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What is This?
Mandatory Reporting in the Context of Home Visitation Programs: Intimate Partner Violence and Children’s Exposure to Intimate Partner Violence

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Abstract

The mandatory reporting of intimate partner violence (IPV) is a controversial issue that is receiving increased attention. A related concern is whether children’s exposure to IPV constitutes child maltreatment, making it reportable to child protective services. These issues have been relatively unexplored within the context of home visitation programs. A secondary analysis of qualitative data collected from community stakeholders, clients, and home visiting nurses in the Nurse–Family Partnership program was carried out. Participants’ perceptions about mandatory reporting of IPV and reporting of children’s exposure to IPV are highlighted. Emergent themes and implications for research, practice, and policy are discussed.

Keywords

home visitation, intimate partner violence, mandatory reporting, children’s exposure, qualitative research

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The mandatory reporting of intimate partner violence (IPV) has become a controversial issue among health care practitioners, victims of IPV, and victim advocates (Rodriguez, McLoughlin, Nah, & Campbell, 2001). As children in homes where IPV is perpetrated often experience co-occurring abuse and/or neglect, the controversy surrounding mandatory reporting of IPV is intensified (Smith et al., 2005). Rates of overlap between IPV and child maltreatment fall between 30% and 60% in the general population (Appel & Holden, 1998; Edleson, 1999). Mandatory reporting of child maltreatment is legally mandated in all 50 U.S. states. However, each state provides its own definition of what constitutes maltreatment, describes the circumstances that obligate reporting, and decides which forms of maltreatment should be criminally punishable (Child Welfare Information Gateway, 2007). Consequently, wide variability in specific definitions of child maltreatment exists between states (Appel & Holden, 1998). There is increasing concern that children exposed to the abuse of their mother constitutes a form of psychological abuse at the most basic level (Holt, Buckley, & Whelan, 2008; Smith et al., 2005). Because child maltreatment is reportable in all 50 U.S. states, equating exposure to IPV with child maltreatment would require all suspected or verified instances of IPV in homes where children are present to be reported to child protective service (CPS) agencies.

The limited amount of previous research concerning IPV reporting has focused on the perspectives of IPV victims (Coulter & Chez, 1997; Douglas & Walsh, 2010; Gielen et al., 2000), female patients in clinical settings (Glass, Dearwater, & Campbell, 2001; Houry, Feldhaus, Thorson, & Abbott, 1999; Rodriguez et al., 2001), and the general population (Sachs, Koziol-McLain, Glass, Webster, & Campbell, 2002). However, little attention has been given to the perspective of the mandated reporter. In addition, most previous studies concentrate on mandatory reporting in clinical settings, such as the emergency department. Some groups of mandated reporters, such as public health nurses or social workers, often provide services within clients’ homes through home visitation programs. Home visiting programs have emerged as a primary intervention for improving the health and well-being of pregnant mothers and families with newborns and young children, particularly among disadvantaged populations. These home visiting programs vary considerably in regards to program content, initiation, frequency, and termination of visits, as well as educational and skill level of the home visitor (Olds & Kitzman, 1993).

The Nurse–Family Partnership (NFP) program is an evidence-based home visitation program for young, first-time, disadvantaged mothers that has been rigorously evaluated in three randomized controlled trials (Kitzman et al., 1997; Mercy & Saul, 2009; Olds, Henderson, Chamberlain, & Tatelbaum, 1986; Olds et al., 2004). Most women enrolled in the NFP program are unmarried (84%) and report low income (median annual income = US$13,500; Nurse–Family Partnership, 2009). The risk indicators for client eligibility to enroll in the NFP are similar to indicators associated with abuse exposure (Coker, Smith, McKeown, & King, 2000); thus, clients enrolled in the NFP program may be more likely to experience IPV than women in the general population. In fact, a sample of NFP clients in a study conducted by Eckenrode et al. (2000) reported IPV at a rate twice as high as in the general population.
Home visiting nurses have opportunities to develop trusting relationships with their clients over time, which may facilitate their ability to identify and respond to their clients’ exposure to IPV (Bekemeier, 1995; Evason, 2006; Shepard, Elliott, Falk, & Regal, 1999). Trying to balance clients’ wishes, confidentiality, and privacy with their legal duty as mandated reporters for child maltreatment may pose legal and ethical dilemmas for nurses. This dilemma is especially pertinent to health care professionals involved in home visitation because of the therapeutic relationship that develops between client and home visitor (Evason, 2006; Jack, DiCenso, & Lohfeld, 2002). As a result, when working in homes where IPV or child maltreatment is occurring, home visitors may face challenges that medical professionals in clinical settings do not routinely encounter (Shepard et al., 1999). Just as in clinical settings, awareness of local mandated reporting duties, including reporting IPV and children’s exposure to IPV, is imperative for providers who work in home settings. The perspectives of home visitors are likely to be informative and may highlight some of the risks and benefits of enacting mandatory reporting laws. The NFP program provides an ideal setting to explore this issue. The purpose of this secondary qualitative analysis study was to identify and describe issues related to mandatory reporting within the context of home visitation. This analysis will focus on: (a) the mandatory reporting of IPV between adults, and (b) the mandatory reporting of children’s exposure to IPV.

Method

The present study is a secondary analysis of data collected from NFP clients, nurses, and community stakeholders for the qualitative phase of a larger, 5-year project aimed at developing an intervention for IPV in the context of the NFP program. The sample of NFP sites \((N = 4)\) was purposefully selected from a sampling frame of all NFP sites that: (a) have graduated at least one cohort of NFP clients, (b) have nurses who are home visiting women exposed to IPV, (c) exhibit low levels of nurse attrition, and (d) have a high percentage of nurses who have provided home visitation services for more than two years.

Participants and Procedures

*Interviews with NFP mothers.* At each of the four NFP sites, clients who reported exposure to moderate or severe levels of IPV within the past one year on the abuse assessment administered as part of the NFP program, were 16 years of age or older, and were English-speaking were invited to participate in two face-to-face interviews. Clients were recruited into the study until the point of saturation. A total of 20 women participated in the first interview and 16 returned for a follow-up interview six months later. Participants were given a US$30 gift certificate and were reimbursed for travel and child care expenses for each interview. The mean age of the clients was 21.3 years. The clients were racially diverse—50% were White, 25% Black, and 15% Hispanic—and the majority (90%) reported being single or never married. Twelve of the women (60%) presently had a partner and seven (35%) were pregnant during the first interview. Their mean number of years of school completed was 11.7 and 80% reported a total income less than US$24,000.
**Focus groups with NFP nurses.** NFP nurses who reported home visiting abused NFP clients were invited via email to participate in two focus group interviews. Two 90- to 120-min focus group interviews were conducted at each of the four selected NFP sites ($N = 8$ focus groups), with the same sample of nurses from each site participating in the first and second focus groups. Each focus group was comprised of 4 to 7 NFP nurses to ensure maximum interaction and participation from participants, resulting in 23 nurses attending the first series of focus groups and 25 nurses participating in the second round of focus group interviews. The mean age of the nurses was 46.2 years and 92% held a bachelor’s degree or more education. Their mean number of years of nursing experience was 19.7 ($range = 5-38$ years) and the mean number of years as a nurse home visitor in the NFP program was 4.4 years.

**Interviews with community stakeholders.** Interviews with NFP program stakeholders were conducted to understand community stakeholders’ roles in supporting women exposed to IPV as well as to identify facilitators and barriers these stakeholders face in responding to IPV within the community. Local research assistants at each site, NFP personnel, and study investigators worked to identify relevant key informants in each of the four communities. Ten (45%) community stakeholders were employed in shelter services, six (27%) worked in law enforcement or legal agencies, four (18%) worked in a hospital or in public health services, and two (9%) were involved in education. Stakeholders reported working in their present positions for a mean of 9.2 years. Their mean age was 50.5 years.

The semistructured interview guides focused on facilitating an in-depth analysis of present practices, needs, and challenges associated with identifying and responding to IPV in a home visiting context. Informed consent, parental assent (if the participant was younger than 18 years of age), and permission to record the interviews were obtained from each study participant. This study was approved by the NFP’s Research and Publication Communication Committee, Hamilton Health Sciences/Faculty of Health Sciences Research Ethics Board (McMaster University), and West Virginia University’s Institutional Review Board.

**Secondary Data Analysis**

Data available for secondary analysis included all 87 transcripts from NFP clients, nurses, and community stakeholders as well as field notes and demographic information. Issues related to mandatory reporting emerged in 43 of the transcripts. Thus, the specific type of secondary analysis used in the present study was “retrospective interpretation,” which involves using existing textual data to develop themes that emerged, but were not thoroughly examined by the original research study (Thorne, 1994, p. 266). Audiotapes were transcribed verbatim and all identifying information was removed. NVIVO 8.0 qualitative analysis software was used to facilitate all aspects of data management, searching, coding, and categorization. Conventional content analysis was used to analyze chunks of data relevant to the study objectives. Content analysis is the established means for secondary analysis of textual data (Thorne, 1994) and is often used within a study whose aim is to gather more information on a phenomenon about which theory or research literature is
limited (Hsieh & Shannon, 2005). A thorough reading of all data was followed by preliminary selective coding of data relevant to issues surrounding the mandatory reporting of IPV and the reporting of children’s exposure to IPV. These codes were created to the point of saturation, that is, where no new variation in the data emerged with review of new transcripts. Once all transcripts had been coded, the codes and categories were reviewed and organized into a hierarchical structure resulting in emergent themes (Hsieh & Shannon, 2005). Coding rules were established for each category and after a training session with the second coder, a final set of main categories was agreed upon. Cohen’s kappa statistic was assessed after all transcripts were independently coded by the primary investigator and second coder. Acceptable reliability was indicated by a kappa statistic of .80 to 1.0 (Cohen, 1998). If the kappa was below .80 for any category, the coders met to remedy any discrepancies and disagreements in data organization and coding until a consensus was reached and an acceptable kappa statistic was attained. This process of peer debriefing with the second coder increases the study’s credibility and overall trustworthiness (Lincoln & Guba, 1985).

Results

Mandatory Reporting of IPV and Children’s Exposure to IPV

Although the purpose of the original qualitative study was not to specifically examine mandatory reporting issues, a considerable amount of important information emerged regarding both mandatory reporting of IPV and reporting of children’s exposure to IPV. There was consensus among NFP clients, nurses, and community stakeholders that home visitors are not mandated to report IPV between adults to the police department or adult protective services. One nurse revealed, “We don’t have to report anything that happens to an adult.” However, several community stakeholders, especially those involved in law enforcement, discussed that nurses should use their own professional judgment to decide whether or not to involve the police when they become aware that a client is in an abusive situation. One police officer explained that although home visiting nurses may not have a legal duty to report IPV, they have a “moral mandate” to mitigate the harm caused by IPV.

Among all study participants, less agreement and more confusion emerged with regard to the mandatory reporting of children’s exposure to IPV to CPS (also referred to as Children’s Services, Child Services Bureau, Social Services, or Department of Family and Child Services throughout the interviews and focus groups). Clients expressed awareness of home visiting nurses’ reporting duties involving child abuse, and many thought a disclosure of IPV and children’s exposure to IPV would require the nurse to report to CPS as well. As one client shared:

I tell her [the nurse] about the verbal abuse but I wouldn’t tell her if he hit me or stuff like that, especially if he was doing it in front of the son or the kid because she’s mandatory to go and tell Social Services. She’s mandatory, mandated to report
it, to tell them. . . . I know that and she’d have to and it’d be right because it’s obvi-
ous, you know, you’re endangering the child. He shouldn’t be witnessing that.

This belief was pervasive among nurses and stakeholders as well, as one community
stakeholder said, “If there’s abuse in the home and there’s a child present, then it’s report-
able.” A nurse explained, “See, we’re mandated reporters for the child, not for the mom.
. . . I think if it’s happening in front of the child you are mandated to report it.” Conversely,
there were also participants who were adamant that notifying CPS in such an instance is
unnecessary. One stakeholder involved with both CPS and IPV services explained:

Domestic violence cannot be the reason why children are removed. There needs to
be abuse and neglect identified to the children. . . . Yes domestic violence is a con-
cern but that can’t be the only reason that children are removed because mom is
failing to protect in their eyes because of domestic violence.

For other participants, the disclosure of IPV in the household was perceived to be an
opportunity to dialogue with the client about the impact of IPV exposure on child health
and development and to frame it for the client as a form of child abuse. As one stakeholder
commented:

If they start talking about domestic violence then at that point engage them in the
discussion about, “Well, do you realize that that is a form of child abuse? Not that
I’m going to report you today or anything but I want you to be aware of that.”

**Clients’ Fears of Losing Custody of Children**

Clients’ fears of losing custody of their children while enrolled in the home visitation
program emerged as a major theme throughout this qualitative study. Clients, nurses and
community stakeholders explained that clients are fearful that their abusive relationships
may be reported to CPS and their children will be removed from their home. A client
expressed:

Yeah, because you don’t want Social Services, you know, because they can go and
report you because they’re mandatory and you’re trying your best. If they’re going to
go tell Social Services, you don’t want your kids taken away. You definitely, you know,
if you’re a good mom, you don’t want your son taken away from you or your daughter.

Nurses’ roles as mandated reporters and clients’ fears of losing their children emerged
as major factors in clients not disclosing their personal experiences of IPV to their nurses.
One client said that if mandatory reporting was not an issue, she would tell her nurse every-
thing about the abuse in her relationship. A client’s quote shows how these fears can limit
the disclosure of IPV:
I say, “No” [when my nurse asks me if I am experiencing abuse] because that’s how you play the game. People are afraid of Social Services. They do not want Social Services to come. . . . That’s my biggest fear is Social Services.

In addition to limiting the disclosure of abuse, it appeared that the fear of losing children may also result in clients’ attrition from the home visitation program, ranging from cancelling visits with nurses to stopping the schedule of home visitation altogether. One client spoke of a friend in the program who avoids her nurse:

Like I was saying about my friend, the reason she don’t [disclose abuse to her nurse] is because she thinks that the nurse is going to call Children Services into the whole situation. And so some people might be scared of that. And my friend she just don’t want Children Services to get involved with her . . . so she, yeah, she avoids her nurse a lot.

One nurse revealed that she was aware of clients’ fears of losing custody of their children and how this fear impacted the nurse–client relationship:

And it’s not that I want to report. It’s not like because I’m out there to try to get them, but then I lose that lack of trust and respect with my clients also. . . . I had relatives wanting to basically kick me out of the home because they saw me as being a spy there for Children Services whose one task in life is to take their child away.

Participants thought help-seeking behavior was limited by abused clients’ fears of losing their children. One nurse discussed that although reporting children’s witnessing of IPV is meant to benefit women, it can actually prevent them from calling for help when they are in danger:

We now have the thing where the police are calling Children’s Services. Well that prevents the mom from calling the police now because now she becomes the victim twice— “Not only have I been hit, now you might take my children because he hit me.” And so it’s something that looked like it was going to work goes in the other direction. . . . It helps mothers get empowered but it also makes mothers not call for help.

Experiences With Child Protective Services

Another major theme that emerged was the fear and mistrust associated with CPS due to the agency’s role in removing children from homes. Many participants indicated that distrust of CPS is common among abused women. Conversations involving clients’ fears of CPS and losing their children often led to debates about the legitimacy of such fears. An IPV victim advocate expressed that fears of losing custody are pervasive among abused women and are often legitimate:
One of the most frequent things you hear is that they will lose custody of their children or that Children Services will become involved and jeopardize their custody. It can be [a legitimate fear], especially if they [Children’s Services] find out that there’s a batterer that’s living in their home.

The qualitative data establish the legitimacy of abused women’s fears of losing custody of their children, as nurses and stakeholders described circumstances in which clients have been involved with CPS and accused of “failure to protect” their children by staying in abusive relationships. One nurse said:

If you’re going through domestic abuse and you get yourself out of that situation, Children Services is less likely to take that child from you. Unfortunately, many people do know somebody who’s had a child taken away from them by Children Services . . . and the clients we deal with, I guarantee you they know at least two or three people have lost their children . . . . You know how are you going to get back that trust? You can’t.

Several community stakeholders involved with CPS and IPV services discussed situations where women they knew have been accused of failing to protect their children and have been subsequently threatened with the loss of their child, as can be seen in the following comment by a community stakeholder:

What has happened, and I’ve heard from Department of Child and Family Services (DCFS), is that if she returns from shelter to that abusive situation she’s putting her children in danger and DCFS may intervene and accuse her of endangering her children by returning to an abusive partner. And unfortunately I’ve seen that happen.

**Strategies Nurses Can Use to Ease Clients’ Fears**

Although clients’ fears of mandated reporting and losing their children seem to act as barriers within the home visitation program, especially with regard to establishing trust between nurse and client and the disclosure of abuse, participants suggested different strategies home visiting nurses can employ within the program to reduce clients’ fears. Clients, nurses, and stakeholders all mentioned the importance of reassuring the client that the purpose of home visits is to support the mother in developing skills to effectively parent. Participants agreed that to increase clients’ trust and comfort level with their home visitors, nurses are recommended to emphasize that they are nonjudgmental and that their goal is not to take charge of the clients’ lives or tell them what to do. Nurses stressed the importance of asking the client what she wanted to do after a disclosure of IPV was made. The following comment shows one client’s suggestions:

Another thing that makes me feel comfortable about her is the fact that none of that information will get out to other people that can possibly, you know, try to take
charge of your life and you know try to take your kid from you . . . that’s one of the first things they should just suggest—no information gets out . . . and to state they’re not judgmental.

Stressing the strict confidentiality between client and nurse was another tactic mentioned to help clients feel at ease within home visitation programs. In addition, participants expressed that making clients aware of the nurses’ duties as mandated reporters at the first home visit was very important. One client stated, “Make sure that they [nurses] do not make them [clients] feel like Social Services is going to come. Put them at ease right away.” However, it was discussed that if a nurse does need to contact CPS, they should notify the client prior to making the report so that the nurse and client can make the call together. One nurse stated, “I always tell mine I’m not going to go behind their back and turn them in even if I do see something. . . . I would tell them we’re going to go call this in now.”

Another tactic mentioned to help reduce clients’ fears of mandated reporting and child removal was for nurses to provide education about CPS and other services that abused women might access. The importance of educating clients that CPS can be used as a positive resource and that their mission is not to remove children from the home was emphasized. One stakeholder involved with CPS and IPV services mentioned:

There’s already a lot of anxiety if you know talk about Children Services. . . . Hopefully [CPS] could be seen as more of a positive support for this mom and the children. . . . One thing is just to educate and talk to moms about what role Children Services can play, and seeing it more as a positive not just a negative experience. . . . Educate that, you know, Children Services is here to help, Children’s Services isn’t here to remove your kids.

Nursing Skills and Knowledge Required for Effective Reporting

To support women experiencing IPV while also fulfilling their legal duties as mandated reporters, nurses stated that they need state-specific, up-to-date, detailed information about mandated reporting policies and procedures. One nurse suggested:

I think you need to have in your literature about mandated reporting because, as nurses, we are mandated reporters and we need to know, again, with that role it needs to be spelled out very clearly because in a court of law that’s what would be thrown at us, if we have fulfilled our responsibilities in what way.

Nurses were correct in their assumptions that they did not have to report the abuse of an adult woman, as the focus groups were conducted in states where reporting of IPV by health care providers is not mandated. Furthermore, children’s exposure to IPV is also not considered a form of child maltreatment in these states, yet nurses were uncertain of their reporting duties for children exposed to abuse. Nurses wanted to know what constitutes
children’s exposure to IPV and under what circumstances it should be reported to CPS. One nurse raised the following question:

And if you know that it is violent and the baby’s there, how far do you go or how do you . . . let this to go if you know that baby can get in the middle of it or . . . they tell you that he hit her but she didn’t call the police. So then we come, what do we do with that? Do we let it go? Or do we . . . are we supposed to report if he hit her?

Another nurse commented:

For instance, the father hit the mom in the mouth with the baby in her arms, or he choked her with the baby in her arms. Is that abuse to the baby? I mean that’s a call that I have to make. You know, was he threatening that child? So you know as a healthcare provider I may be obligated to report that.

**Discussion**

The results of this secondary analysis of qualitative data indicate that issues surrounding mandatory reporting of IPV between adults and mandatory reporting of children’s exposure to IPV in the context of home visitation are salient and warrant further investigation. Previous research on these two issues has focused on reporting in clinical settings (Glass et al., 2001; Houry et al., 1999; Rodriguez et al., 2001), but the results of this study show that these mandated reporting issues transcend clinical care and have significant consequences for abused women and health care professionals in other settings. Although most participants did not endorse IPV reporting to police or adult protective services, knowledge, attitudes, and opinions differed with regard to reporting children’s exposure to IPV to CPS. As home visiting nurses are mandated reporters of child abuse, it is crucial that they are aware of the specific circumstances that constitute child maltreatment and those that do not. The qualitative data indicate that many nurses are not confident in their knowledge of this distinction. Some participants in the present study equated children’s exposure to, or witnessing of, IPV to child maltreatment, whereas others clearly stated that IPV cannot be the sole reason to call CPS or remove children from homes. It became apparent that mandatory reporting policies and procedures regarding children’s exposure to IPV were not the same at each NFP site, as clients, nurses and community stakeholders as a whole were not entirely in agreement about which instances nurses should report to CPS. The lack of consensus is not surprising; the delineation between children’s exposure to IPV and child maltreatment has often been referred to as a complex and complicated grey area in research on this topic (Verhoek-Oftedahl & Devine, 2003).

Several themes that emerged in this study have been documented in other qualitative studies examining abused women’s perspectives on mandated reporting. Abused women’s fears of losing custody of their children have previously been established as barriers to service delivery and help-seeking behaviors (DeVoe & Smith, 2003; Sullivan & Hagen, 2005). Other studies have documented abused women’s fears of police or CPS involvement...
as barriers to seeking acute care and/or disclosing abuse in clinical settings (Gielen et al., 2000; Sachs et al., 2002). Our study shows abused women’s reluctance to fully engage in a home visitation program (e.g., cancellation of visits) and disclose abuse to home visiting nurses. Thus, it may be that any interaction with an individual who is perceived to be a mandated reporter, and not the particular setting (e.g., emergency department, clinic, client’s home), that elicits apprehension.

The theme Experiences with CPS clarifies whether or not the fears that women hold about losing their children are realistic or legitimate. The data show that not only are these fears prevalent among the abused clients in our study, but they are indeed justified. Nurses and stakeholders shared real-life experiences about the ways in which abused women have been accused of failing to protect their children and how CPS has threatened women with the loss of their children if they do not leave their batterers. Douglas and Walsh (2010) conducted focus groups with community workers who support mothers to gain insight into the workers’ perceptions of how CPS responds when mothers experience IPV. As in our study, the community workers claimed that CPS has often presented abused women with ultimatums about leaving their batterers or losing their children. Based on their experiences supporting abused women and navigating CPS systems, the community workers concluded that abused women’s fears of CPS are indeed reasonable. In addition, Sullivan and Hagen (2005) used a qualitative framework to examine abused women’s experiences with mandatory reporting and state that participants’ fears of CPS involvement are “not an idle threat but a stark reality” (p. 354). English, Edleson, and Herrick (2005) add that there is evidence that these fears can be accurate, citing a lawsuit against New York City’s CPS agencies for unconstitutionally removing children from homes solely because their mothers were victims of IPV (see Jackson, 2005). Although a CPS referral alone is very unlikely to lead to the removal of children from the home (English, Edleson, & Herrick, 2005), it is important to note that mere contact with CPS opens up the possibility of child removal and this is surely a legitimate fear for abused women.

Addressing NFP clients’ fears of losing their children and mistrust of CPS is critical, as these fears have the potential to negatively impact the nurse–client relationship and the mission and goals of home visitation programs. The present study indicates that nurses’ duties as mandated reporters coupled with clients’ fears of losing their children can hinder the nurse–client relationship. Fortunately, the study participants offered myriad suggestions and tactics that NFP nurses can use with clients to reduce fears of mandated reporting, removal of children, and other CPS-related issues. However, before home visiting nurses can demystify any stigma or mistrust associated with CPS for their clients, they must receive training and education on issues regarding mandatory reporting and CPS referrals themselves. Nurses need state-specific guidelines about mandatory reporting of IPV and children’s exposure to IPV as well as detailed information about which circumstances require a CPS report and which do not. Therefore, it would be beneficial if individuals working within law enforcement, CPS, and IPV shelters could play an active role in training home visiting nurses on their duties as mandated reporters and system navigation.

Participants mentioned initiatives where local service agencies have worked with the NFP
program to reduce confusion and improve the relationship between CPS and IPV services, demonstrating that this important collaboration has already begun at several NFP sites.

**Strengths and Limitations**

These findings should be viewed with regard to the study’s strengths and weaknesses. According to Thorne (1994), the fit between the original data and new research question posed by the secondary analyst is critical when determining the appropriateness of secondary analysis. Because one aim of the original study was to explore NFP nurses’ responses to IPV within the context of home visitation, and mandatory reporting was frequently mentioned as a response to disclosure of IPV, the data from the original study provided an appropriate and rich data source that was ideally suited for secondary analysis (Szabo & Strang, 1997). Furthermore, the use of multiple data sources (i.e., NFP clients, nurses, and community stakeholders) from multiple sites allows for data triangulation, which aids in ensuring that a complete and credible understanding of the issues surrounding mandatory reporting in home visitation has been obtained, strengthening the accuracy of research findings and increasing the study’s confirmability (White & March, 2006). Furthermore, the detailed description of the original research methods, participants, and analysis process and rich description of the results of the present analysis address the present study’s transferability from one context to another (Lincoln & Guba, 1985; White & Marsh, 2006).

There are limitations to the present study. Because this study is a secondary analysis of qualitative data, the data reflect the perspectives and research questions proposed by the original study. The purpose of the original study was not to specifically examine mandatory reporting of IPV or reporting of children’s exposure to IPV to CPS, and thus conducting a secondary analysis of these data precluded our ability to gather additional information on our topic of interest. Therefore, an important limitation of the present study that is inherent to secondary data analysis is that further sampling and probing techniques could not be used and the emergent themes examined by this secondary analysis may not have achieved adequate saturation (Szabo & Strang, 1997).

**Implications for Research, Practice, and Policy**

The present study has important implications for future research as well as practice and policy. This study shows that issues related to mandated reporting of IPV and mandated reporting of children’s exposure to IPV to CPS are not limited to clinical care settings. Further research should be conducted with the specific purpose of examining these mandatory reporting issues in the context of home visitation, as the present study indicates that health care professionals involved in home visitation are not unaffected by the issues related to mandated reporting in these two controversial instances. Future research must be carried out on a larger scale to determine if the emergent themes found in this study apply to nurse home visitors at other NFP sites or in other home visitation programs. Furthermore, several participants in the present study recommended that home visitors use their own judgment with regard to IPV reporting. One police officer stated that home
visiting nurses have a “moral mandate” to report IPV regardless of state laws. Although prior research has examined the perspectives of mandated reporters in clinical settings (e.g., Sachs et al., 2002), little is known about home visitation providers’ attitudes toward mandatory reporting of IPV or children’s exposure to IPV. Future research capturing home visitors’ opinions toward mandatory reporting in these instances in conjunction with their knowledge of reporting policies is needed to fill the present gap in the literature.

At the practice level, this study has implications for the ways in which home visiting nurses and other service agencies interact with women in abusive relationships. Mandated reporting duties of health care professionals in conjunction with the mistrust of CPS and service agencies in general can negatively affect the relationship between abused women and those who can offer help, leading women in need of the most care to avoid seeking help. The present study offers suggestions for enhancing the nurse–client relationship, including reassurance and education early in the visitation schedule, to reduce fears that abused women in home visitation programs might face. Ideally, easing clients’ fears and strengthening the therapeutic relationship between nurse home visitor and client will lead to more disclosures of IPV and more opportunities for women and children exposed to IPV to receive help.

Last, this comprehensive examination of clients, nurses, and community stakeholders at several home visitation sites illustrates that despite the presence or absence of IPV and children’s exposure to IPV reporting laws in each state, the public perception of these policies has a significant impact on home visitation practice. Thus, when policies related to mandatory reporting of adult IPV or children’s exposure to IPV are implemented, it is important to consider the impact these policies will have on patients and health care professionals outside of clinical settings. Policymakers should specify reporting duties for health care professionals that routinely interact with patients, but do not necessarily provide clinical treatment, such as social workers and home visitation providers. Furthermore, those individuals involved in creating mandatory reporting policies should be aware of the impact that these laws have on the disclosure of abuse and help-seeking behavior for victims of IPV.

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