scores must be considered in all categories when assessing the entire paper for a more accurate final analysis. In this review, CCAT scores ranged from 26 to 39 with the four studies undertaken prior to 2011 having quality scores less than 28 (70%; Grafton et al., 2006; Vanderburg et al., 2010; Webster et al., 2006). The remaining studies (n = 11) scored >88%.

3.6 | Data extraction

Data from the 15 included studies were extracted and categorized according to the country where the study took place, the community nursing service, study aims and objectives, research

TABLE 2 Eligibility criteria

Inclusion	Exclusion
Community healthcare setting; primary care/health centre/home visiting setting	Acute Health Care Setting—Emergency department, trauma wards, orthopaedic, maternity ward
	Community based—Family planning clinics/sexual health clinics/well-woman clinics/drug and alcohol settings/mental health settings/dental care/general practice
Public Health Nurse/Maternal and Child Health Nurse/Child Health Nurse/Health Visitor/Community Midwife, Nurse-led targeted programme—Nurse–Family Partnership, Family–Nurse partnership	General Practitioners and Practice Nurse Independent/private midwife
Postnatal care in the community setting up to 2 years postnatal	Postnatal care in the hospital setting
Antenatal care if part of a programme which delivers continuity antenatal/postnatal community nursing care	Hospital-based midwifery care/antenatal clinic
Identification Interventions—Healthy relationship discussion/information giving/routine enquiry/universal screening/case finding	
Response interventions—information giving/referral on/safety planning/brief nurse counselling/domestic abuse nurse-led programme	Advocacy services/legal advice or assistance/domestic abuse services
Primary research studies; quantitative, qualitative or mixed-method studies	
Research undertaken in developed world	Studies undertaken in the developing world
Year of publication 2005 to present English language Peer-reviewed empirical studies and major official reports	Unpublished manuscripts, dissertations and conference abstracts

methodology, sample size and population, data collection method, domestic abuse intervention and main findings. See overview in Table 3.

3.7 | Synthesis

Quantitative data in terms of direct outcomes from domestic abuse interventions such as numbers screened, safety planning, referrals and negative impacts were collated. Qualitative data were extracted, and analysed using a thematic analysis framework (Braun & Clarke, 2006). Having read and reread the data, it was organized into codes. The codes were then reviewed and sorted into three key themes. Ongoing analysis enabled defining and refining of the themes.

4 | RESULTS

4.1 | Characteristics of selected studies

The studies identified were from Canada, Australia, Europe and the USA. The community nursing interventions took place at a home visit or a child health clinic. As expected with various methodologies, study sizes varied with participants ranging from 6 to 2784. Recruitment of participants in the qualitative studies was through purposive sampling, and data collection methods included semi-structured interviews, telephone interviews and focus groups. Quantitative data were collected from participants through surveys, questionnaires and chart reviews.

The inclusion criteria stipulated that the DV intervention can be carried out by community nurses postnatally; however, it became apparent that the interventions themselves varied. All the community nurse programmes included an element of home visiting, however, the Maternal and Child Health Nurses (MCHN; Australia) and Child Health Care Nurses (CHCN; Sweden) appear to carry out more contacts in clinic settings. Some DV interventions were delivered in a more targeted nursing service, with interventions being more intensive (Bacchus et al., 2016; Burnett et al., 2019; Feder et al., 2018; Jack et al., 2017; Mejdoubi et al., 2013; Sharps et al., 2016). The DOVE trial and the Nurse Family Partnership Programme (NFP) delivered intensive domestic abuse screening and education over several visits, while the universal approach of the MCHNs (Hooker et al., 2015, 2016; Taft et al., 2015) and CHCNs (Almqvist et al., 2018; Anderzen-Carlsson et al., 2018) was more conducive to one off or multiple points of screening or with brief interventions, for example, safety planning and referral for positive disclosures.

4.2 | Quantitative outcomes

Findings suggest that although referral by community nurses to DV services remained low (<1%; Hooker et al., 2015; Taft et al., 2015), there was increased disclosures (Almqvist et al., 2018; Vanderburg

TABLE 3 Data extraction table

Authors/country/year	Methodology	Participants	Intervention/trial	CCAT score	Key messages
Grafton et al. (2006)Canada	Quantitative	2344 (charts)	RUCS	26/40 65%	Documentation cues can improve routine abuse enquiry. There was an increase in documentation of abuse enquiry for low-risk women following the year-long professional development strategy (0.8%–20.5%). However, this was still low given that PHNs were to ask all women. This study shows that new policy can be combined with existing programmes and infrastructure
Webster et al. (2006) Canada	Qualitative	11	RUCS	27/40 68%	Despite limitations, this study provides rich narrative data describing PHNs' experiences of dealing with domestic abuse
Jack et al. (2008)Canada	Qualitative	6	Universal screening	28/40 70%	PHNs perceived that domestic abuse screening was within their role and would increase awareness and create opportunities for disclosure. However, multiple barriers to disclosure were identified. PHN education and training was necessary for screeners to be knowledgeable and skilled in their response
Vanderburg et al. (2010) Canada	Quantitative	1089 (charts)	RUCS	27/40 68%	This study concludes that asking about abuse in the postpartum is both feasible and worthwhile, given the significant increase in disclosures. However, the number of enquiries reduced significantly with the introduction of the new protocol. Emphasizes the importance of training, and incorporating privacy and safety for women disclosing abuse
Mejdoubi et al. (2013)The Netherlands	Quantitative	460	VoorZorg (NFP)	36/40 90%	VoorZorg is an intensive home visiting intervention targeting a high-risk group of mothers. This intervention may reduce all types of intimate partner violence (IPV), but findings can only be generalized to high-risk mothers receiving a similar NFP intervention
Hooker et al. (2015) Australia	Mixed methods	183	MOVE	37/40 93%	This study identifies barriers and enablers to domestic abuse identification and response. Resources such as guidelines and clinical pathways contribute to sustainability of a domestic abuse intervention, however, ongoing training, support from colleagues and interagency working are essential to truly sustain practice improvement

TABLE 3 (Continued)

Authors/country/year	Methodology	Participants	Intervention/trial	CCAT score	Key messages
Taft et al. (2015)Australia	Quantitative	2784	MOVE	39/40 98%	Timing of screening is important. Screening at a later time of 3 month postpartum, with the use of the maternal and child health checklist, was preferable as the mother physically recovered from birth and her partner was less likely to be present. The use of a self-report (checklist) rather than direct questioning increased safety planning rate, however, referrals remained low
Bacchus et al. (2016)USA	Qualitative	26	DOVE	37/40 93%	Women valued opportunities to discuss domestic abuse and access support. Disclosure was a staged process with a trusting relationship being central to disclosure. Safety planning was seen as important. Women highlighted the need for post-abuse support services. Domestic abuse training for home visitors (HVs) is essential with a communication skills component. Opportunities for refresher training are important for sustainability and to enhance HV's confidence. Rigorous protocol on safety of HVs and women
Hooker et al. (2016) Australia	Mixed methods	174	MOVE (Improving Maternal and Child Health Care for Vulnerable Mothers)	39/40 98%	Identifying the enablers and barriers to successful implementation of a domestic abuse intervention can enhance sustainability. The implementation of a domestic abuse intervention is complex, one that entails commitment from all levels of organizational structures, personal commitment and interagency participation
Sharps et al. (2016)USA	Quantitative	239	DOVE	35/40 88%	The DOVE intervention was effective in decreasing domestic abuse. The intervention is brief, therefore, can be integrated into home visiting programmes. The results support the case for universal screening of all pregnant women as DOVE can only be implemented if abused women are identified
Jack et al. (2017)Canada	Qualitative	63	NFP-IPV (Nurse–Family Partnership-IPV)	35/40 88%	Very comprehensive analysis and needs assessment, recommending discussions around healthy relationships. Nurses must have the knowledge to identify risk indicators and raise the issue (case finding). The nurse requires a domestic abuse assessment tool that can be administered multiple times, but not at first visit. This study supports skill development

(Continues)

TABLE 3 (Continued)

Authors/country/year	Methodology	Participants	Intervention/trial	CCAT score	Key messages
Almqvist et al. (2018) Sweden	Mixed methods	128	CHCN	34/40 88%	Mothers appreciate information and routine questions about domestic abuse once they are asked in private, by a well-informed nurse. Mothers had a preference for a self-completed questionnaire followed by discussion with the nurse. 16% of mothers who were asked in this study disclosed a lifetime exposure to domestic abuse
Anderzen-Carlsson et al. (2018)Sweden	Qualitative	13	CHCN	36/40 90%	The family violence questionnaire was a useful tool and could be implemented in practice. Education of nurses prior to implementation of routine asking is important. Time and place are important with privacy essential. Additional benefits from introducing a domestic abuse screening initiative include growing confidence in nurses in dealing with domestic abuse and use of a case finding approach
Feder et al. (2018)USA	Quantitative	238	NFP+	39/40 98%	This study concluded that this Nurse Family Partnership (NFP) intervention was not suitable for women already exposed to domestic abuse but may have a preventative effect with those high-risk women who have not been exposed to domestic abuse. Overall the intervention is effective in reducing some forms of violence among those not experiencing violence at baseline, but was ineffective or potentially harmful for those already experiencing IPV. When implementing a domestic abuse intervention, there needs to be consideration of the possibility of harmful effects on women exposed to domestic abuse
Burnett et al. (2019)USA	Qualitative	13	DOVE	35/40 88%	Home Visitors (HVs) endorsed DOVE as the preferred choice for domestic abuse screening and intervention. Dove enhanced HVs knowledge, screening and intervening skills. Establishing a relationship with the women prior to screening was important. Training, ongoing support enhanced comfort level of HVs in identifying and responding to domestic abuse. DOVE offers HCPs a standardized approach to move beyond screening to brief counselling. Consideration must be given to social and community supports capacity and availability and the ways in which HCPs and community services can be coordinated

et al., 2010). The MOVE trial had an increase in safety planning over 2 years with the intervention group increasing from 4.2% to 5.9% with the control group remaining static at 1.4% (Hooker et al., 2015; Taft et al., 2015). There was significant reduction in abuse experienced by women over time, where therapeutic components were part of the intervention (Feder et al., 2018; Mejdoubi et al., 2013; Sharps et al., 2016). Potential harm to women already experiencing abuse before the intervention took place was reported (Feder et al., 2018). Direct quantitative outcomes are outlined in Table 4.

TABLE 4 Direct quantitative outcomes from community nurse-led domestic abuse interventions

Outcome	Numbers screened	Disclosure	Referrals	Safety planning	Harm	Reduction in victimization
Findings	Over 2 years there was an increase in numbers screened at **IG** 4 weeks 37.1% to 50.6% at 4 months **IG** 36% to 29% (CG—42% to 56%, 23% to 35%) No significance between IG and CG (Taft et al., 2015) Pre-RUCS 0.8% had documented enquiry/ post 20.5% documented enquiry (Grafton et al., 2006) Number screened 48 h postpartum reduced from 388 to 76. There was a change in method from family relations questions to direct domestic abuse questions (Vanderburg et al., 2010)	16% mothers disclosed exposure to IPV (13%—in the past >3 years ago, 2.5%—1 to 3 years 0.5%—in the past year) (Almqvist et al., 2018) HBHC home visiting service—there was an increase in disclosures 48 hr postpartum from 3% to 11% despite a reduction in number of women being asked (Vanderburg et al., 2010)	Referrals IG 0.6% at 1 year to 0.9% year 3. CG 0.7%–0.9%—no significant difference between groups and small number of referral noted (Taft et al., 2015) Referral remained low in both CG and IG < 1% (Hooker et al., 2015)	Safety planning IG 4.2%–5.9% CG 1.4% to 1.4% which was a significant increase in safety planning (Taft et al., 2015)	No harm from intervention, no differences in IG and CG in women reporting discomfort. One in 10 survey respondents would have preferred not to be asked. Measured via survey. (Taft et al., 2015) No negative effects were described by mothers (Almqvist et al., 2018) Ineffective or potentially harmful for those already experiencing IPV (Feder et al., 2018)	Significant decrease in IPV over time using CTS2 scores at 1, 3, 6, 12, 18 and 24 months postpartum time points (all $p < 0.001$) **DOVE treatment effect.** Intervention group reported larger mean decrease in CST2 scores from baseline: IG 40.82 compared to UC 35.87 (Sharps et al., 2016) IG—significantly less IPV than control group in all types of abuse. Effective in reducing IPV 2 years post-birth in young high risk women. Mejdoubi et al., 2013) Effective in reducing some forms of IPV in women who had not experienced IPV in the past (Feder et al., 2018)

5 | QUALITATIVE THEMATIC ANALYSIS

5.1 | Benefits to women and nurses

Gaining knowledge and confidence in dealing with DV and having clear processes to respond to disclosure is vital for community nurses (Anderzen-Carlsson et al., 2018; Bacchus et al., 2016; Burnett et al., 2019; Hooker et al., 2015; Hooker et al., 2016; Jack et al., 2008; Webster et al., 2006). Burnett et al. (2019) describe the 'empowering' aspects of the DOVE intervention for nurses who reported increased knowledge and confidence in responding to DV. Additional benefits of screening initiatives include growing confidence in nurses in dealing with DV using a case finding approach (Anderzen-Carlsson et al., 2018). Understanding and acceptance of the nurses' role in delivering DV interventions increased over time with experience, supportive supervision and reflective practice, which enhanced nurse's confidence and competence to deal with DV (Burnett et al., 2019; Hooker et al., 2016).

Screening has multiple purposes, for example, health promotion, sharing information on DV and healthy relationships and protecting women against DV (Burnett et al., 2019). Discussing DV is central to increasing women's awareness of the unacceptability of abuse, enabling some women to define their own experiences as abusive and access support services (Anderzen-Carlsson et al., 2018; Jack et al., 2008; Webster et al., 2006). CHC nurses considered routine screening as a means to offer support mechanisms to mothers exposed to DV (Anderzen-Carlsson et al., 2018). PHNs acknowledged regular contact helped build trust which could create opportunities for disclosure (Jack et al., 2008). Anderzen-Carlsson et al. (2018) noted domestic abuse screening carried a significant workload. Webster et al. (2006) reported that PHNs in the USA, considered they were 'providing a bridge to other services', which was mirrored by mothers' perspectives in Sweden (Almqvist et al., 2018).

5.2 | Approaches to domestic abuse identification and response intervention

The approaches to screening varied but asking all women 'routinely' was considered acceptable to reduce stigmatization (Almqvist et al., 2018; Anderzen-Carlsson et al., 2018). Opportunities for 'screening' or discussion ranged from one off screening to multiple opportunities or phased discussions. Many nurses and women expressed the need to build a trusting relationship prior to screening (Bacchus et al., 2016; Burnett et al., 2019; Hooker et al., 2016; Jack et al., 2008; Jack et al., 2017). Some nurses valued multiple opportunities to discuss abuse, adopting a more conversational indicator-based approach (Burnett et al., 2019; Jack et al., 2008; Jack et al., 2017). Where postnatal screening was delivered in a structured universal way, the preferred timing was 3–4 months postpartum or later, as all agreed the first postnatal visit may not allow time to develop a therapeutic relationship (Almqvist et al., 2018; Anderzen-Carlsson et al., 2018;Hooker et al., 2015; Hooker et al., 2016). A screening tool was used in most studies for initial identification (Table 5). The majority of women preferred the combination of a self-completion questionnaire, with follow up face-to-face discussion with the nurse. (Almqvist et al., 2018; Hooker et al., 2015; Hooker et al., 2016; Taft et al., 2015). Regardless of where the domestic abuse intervention occurred, nurses and women agreed that the woman must be alone, in private and treated in a confidential and respectful manner (Almqvist et al., 2018; Bacchus et al., 2016; Hooker et al., 2015; Jack et al., 2008; Jack et al., 2017). Hooker et al. (2015) found lack of privacy was the most significant barrier to screening.

5.3 | Implementation and sustainability of the domestic abuse intervention

Training and skills development prior to implementation of the domestic abuse intervention were vital to success, as was continuous professional development and refresher training (Anderzen-Carlsson et al., 2018; Bacchus et al., 2016; Burnett et al., 2019; Hooker et al., 2015; Hooker et al., 2016; Webster et al., 2006). Nurses' level of comfort, confidence and competence were directly related to the preparation, resources and ongoing support they received. Resources, for example, clinical guidelines, referral pathways, documentation and safety protocols, were essential, with nurses reporting the use of standardized checklists alleviating discomfort when discussing domestic abuse (Bacchus et al., 2016; Burnett et al., 2019; Hooker et al., 2015; Hooker et al., 2016; Jack et al., 2012; Jack et al., 2017).

Ongoing clinical support and supervision were seen as beneficial and necessary (Burnett et al., 2019; Hooker et al., 2016; Jack

TABLE 5 Domestic Abuse Screening Tools

Screening tool used	Study
Abuse Assessment Screen (AAS)	Anderzen-Carlsson et al. (2018) Almqvist et al. (2018)
MOVE maternal health & wellbeing checklist (IPV questions only)	Hooker et al. Taft (2015, 2016)
Woman Abuse Screening Tool (WAST)	Jack et al. (2008)
Partner Violence Screening Questionnaire (PVS)	Jack et al. (2008)
Psychological maltreatment of women Inventory (PMWI)	Feder et al. (2018)
Routine Universal Comprehensive Screening (RUSC)	Vanderburg et al. (2010)
Women's experience of battering scale (WEB)	Sharps et al. (2016)

TABLE 6 Barriers and facilitators to implementation and sustainability

Facilitators	Barriers
Training with follow-up workshops and refresher training	Community nurses lack of knowledge, skills, confidence or comfort in dealing with domestic abuse
Educational material and resources to support intervention delivery	No revision material or clear guide on how to carry out the domestic abuse intervention
Clear referral pathways	Asking about domestic abuse without any clear pathway of care or referral
Documentation protocol or guideline	Lack of clarity around safe documentation
Guidelines on safety/safety protocol	Lack of guidance about safety especially with lone working and home visiting
Organization support and increased clinical resources	Time constraints, heavy workloads and reliance on relief nurses who are less familiar with intervention
Privacy, in a safe location and low risk of being interrupted	Lack of Privacy, family members or perpetrator within the vicinity
Confidentiality, trust and respect	Lack of therapeutic relationship and trust
Supervision, clinical support and reflective practice	Minimal clinical support or time for team discussion
Clinical support from an expert, domestic abuse programme coordinator or domestic abuse services liaison person	No expert to turn to, no support for managers or clinical supervisors
Good relationships with local domestic abuse services and collaborative working	Poor relationships with community services or lack of interagency working or joined up thinking
Well-resourced community domestic abuse services	Lack of community supports or poorly resourced community services

et al., 2017). Enhanced support from domestic abuse nurse mentors/champions and liaison workers offered a greater level of expert support and mentorship (Hooker et al., 2015, 2016; Burnett et al. (2019). Collaborative working with local domestic abuse services enhanced confidence, leading to higher levels of engagement, screening rates and safety plans (Hooker et al., 2015; Hooker et al., 2016). Where organizational support and resources were provided, higher screening and safety planning rates resulted (Hooker et al., 2015; Hooker et al., 2016). Workload and time constraints appeared to continually impact on preventive domestic abuse work. Barriers and facilitators to implementation and sustainability are summarized in Table 6.

6 | DISCUSSION

This integrative review examined community nurse-led interventions for identifying and responding to domestic abuse postnatally. Outcomes identified included an increase in domestic abuse disclosure and safety planning, however, referrals remained low. Thematic analysis identified key themes: benefits to nurses and women, approaches to domestic abuse identification and response interventions, and implementation of domestic abuse interventions.

Findings indicated referrals by community nurses to domestic abuse services remained low but there was increased safety planning (Hooker et al., 2016; Taft et al., 2015). Measuring a reduction in domestic abuse (O'Campo et al., 2011) or quantifying referrals (Reisenhofer & Taft, 2013) as stand-alone outcomes may not be appropriate when evaluating the impact of screening. Women experiencing DV may not desire a referral as their readiness for change within an abusive relationship is situated within a 'stages of change' continuum (Reisenhofer & Taft, 2013). Women in this review valued the safety planning component of the domestic abuse intervention DOVE, whether the abuse was current or had ended (Bacchus et al., 2016). Reisenhofer and Taft (2013) suggested that support offered by clinicians must relate to the stage a women is at:

1. promotion of well-being in an abusive relationship while minimizing harm
2. safety and well-being in the relationship by ending the abuse
3. safety by leaving the relationship

Therefore, it is worth analysing the wider effects of domestic abuse interventions rather than outcomes such as referral or victimization.

Community settings present unique safety challenges; location of enquiry, being alone with the woman, home visiting, lone-working and no on-site support were reported (Hooker et al., 2015; Hooker et al., 2016). Only three interventions documented a safety protocol (Hooker et al., 2015; Hooker et al., 2016; Jack et al., 2008; Jack et al., 2017) but the safety of the woman and nurse must be considered by health service managers. In fact, one study reported the partner being asked to wait outside while carrying out the domestic abuse intervention (Anderzen-Carlsson et al., 2018), which could have serious safety risks for the woman. This review highlights how privacy and confidentiality are essential prerequisites to screening. Lack of privacy is commonly cited as a barrier to domestic abuse screening and disclosure (Stenson et al. 2005; Lauti & Miller, 2008; Finnbogadóttir & Dykes, 2012; Taylor et al., 2013) but cannot remain an excuse for lack of progress in this area. All domestic abuse interventions must be supported with safety protocols and resourced accordingly.

Women strongly support being asked about domestic abuse in healthcare settings (Almqvist et al., 2018; Bacchus et al., 2016), a

finding supported by previous studies (Bacchus et al., 2003; Feder et al., 2009; O'Doherty et al., 2015; Pratt-Eriksson et al., 2014; Spangaro et al., 2010; Spangaro et al., 2016; Taylor et al., 2013; Usta et al., 2012). Most domestic abuse interventions were seen as more than just identification of women experiencing domestic abuse. Health promotion around healthy relationships, identifying abusive behaviour and safety planning were additional benefits (Almqvist et al., 2018; Anderzen-Carlsson et al., 2018; Bacchus et al., 2016; Burnett et al., 2019; Hooker et al., 2015, 2016; Jack et al., 2017). Burnett et al. (2019) state that domestic abuse 'screening' interventions can have an empowering effect on both women and nurses, enabling women to 'reveal strengths' in vulnerable family conditions. Organizations must give due consideration to the components of domestic abuse screening interventions as even brief interventions must be meaningful.

This review reveals that a consistent approach to DV identification, with standard questions or topics of discussion, is welcomed by nurses, and with regular use and support, nurses become more skilled and confident implementing the intervention (Anderzen-Carlsson et al., 2018; Hooker et al., 2015, 2016). The exact method or approach to screening preferences of women varied across studies. Women appeared satisfied with a conversational approach to defining healthy relationships (Jack et al., 2017), and face-to-face screening (Bacchus et al., 2016) or a combination of self-report questionnaire followed by a discussion with the nurse (Almqvist et al., 2018), but this may have limitations, especially for those with literacy difficulties. A clear message is that women want to be asked about domestic abuse by well-informed, confident, caring nurses, with whom they have a trusting and therapeutic relationship; findings consistent with previous studies (Bacchus et al., 2003; Pratt-Eriksson et al., 2014; Spangaro et al., 2010; Spangaro et al., 2016; Taylor et al., 2013; Usta et al., 2012). Lack of trust and care leads to non-disclosure, false negatives and re-victimization of the women (Häggblom & Möller, 2007; Pratt-Eriksson et al., 2014; Spangaro et al., 2010, 2016).

The timing of domestic abuse interventions warrants consideration. Women and nurses preferred screening to take place after they had time to develop a relationship. This review found that enrolment in the home visiting programme or the first postnatal visit were not suitable times to screen mothers. Three to 4 months postpartum or later, or using a staged approach in the antenatal/postnatal period, were preferred options (Almqvist et al., 2018; Anderzen-Carlsson et al., 2018; Bacchus et al., 2016; Burnett et al., 2019; Hooker et al., 2015; Hooker et al., 2016; Jack et al., 2008; Jack et al., 2017). PHNs throughout Ireland offer a 3-month core check to mothers with babies aged 3–4 months. This is a feasible time to open discussions about domestic abuse, however, resources must be put in place to enable the PHN adequate time for discussions, as a lack of time, or asking a question in a rushed or cursory manner, is a barrier to enquiry and disclosure (Jack et al., 2008). The key message from this review is that women should be asked about domestic abuse in a sincere caring way, in a safe and private location, by a nurse who is confident in her response to a disclosure.

This review found that community nurses valued training prior to the introduction of, and during domestic abuse intervention trials, as many had no previous formal training on DV (Anderzen-Carlsson et al., 2018; Burnett et al., 2019; Hooker et al., 2015, 2016; Jack et al., 2017). Well-supported interventions had positive outcomes in terms of increased safety planning (Taft et al., 2015), a decrease in domestic abuse victimization (Feder et al., 2018; Mejdoubi et al., 2013; Sharps et al., 2016) and increased confidence among nurses undertaking the interventions (Anderzen-Carlsson et al., 2018; Burnett et al., 2019; Hooker et al., 2015, 2016; Jack et al., 2017). Where minimal support was provided to nurses, they reported less positive outcomes and poorer satisfaction with complex domestic abuse work (Grafton et al., 2006; Vanderburg et al., 2010; Webster et al., 2006). Evidence suggests that nurses themselves may experience IPV (Sharma & Vatsu, 2011), may not recognize abuse as DV at first and require supports from employers. Christensen et al. (2021) reported the emotional burden of care when supporting and protecting victims of DV can be immense, can lead to distancing, emotional self-protection as well as increasing compassion fatigue due to secondary vicarious trauma. It is imperative that PHNs know contact details of local domestic violence services to ensure they can offer timely support and referrals. Interdisciplinary working is paramount to combat complex social problems such as DV, and disclosure-friendly environments may assist women to seek help (O'Brien Green, Brien2021).

Clinical support, such as supervision, team discussion and debriefing, was seen as beneficial and necessary for nurses undertaking domestic abuse interventions (Burnett et al., 2019; Hooker et al., 2016; Jack et al., 2017). Enhanced support from experts, for example, DV coordinators, DV liaison workers, nurse mentors or 'practice champions' offered enhanced support and mentorship. Collaboration with local DV services and community supports in terms of housing and finances are important and signposting women to routes of safety is essential. Interagency working was only discussed by Hooker et al. (2015, 2016), but is critical from a practice perspective so that clear channels of communication can strengthen the links with DV, housing or policing services. These findings are consistent with conclusions from a systematic review (O'Campo et al., 2011), which found that programmes with institutional support, ongoing training, effective screening protocols and immediate access to support services, report higher screening and identification rates.

Only two of the 15 studies specifically provided opinions of women on the delivery of the DV interventions (Almqvist et al., 2018; Bacchus et al., 2016). This lack of women's perspectives is a gap in the evidence base, especially related to nursing interventions (Happell et al., 2019). Women who are 'experts by experience' have opened societal debate about DV and the inadequacy of responses. Due to the unique complexities for community nurses identifying domestic abuse, the voices of women are crucial to shape health service reform.

6.1 | Limitations

The limitations of this integrative review include limiting the review to community-based settings postnatally. Given the heterogeneity of the methodologies and the domestic abuse interventions, it was difficult to compare the results. Although the main focus was postpartum interventions, some of the interventions had an antenatal component. Some community nurses provided home visiting services, while others were clinic based. Some community nursing programmes were more intensive and targeted high-risk mothers, while others were more universal. There were no studies in Ireland or the UK fitting the inclusion criteria, therefore, results may not be generalizable to the Irish setting. When examining the direct quantitative outcomes of the interventions, the diversity made the pooling of the data more complex. Some studies reported implementation of the interventions in detail, while others lacked details of protocols and training, preventing full understanding of why interventions were successful or not.

7 | CONCLUSION

A more proactive response to DV in society is required and PHNs are well placed to respond postnatally as they are trusted community-based professionals accessible to most mothers. The presentation, dynamics and impact of DV are better understood than ever before. The current pandemic has led to escalating DV rates (Usher et al., 2021, Bradbury-Jones & Nikupeteri, 2021). Greater understanding of coercive control, digital and technological tracking of women's conversations and movements means interdisciplinary working is essential to ensure safety for women and nurses. Wyatt et al. (2019) in an American study raised important points about newly registered nurses relevant for community nurses also. Difficulties experienced by nurses when screening for DV related to themes such as taboo and discomfort, while several participants confessed to 'checking boxes' when they had not actually screened the patient which is concerning for patient safety.

Community nurse-led DV interventions lead to positive outcomes for women; increasing awareness, helping women to identify their experiences as abusive, boosting self-esteem and enhancing their ability to seek help. Women value supportive nurses they trust, however, complexities involved in DV sometimes mean women delay disclosure due to fear or depression. Home visitation may reveal aspects of psychological, coercive or economic control in the home that may not be observed in a clinic setting. At times, a duty of care warranted intervention, but nurses were hindered by their own inadequacies to deal with trauma and a lack of community resources. Safety risks are associated with inappropriate nursing responses, therefore, an evidence-based approach to domestic abuse interventions to identify and respond to domestic abuse is required.

Key recommendations include:

- Interagency training for identifying and responding to domestic abuse, including refresher updating, supervision and mentorship with domestic abuse screening and referral.
- Development of clear guidelines, referral pathways, safety protocols and planning guidance.
- Collaborative working enabling PHNs to develop greater links with domestic abuse services.
- Nurse mentors/champions with experience supporting women experiencing DV, to lead the implementation of sustainable domestic abuse initiatives. For example, Advanced Nurse Practitioner or DV liaison worker
- Organizational support with enhanced resources and commitment at government level to the provision of domestic abuse services to meet the needs of women experiencing abuse are crucial for sustainability of domestic abuse initiatives.

- Further research and engagement with PHNs and women
  - To tailor the training for the PHN service,
  - To evaluate the outcomes from piloted domestic abuse initiatives.
  - To identify women's experiences of any piloted intervention prior to full implementation.

Domestic abuse is grossly unacceptable and PHNs cannot ignore this pervasive societal problem. They are challenged to respond appropriately and compassionately, while ensuring the safety of women and children is central to ongoing service development.

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CONFLICT OF INTEREST

No conflict of interest to declare.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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REFERENCES

Almqvist, K., Källström, Å., Appell, P., & Anderzen-Carlsson, A. (2018). Mothers' opinions on being asked about exposure to intimate partner violence in child healthcare centres in Sweden. *Journal of Child Health Care*, *22*(2), 228–237. https://doi.org/10.1177/1367493517753081

Anderzen-Carlsson, A., Gillå, C., Lind, M., Almqvist, K., Lindgren Fändriks, A., & Källström, Å. (2018). Child healthcare nurses' experiences of asking new mothers about intimate partner violence. *Journal of Clinical Nursing*, *27*(13–14), 2752–2762. https://doi.org/10.1111/jocn.14242

Antle, B. F., Barbee, A. P., Sullivan, D., Yankeelov, P., Johnson, L., & Cunningham, M. R. (2007). The relationship between domestic violence and child neglect. *Brief Treatment and Crisis Intervention*, *7*(4), 364–382. https://doi.org/10.1093/brief-treatment/mhm013

Australian Bureau of Statistics (2016) Personal safety, Australia, 2016: Experience of partner violence. Retrieved on 18th August 2018 from http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/bySubject/4906.0~2016~MainFeatures~Prevalenceofpartnerviolence

Bacchus, L., Mezey, G., & Bewley, S. (2003). Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health & Social Care in the Community*, *11*(1), 10–18.

Bacchus, L. J., Bullock, L., Sharps, P., Burnett, C., Schminkey, D., Buller, A. M., & Campbell, J. (2016). 'Opening the door': A qualitative interpretive study of women's experiences of being asked about intimate partner violence and receiving an intervention during perinatal home visits in rural and urban settings in the USA. *Journal of Research in Nursing*, *21*(5/6), 345–364. https://doi.org/10.1177/1744987116649634

Baird, K., Salmon, D., & White, P. (2013). A five year follow-up study of the Bristol pregnancy domestic violence programme to promote routine enquiry. *Midwifery*, *29*(8), 1003–1010.

Bateman, W. and Whitehead, K. (2004) 'Health visitors domestic violence routine questioning tool: An exploration of women's experience, effectiveness and acceptability', *International Journal of Health Promotion and Education*, *42*(1), 14–22, available: https://doi.org/10.1080/14635240.2004.10708005

Begley, C., Brady, A.M., Byrne, G, Macgregor, C., Griffiths, C. & Horan, P. (2004) A study of the role and workload of the public health nurse in the Galway Community Care Area (Prepared for the Nursing and Midwifery Planning and Development Unit, HSE Western Area by the School of Nursing and Midwifery Studies, Trinity College Dublin.) Final Report. Retrieved from https://www.inmo.ie/tempDocs/RoleWorkloadofthePHNinGalwayCommunityCare.pdf

Beydoun, H. A., Beydoun, M. A., Kaufman, J. S., Lo, B., & Zonderman, A. B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: A systematic review and meta-analysis. *Social Science & Medicine*, *75*(6), 959–975. https://doi.org/10.1016/j.socscimed.2012.04.025

Bradbury-Jones, C., & Broadhurst, K. (2015). Are we failing to prepare nursing and midwifery students to deal with domestic abuse? Findings from a qualitative study. *Journal of Advanced Nursing*, *71*(9), 2062–2072. https://doi.org/10.1111/jan.12666

Bradbury-Jones, C., & Nikupeteri, A. (2021). Intimate partner violence, stalking and the pandemic: yet more paradoxes? *Journal of Advanced Nursing*, *77*, 2117–2118. https://doi.org/10.1111/jan.148200

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Burnett, C., Crowder, J., Bacchus, L. J., Schminkey, D., Bullock, L., Sharps, P., & Campbell, J. (2019). "It doesn't freak us out the way it used to": An evaluation of the domestic violence enhanced home visitation program to inform practice and policy screening for IPV. *Journal of Interpersonal Violence*, *36*(13-14), NP7488–NP7515. https://doi.org/10.1177/0886260519827161

Christensen, M. M., Metcalfe, L. L., & O'Reilly, R. (2021). Emergency department nurses experiences of female domestic violence presentations: A review of the qualitative literature. *Nursing Forum*, *56*(4), 925–937. https://doi.org/10.1111/nuf.12632

Crowe, M., & Sheppard, L. (2011). A general critical appraisal tool: An evaluation of construct validity. *International Journal of Nursing Studies*, *48*(12), 1505–1516.

Devaney, J. (2015). Research review: The impact of domestic violence on children. *Irish Probation Journal*, *12*, 79–94.

Devaney, J., Bradbury-Jones, C., Macy, R. J., Overlien, C., & Holt, S. (2021). *Routledge International handbook of domestic violence and abuse*. Routledge.

Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L. B., Deyessa, N., Heise, L., Durand, J., Mbwambo, J., Jansen, H., Berhane, Y., Ellsberg, M., & Garcia-Moreno, C. (2011). Violence against women is strongly associated with suicide attempts: Evidence from the WHO multi-country study on women's health and domestic violence against women. *Social Science & Medicine*, *73*(1), 79–86. https://doi.org/10.1016/j.socscimed.2011.05.006

Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet*, *371*(9619), 1165–1172.

Feder, G., Ramsay, J., Dunne, D., Rose, M., Arsene, C., Norman, R., Kuntze, S., Spencer, A., Bacchus, L., Hague, G., Warburton, A., & Taket, A. (2009). How far does screening women for domestic (partner) violence in different health-care settings meet the UK National Screening Committee criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*, *13*(37), 1–347. https://doi.org/10.3310/hta13160

Feder, L., Niolon, P. H., Campbell, J., Whitaker, D. J., Brown, J., Rostad, W., & Bacon, S. (2018). An intimate partner violence prevention intervention in a nurse home visitation program: A randomized clinical trial. *Journal of Women's Health*, *27*(12), 1482–1490. https://doi.org/10.1089/jwh.2017.6599

Finnbogadóttir, H., & Dykes, A.-K. (2012). Midwives' awareness and experiences regarding domestic violence among pregnant women in southern Sweden. *Midwifery*, *28*(2), 181–189. https://doi.org/10.1016/j.midw.2010.11.010

Finnbogadóttir, H., & Dykes, A. K. (2016). Increasing prevalence and incidence of domestic violence during the pregnancy and one and a half year postpartum, as well as risk factors: -a longitudinal cohort study in Southern Sweden. *BMC Pregnancy and Childbirth*, *16*, 327. https://doi.org/10.1186/s12884-016-1122-6

Ghani, A. M. (2018). The impacts of domestic violence on children: Perspectives from women in Malaysia who experience abuse. *Child Welfare*, *96*(3), 103–117.

Giltenane, M., Sheridan, A., Kroll, T., & Frazer, K. (2021a). Identifying the role of public health nurses during first postnatal visits: Experiences of mothers and public health nurses in Ireland. *International Journal of Nursing Studies Advances*, *3*, 7. https://doi.org/10.1016/j.ijnsa.2020.100017

Giltenane, M., Sheridan, A., Kroll, T., & Frazer, K. (2021b). Work environment challenging Irish public health nurses' care quality: First post natal visits. *Public Health Nursing*, *39*, 202–213. https://doi.org/10.1111/phn.12993

Goff, H. W., Shelton, A. J., Byrd, T. L., & Parcel, G. S. (2003). Preparedness of health care practitioners to screen women for domestic violence in d border community. *Health Care for Women International*, *24*(2), 135–148. https://doi.org/10.1080/07399330304009

Grafton, D., Wright, B. L., Gutmanis, I., & Ralyea, S. (2006). Successful implementation of universal woman abuse

inquiry. *Public Health Nursing*, *23*(6), 535–540. https://doi.org/10.1111/j.1525-1446.2006.00593.x

Häggblom, A. M. E., & Möller, A. R. (2007). Fighting for survival and escape from violence: Interviews with battered women. *International Journal of Qualitative Studies on Health & Well-Being*, *2*(3), 169–178. https://doi.org/10.1080/17482620701296259

Happell, B., Platania-Phung, C., Scholz, B., Bocking, J., Horgan, A., Manning, F., Doody, R., Hals, E., Granerud, A., Lahti, M., Pullo, J., Vatula, A., Koski, J., Vaart, K. J., Allon, J., Griffin, M., Russell, S., MacGabhann, L., Bjornsson, E., & Biering, P. (2019). Changing attitudes: The impact of expert by experience involvement in mental health nursing education: An international survey study. *International Journal of Mental Health Nursing*, *28*(2), 480–491. https://doi.org/10.1111/inm.12551

Health Service Executive. (2010). *HSE policy on domestic, sexual and gender based violence*. HSE.

Health Service Executive. (2019). *HSE National Domestic, sexual and gender-based violence training resource manual*. HSE Social Inclusion.

Henriksen, L., Garnweidner-Holme, L. M., Thorsteinsen, K. K., & Lukasse, M. (2017). "It is a difficult topic"—a qualitative study of midwives' experiences with routine antenatal enquiry for intimate partner violence. *BMC Pregnancy & Childbirth*, *17*, 1–9. https://doi.org/10.1186/s12884-017-1352-2

Higgins, J. P. T., Green, S., & Cochrane, C. (2008). *Cochrane handbook for systematic reviews of interventions*. Wiley.

Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect*, *32*(8), 797–810. https://doi.org/10.1016/j.chiabu.2008.02.004

Holt, S., & Devaney, J. (2015). Understanding domestic abuse and sexual violence: Prevalence, policy and practice. In D. Healy, C. Hamilton, Y. Daly, & M. Butler (Eds.), *The Routledge handbook of Irish criminology*. Routledge.

Home Office. (2012). *Cross-government definition of domestic violence—a consultation summary of responses*. Home Office Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/157800/domestic-violence-definition.pdf

Hooker, L., Small, R., Humphreys, C., Hegarty, K., & Taft, A. (2015). Applying normalization process theory to understand implementation of a family violence screening and care model in maternal and child health nursing practice: A mixed method process evaluation of a randomised controlled trial. *Implementation Science*, *10*(1), 39. https://doi.org/10.1186/s13012-015-0230-4

Hooker, L., Small, R., & Taft, A. (2016). Understanding sustained domestic violence identification in maternal and child health nurse care: Process evaluation from a 2-year follow-up of the MOVE trial. *Journal of Advanced Nursing*, *72*(3), 533–544. https://doi.org/10.1111/jan.12851

Izaguirre, A., & Calvete, E. (2015). Children who are exposed to intimate partner violence: Interviewing mothers to understand its impact on children. *Child Abuse & Neglect*, *48*, 58–67. https://doi.org/10.1016/j.chiabu.2015.05.002

Jack, S. M., Ford-Gilboe, M., Davidov, D., MacMillan, H. L., O'Brien, R., Gasbarro, M., Olds, D., Johnston, C., Coben, J., Scribano, P., Stevens, J., Wathen, N., & McNaughton, D. (2017). Identification and assessment of intimate partner violence in nurse home visitation. *Journal of Clinical Nursing*, *26*(15–16), 2215–2228. https://doi.org/10.1111/jocn.13392

Jack, S. M., Ford-Gilboe, M., Wathen, C. N., Davidov, D. M., McNaughton, D. B., Coben, J. H., Olds, D. L., & MacMillan, H. L. (2012). Development of a nurse home visitation intervention for intimate partner violence. *BMC Health Services Research*, *12*(1), 1–14. https://doi.org/10.1186/1472-6963-12-50

Jack, S. M., Jamieson, E., Wathen, C. N., & MacMillan, H. L. (2008). The feasibility of screening for intimate partner violence during postpartum home visits. *Canadian Journal of Nursing Research*, *40*(2), 150–170.

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*(2), 339–352. https://doi.org/10.1037/0022-006X.71.2.339

Lauti, M., & Miller, D. (2008). Midwives' and obstetricians' perception of their role in the identification and management of family violence. *New Zealand College of Midwives Journal*, 12–16.

Lazenbatt, A., Taylor, J., & Cree, L. (2009). A healthy settings framework: An evaluation and comparison of midwives' responses to addressing domestic violence. *Midwifery*, *25*(6), 622–636. https://doi.org/10.1016/j.midw.2007.11.001

Leahy-Warren, P. (2007). Social support for first-time mothers: An Irish study. *The American Journal of Maternal Child Nursing*, *32*(6), 368–374. https://doi.org/10.1097/01.nmc.0000298133.39785.a2

LoBiondo-Wood, G., & Harber, J. (2016). *Nursing research: Methods and critical appraisal for evidence-based practice* (10th ed.). Elsevier.

McGavock, L., & Spratt, T. (2017). Children exposed to domestic violence: Using adverse childhood experience scores to inform service response. *British Journal of Social Work*, *47*, 1128–1146. https://doi.org/10.1093/bjsw/bcw073

Mejdoubi, J., van den Heijkant, S. C. C. M., van Leerdam, F. J. M., Heymans, M. W., Hirasing, R. A., & Crijnen, A. A. M. (2013). Effect of nurse home visits vs. usual care on reducing intimate partner violence in young high-risk pregnant women: A randomized controlled trial. *PLoS One*, *8*(10), e78185. https://doi.org/10.1371/journal.pone.0078185

Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G., The PRISMA Group (2009) Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine 6*(7): e1000097. https://doi.org/10.1371/journal.pmed.1000097

National Institute for Health and Care Excellence (NICE) (2016) *Domestic violence and abuse; quality standard*. NICE. https://www.nice.org.uk/guidance/qs116

Naughton, C. M., O'Donnell, A. T., & Muldoon, O. T. (2017). Exposure to domestic violence and abuse: Evidence of distinct physical and psychological dimensions. *Journal of Interpersonal Violence*, *1-22*, 3102–3123. https://doi.org/10.1177/0886260517706763

Niolon, P., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). *Preventing intimate partner violence across the lifespan: A technical package of programs, policies, and practices*. Division of Violence Prevention National Center for Injury Prevention and Control Centers for Disease Control and Prevention.

O'Brien Green, S. (2020) Domestic violence and pregnancy in Ireland: Women's routes to seeking help and safety. PhD Thesis. http://www.tara.tcd.ie/handle/2262/91289

O'Brien Green, S. (2021). Domestic violence and pregnancy in Ireland. *World of Irish Nursing*, *29*, 50–51.

O'Campo, P., Kirst, M., Tsamis, C., Chambers, C., & Ahmad, F. (2011). Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. *Social Science & Medicine*, *72*(6), 855–866. https://doi.org/10.1016/j.socscimed.2010.12.019

O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L. L., Feder, G., & Taft, A. (2015). Screening women for intimate partner violence in healthcare settings. *The Cochrane Database of Systematic Reviews*, *7*, CD007007. https://doi.org/10.1002/14651858.CD007007.pub3

Office for National Statistics (2018) Domestic abuse: findings from the Crime Survey for England and Wales: Year ending March 2018. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018

Pallitto, C. C., García-Moreno, C., Jansen, H. A., Heise, L., Ellsberg, M., Watts, C., Pallitto, C. C., García-Moreno, C., Jansen, H. A. F. M., Heise, L., Ellsberg, M., & Watts, C. (2013). Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO multi-country study on Women's health and domestic violence.

International Journal of Gynecology & Obstetrics, *120*(1), 3–9. https://doi.org/10.1016/j.ijgo.2012.07.003

Parveen, A., & McGarry, J. (2020). *Domestic violence in health contexts: A guide for Healthare professionals*. Springer Press.

Peckover, S. (2003). "I could have just done with a little more help": An analysis of women's help-seeking from health visitors in the context of domestic violence. *Health Social Care Community.*, *11*(3), 275–282. https://doi.org/10.1046/j.1365-2524.2003.00423.x

Pratt-Eriksson, D., Bergbom, I., & Lyckhage, E. D. (2014). Don't ask don't tell: Battered women living in Sweden encounter with healthcare personnel and their experience of the care given. *International Journal of Qualitative Studies on Health & Well-Being*, *9*, 1–7. https://doi.org/10.3402/qhw.v9.23166

Ramsay, J., Richardson, J., Carter, Y. H., Davidson, L. L., & Feder, G. (2002). Should health professionals screen women for domestic violence? Systematic review. *British Medical Journal (International Edition)*, *325*(7359), 314–318. https://doi.org/10.1136/bmj.325.7359.314

Reisenhofer, S., & Taft, A. (2013). Women's journey to safety - the transtheoretical model in clinical practice when working with women experiencing intimate partner violence: A scientific review and clinical guidance. *Patient Education and Counseling*, *93*(3), 536–548. https://doi.org/10.1016/j.pec.2013.08.004

Royal College of General Practitioners (RCGP)/National Society for the Prevention of Cruelty to Children (NSPCC). (2011). *Safeguarding children and young people: The RCGP/NSPCC safeguarding children toolkit for general practice*. RCGP. http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx

Salmon, D., Baird, K. M., & White, P. (2015). Women's views and experiences of antenatal enquiry for domestic abuse during pregnancy. *Health Expectations*, *18*(5), 867–878. https://doi.org/10.1111/hex.12060

Sharma, K. K., & Vatsu, M. (2011). Domestic violence against nurses by their marital partners: A facility-based study at a tertiary care hospital. *Indian Journal of Community Medicine*, *36*(3), 222–227. https://doi.org/10.4103/0970-0218.86525

Sharps, P. W., Bullock, L. F., Campbell, J. C., Alhusen, J. L., Ghazarian, S. R., Bhandari, S. S., & Schminkey, D. L. (2016). Domestic violence enhanced perinatal home visits: The DOVE randomized clinical trial. *Journal of Women's Health*, *25*(11), 1129–1138. https://doi.org/10.1089/jwh.2015.5547

Smith, S. G., Chen, J., Basile, K. C., Gilbert, L. K., Merrick, M. T., Patel, N., Walling, M., & Jain, A. (2017). *The National Intimate Partner and sexual violence survey (NISVS): 2010–2012 state report*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Spangaro, J., Koziol-McLain, J., Zwi, A., Rutherford, A., Frail, M.-A., & Ruane, J. (2016). Deciding to tell: Qualitative configurational analysis of decisions to disclose experience of intimate partner violence in antenatal care. *Social Science & Medicine*, *154*, 45–53. https://doi.org/10.1016/j.socscimed.2016.02.032

Spangaro, J., Zwi, A., Poulos, R., & Man, W. (2010). Who tells and what happens: Disclosure and health service responses to screening for intimate partner violence. *Health & Social Care in the Community*, *18*(6), 671–680. https://doi.org/10.1111/j.1365-2524.2010.00943.x

Stenson, K., Sidenvall, B., & Heimer, G. (2005). 'Midwives' experiences of routine antenatal questioning relating to men's violence against women'. *Midwifery*, *21*(4), 311–321. https://doi.org/10.1016/j.midw.2005.01.002

Taft, A. J., Hooker, L., Humphreys, C., Hegarty, K., Walter, R., Adams, C., Agius, P., & Small, R. (2015). Maternal and child health nurse screening and care for mothers experiencing domestic violence (MOVE): A cluster randomised trial. *BMC Medicine*, *13*(1), 150. https://doi.org/10.1186/s12916-015-0375-7

Taylor, J. (2019). Childhood experiences of domestic violence and adult outcomes. Where are we now; challenges, debates and interventions? In E. Bates & E. Taylor (Eds.), *Intimate partner violence: New perspectives in research and practice*. Routledge, Taylor & Francis.

Taylor, J., Bradbury-Jones, C., Kroll, T., & Duncan, F. (2013). Health professionals' beliefs about domestic abuse and the issue of disclosure: A critical incident technique study. *Health & Social Care in the Community*, *21*(5), 489–499. https://doi.org/10.1111/hsc.12037

Taylor, J. C., Bates, E. A., Colosi, A., & Creer, A. (2021). Barriers to men's help seeking for intimate partner violence journal of interpersonal violence. *Journal of Interpersonal Violence*, 1–28. https://doi.org/10.1177/08862605211035870

United Nations Office of Drugs and Crime (2019) *Global study on homicide Gender-related killing of women and girls*. United Nations Office on Drugs and Crime. Retrieved from https://www.unodc.org/documents/data-and-analysis/gsh/Booklet_5.pdf

US Preventive Services Task Force. (2018). Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: US preventive services task force final recommendation statement, JAMA. *Journal of the American Medical Association*, *320*(16), 1678–1687. https://doi.org/10.1001/jama.2018.14741

Usher, K., Bradbury Jones, C., Bhullar, N., Durkin, D. J., Gyamfi, N., Fatema, S. R., & Jackson, D. (2021). COVID-19 and family violence: is this a perfect storm? *International Journal of Mental Health Nursing*, *30*(4), 1022–1032. https://doi.org/10.1111/inm.12876

Usta, J., Antoun, J., Ambuel, B., & Khawaja, M. (2012). Involving the health care system in domestic violence: What women want. *Annals of Family Medicine*, *10*(3), 213–220.

Vanderburg, S., Wright, L., Boston, S., & Zimmerman, G. (2010). Maternal child home visiting program improves nursing practice for screening of woman abuse. *Public Health Nursing*, *27*(4), 347–352. https://doi.org/10.1111/j.1525-1446.2010.00865.x

Webster, F., Bouck, M. S., Wright, B. L., & Dietrich, P. (2006). Nursing the social wound: Public health nurses' experiences of screening for woman abuse. *Canadian Journal of Nursing Research*, *38*(4), 137–153.

Webster, J., Stratigos, S. M., & Grimes, K. M. (2001). Women's responses to screening for domestic violence in a health-care setting. *Midwifery*, *17*, 289–294. https://doi.org/10.1054/midw.2001.0279

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing*, *52*(5), 546–553. https://doi.org/10.1111/j.1365-2648.2005.03621.x

World Health Organisation. (2013a). *Global and regional estimates of violence against women*. World Health Organisation.

World Health Organisation. (2013b). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. World Health Organization.

Wyatt, T., McClelland, M. L., & Spangaro, J. (2019). Readiness of newly licensed associated degree registered nurses to screen for domestic violence. *Nurse Education in Practice*, *35*, 75–82. https://doi.org/10.1016/j.nepr.2018.12.010

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