



Sustainability of identification and response to domestic violence in antenatal care

(The SUSTAIN study)

KELSEY HEGARTY | JO SPANGARO | JANE KOZIOL-McLAIN
JEANNETTE WALSH | AMELIA LEE | MINERVA KYEI-ONANJIRI
ROBYN MATTHEWS | JODIE VALPIED | JENNY CHAPMAN
LEESA HOOKER | ELIZABETH McLINDON | KITTY NOVY | KIM SPURWAY

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Acknowledgement of Country

ANROWS acknowledges the Traditional Owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and future, and we value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We are committed to standing and working with Aboriginal and Torres Strait Islander peoples, honouring the truths set out in the Warawarni-gu Guma Statement.

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PROFESSOR KELSEY HEGARTY

Professor of Family Violence Prevention Research, University of Melbourne and Royal Women's Hospital

PROFESSOR JO SPANGARO

Professor of Social Work, University of Wollongong

PROFESSOR JANE KOZIOL-McLAIN

Professor of Nursing, Auckland University of Technology

JEANNETTE WALSH

Research Associate, University of New South Wales

DR AMELIA LEE

Research Fellow, University of Melbourne and Royal Women's Hospital

DR MINERVA KYEI-ONANJIRI

Research Fellow, University of Melbourne and Royal Women's Hospital

ROBYN MATTHEWS

Research Midwife, Midwifery and Maternity Services Research Unit, Royal Women's Hospital

DR JODIE VALPIED

Research Fellow, University of Melbourne

JENNY CHAPMAN

Project Manager Strengthening Hospital Responses to Family Violence, Royal Women's Hospital

DR LEESA HOOKER

Nurse/Midwife Academic and Research Fellow, Judith Lumley Centre, La Trobe University

ELIZABETH McLINDON

Research Officer, University of Melbourne and Royal Women's Hospital

KITTY NOVY

Administrative Officer, University of Melbourne and Royal Women's Hospital

DR KIM SPURWAY

Lecturer, University of New South Wales

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The University of Melbourne
Parkville, Victoria, 3010

University of New South Wales
Sydney, NSW, 2052

The Royal Women's Hospital
20 Flemington Road, Parkville, Victoria, 3052

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ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include: 1800 RESPECT - 1800 737 732 and Lifeline - 13 11 14.

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Definition of terms

Domestic violence (DV) or intimate partner violence (IPV)	The World Health Organization (WHO) defines IPV as “behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours” (World Health Organization, 2013b, p. vii). This definition covers violence by current and former spouses and other intimate partners. Other terms include wife or spouse abuse and wife/spouse battering. Dating violence usually refers to intimate relationships among young people, which may be of varying duration and intensity, and do not involve cohabiting (World Health Organization, 2013b).
Family violence	Violence and abuse perpetrated by an intimate partner as well as occurring between family members, such as between siblings or across generations (Australian Institute of Health and Welfare, 2018).
Holistic assessment	Care that is characterised by focusing on the whole person, considering the context of the person’s unique circumstances. “A holistic approach acknowledges and addresses the physiological, psychological, sociological, developmental, spiritual and cultural needs of the patient.” (Wallace, 2013, p. 24)
Woman-centred care	Care that is focused on the woman’s unique individual needs, expectations and aspirations, rather than the needs of the profession or institution (Leap, 2009).
Family-centred care	Healthcare that “fosters family unity through sensitivity and responsiveness to the beliefs, values, and customs that are specific to each mother’s culture, ethnic group, and/or religion” (Zwelling & Phillips, 2001, p. 5).

Acronyms

AAS	Abuse Assessment Screen
A&TSI	Aboriginal and/or Torres Strait Islander
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisations
AIHW	Australian Institute of Health and Welfare
ANROWS	Australia's National Research Organisation for Women's Safety
BMI	Body mass index
BOS	Birth Outcomes System
CAS	Composite Abuse Scale
CALD	Culturally and linguistically diverse
CISS	Child Information Sharing Scheme
DV	Domestic violence
DOVE	Domestic Violence Enhanced Home Visitation Program
FACS	Family and Community Services
FVISS	Family Violence Information Sharing Scheme
HARK	Humiliation, Afraid, Rape and Kick
HITS	Hurts, Insults, Threaten, Scream
IPV	Intimate partner violence
IRSD	Index of Relative Socio-economic Disadvantage
ISA	Index of Spouse Abuse
LGA	Local government area
LIVES	Listen, Inquire about needs, Validate, Enhance safety, ensure Support

- MARAM** Multi-Agency Risk Assessment and Management Framework
- NSW** New South Wales
- PRISMA** Preferred Reporting Items for Systematic Reviews and Meta-Analyses
- PVS** Partner violence screen
- RCT** Randomised controlled trial
- RWH** The Royal Women's Hospital
- SEIFA** Socio-economic indexes for areas
- SUSTAIN** Sustainability of Identification and Response to Domestic Violence in Antenatal Care
- VIC** Victoria
- VIP** Violence intervention program
- WAST** Woman abuse screening tool
- WITH** Women's Input into a Trauma-informed systems model of care in Health settings
- WHO** World Health Organization

Executive Summary

Background

One in six (1.6 million) Australian women have experienced physical or sexual violence by a current or former partner since the age of 15 years (Australian Bureau of Statistics, 2017). Domestic violence (DV) damages the mental and physical health of individual women, men, young people and children (World Health Organization, 2013a) and is a leading contributor to death and disability for women of child-bearing age (Ayre, Lum On, Webster, Gourley, & Moon, 2016). A significant number of women experience DV during pregnancy, and for one quarter of women who experience DV, the violence commences during this time (Australian Bureau of Statistics, 2017). Pregnancy is an opportune time for early intervention for women and their families to receive support, risk assessment and safety planning, due to the frequent ongoing contact with health services (Campo, 2015; World Health Organization, 2013b).

Early engagement in health systems is urgently needed, and sustainability of identification and first-line response is imperative to effectively address DV (Garcia-Moreno et al., 2014). Our literature review focused on current evidence for screening and responses for DV in pregnancy, and on which supports are required for sustainable and effective screening and response. The review found that for optimal antenatal screening, tools and responses need to address varied types of abuse and be well tested and validated for relevance across populations and contexts. In addition, system audits need to be undertaken to enable a deep understanding of the whole system that supports screening and first-line response in antenatal care. The Sustainability of Identification and Response to Domestic Violence in Antenatal Care (SUSTAIN) study has an opportunity to further inform the DV field and influence the current policy direction locally and nationally.

The aim of the SUSTAIN study was to support the integration of evidence-based screening, risk assessment and first-line responses to DV into the complex system of antenatal care. The study focused on women attending health services for pregnancy who may or may not have ever discussed DV with a health worker or accessed specialist DV services. The main research questions of the SUSTAIN study were:

1. How can we integrate and sustain screening, risk assessment and first-line responses to DV effectively into the complex health system of antenatal care?
2. How can we overcome the specific challenges for health systems in regional and rural settings with low resources?

Method

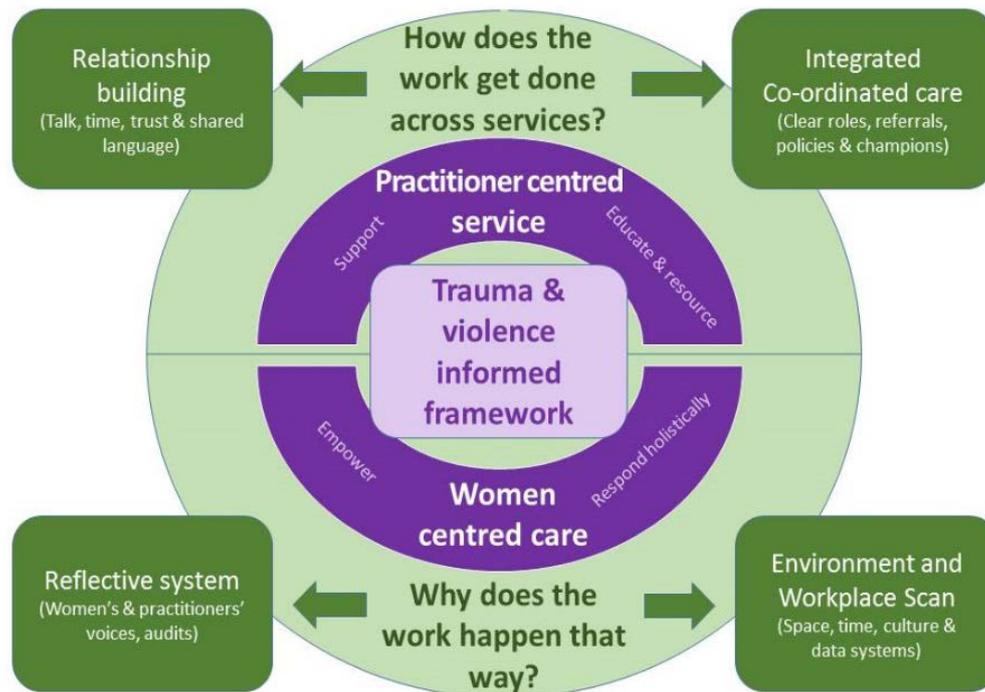
We explored the complex area of addressing DV in antenatal care from multiple perspectives using an existing Health Systems Implementation Model framework from the Women's Input into a Trauma-informed systems model of care in Health settings (WITH) study (Hegarty, Tarzia, Fooks, & Rees, 2017) (see Figure 1).

A case study approach (Stake, 2005), across six hospital antenatal clinics in Victoria and New South Wales (NSW), allowed us to examine system barriers and facilitators for implementing and sustaining DV screening and responses.

The case study involved:

- examining workplaces: collecting hospital antenatal clinic context data and auditing readiness to respond to DV (World Health Organization, 2017)
- listening to women's voices: surveying 1219 women at two Victorian sites, supplemented by interviewing five women at two NSW sites to provide insight into the complexity of the pathways to disclosure and safety
- listening to practitioners' voices: conducting 12 focus groups and eight interviews with 91 antenatal staff members at six hospitals
- data synthesis: convening two in-depth researcher workshops to synthesise data across methods and study sites and propose a new transformation model for implementing sustainable DV screening and response in antenatal care.

Figure 1 WITH Health System Implementation Model



Key findings

Workplace context and readiness

The SUSTAIN study was implemented across a total of six publicly funded health services hospitals: three in NSW (sites N1, N2 and N3) and three in Victoria (sites V4, V5 and V6). The sites were equally distributed between regional and rural (sites N3 in NSW and V5 and V6 in Victoria) and urban hospitals (sites N1 and N2 in NSW and V4 in Victoria). All of the hospitals have designated service areas including surrounding suburbs or towns with “catchment” populations. The six hospital sites varied greatly in terms of size; number of births; socio-economic status; cultural catchment population areas; and whether they were located in urban, regional or rural settings. Five study sites fell within the bottom 40 percent of disadvantaged areas. Regional and rural sites had high populations of Aboriginal and Torres Strait Islander peoples, while urban sites had a high percentage of people born overseas.

Using a World Health Organization (WHO) checklist,¹ all sites demonstrated a readiness to respond to DV. The checklist, intended for use in countries with less developed health services, addressed responsiveness at a broad level without specific measurement notes or the ability to identify

“partial” achievement. The positive results across sites indicated that considerable planning and service reform had been undertaken, whether or not screening had yet to be formally introduced.

Women’s voices

The survey of over 1000 women (1219/1711; response rate 71%) at two Victorian sites showed:²

- DV is prevalent among pregnant women in our antenatal services.
 - Ninety-nine participants (8.3%) had experienced DV in the 12 months preceding the survey based on the “yes/no” screening items. Types of behaviours experienced included fear of partner/ex-partner (5.6%, n = 67), controlling behaviour (4.7%, n = 56), threatening behaviour (1.7%, n = 20), and being slapped/kicked/hurt (1.2%, n = 14).
 - Additional participants (n = 71) screened positive on the frequency screening items or the Composite Abuse Scale (CAS),³ to bring the overall total of women experiencing DV to 14.2 percent (n = 170).

1 This checklist was developed for the WHO Strengthening Health Systems Manual.

2 Denominators vary in the figures shown below, as women may not have answered all questions.

3 Composite Abuse Scale is a validated measure of physical, emotional and sexual abuse.

- DV experience is typically not known by health providers, but some women are open to getting help.
 - Only 26 percent (15/57) of participants who had been fearful of a partner had ever talked to a doctor or midwife about it. A proportion of all respondents (16%, 192/1190) stated they would consider using help from a doctor or midwife for this issue.
- Women are okay to be asked about DV, whether they have experienced abuse or not.
 - Only a small minority of women (4%, n = 40) thought health providers should not ask about DV. Most thought it should be asked about, with around half of the women (n = 543) responding that it should be asked about at every visit, one third (n = 392) at some visits and 14 percent (n = 157) at the first visit only.
 - About 13 percent (161/1215) of women thought that health professionals were there only for pregnancy care. However, there were differences between abused and non-abused categories. Nearly one quarter of women (24%) who indicated they had experienced abuse thought the midwife or doctor was only there for pregnancy care, while only about 12 percent of non-abused participants held this belief.
 - Twenty percent of abused participants thought the doctor was often busy and did not have time to listen, while only 10 percent of non-abused participants held this belief. Although only a small percentage of participants thought this about midwives (4 percent of participants overall), this issue was more common among abused participants than non-abused women.
- Rates of asking about DV varied across states and referral rates varied across hospitals.
 - At Victorian study sites, 41 percent (483/1180) of participants were asked about their own safety (prior to screening being introduced) and 17 percent (103/593) of women with children aged under 18 years were asked about the safety of their children.
 - At NSW study sites (where routine DV screening in maternity services has been in practice for about a decade), a 12-month clinical audit for the period 1 July 2017 to 30 June 2018, carried out as part of this study, showed that screening rates ranged from 82.4 percent to 98.9 percent.
 - From the survey, Victorian midwives tended to make enquiries about relationship and safety issues more often than other categories of health professionals, who tended to see women less frequently. Both doctors and midwives were seen as supportive; however, participants expressed that midwives asked more questions that helped them to talk about emotional and social problems.
 - At the larger Victorian urban site, 40 percent (12/30) of women who had experienced abuse were referred to other hospital services; at the regional site, 25 percent (1/4) were referred to social work. In the NSW clinical audit, referral rates varied from 40 percent to 82.4 percent to multidisciplinary case discussions (Safe Start) across hospitals and from 41 percent to 47 percent to social work.

Practitioners' voices

Twelve focus groups and eight interviews were conducted with midwives, doctors and social workers at the six sites, with a total of 91 health professionals involved. Analysis was organised according to three questions, and the WITH Health System Implementation Model, as below.

What does woman-centred care look like for women who have experienced domestic violence?

Health practitioners at all sites valued woman-centred care. Four main themes that emerged are shown in Figure 2. These included asking directly; seeing all of the woman; asking alone, for privacy, and after a relationship might have developed over time; and responding holistically, supporting choice and agency.

What do health practitioners need to provide woman-centred care for domestic violence survivors?

Health practitioners identified four support needs to provide care (Figure 3). Consensus existed across practitioners that the role of screening best fitted with midwives who have an initial role in risk assessment and management, and that

Figure 2 Themes identified for woman-centred care



Figure 3 Themes identified for health practitioners supporting women



Figure 4 Themes identified for health system supporting health practitioners

social workers are best placed to provide a comprehensive response. Participants valued having an immediate onsite social work response. However, this may be challenging in rural areas with staffing shortages, where social workers may not often be readily available.

What does the health system need to provide support to health practitioners to work with women experiencing domestic violence?

The workplace needs to provide structural support to enable practitioners to respond to women. Practitioners identified seven health system facilitators (Figure 4). A focus on providing bilingual responsiveness supports working with women from diverse cultural and language backgrounds.

Rural challenges

Rural sites identified complexity in managing confidentiality and privacy for women where health practitioners' and women's lives are intertwined. Further responses are challenging in rural areas with staffing shortages, where social workers may often not be readily available. Some of the specific challenges for implementing a DV health systems change model in a rural setting may include recruiting facilitators, access to health practitioners, absence of DV services in the community and safety from perpetrators who may also be known to the practitioners. Further, lack of resources was heightened in rural areas, in particular accommodation

for women leaving violence, exacerbated by long distances, isolation and women's lack of access to transport. On the positive side, relationship building across teams in rural areas is often easier because of the existing connections in rural communities.

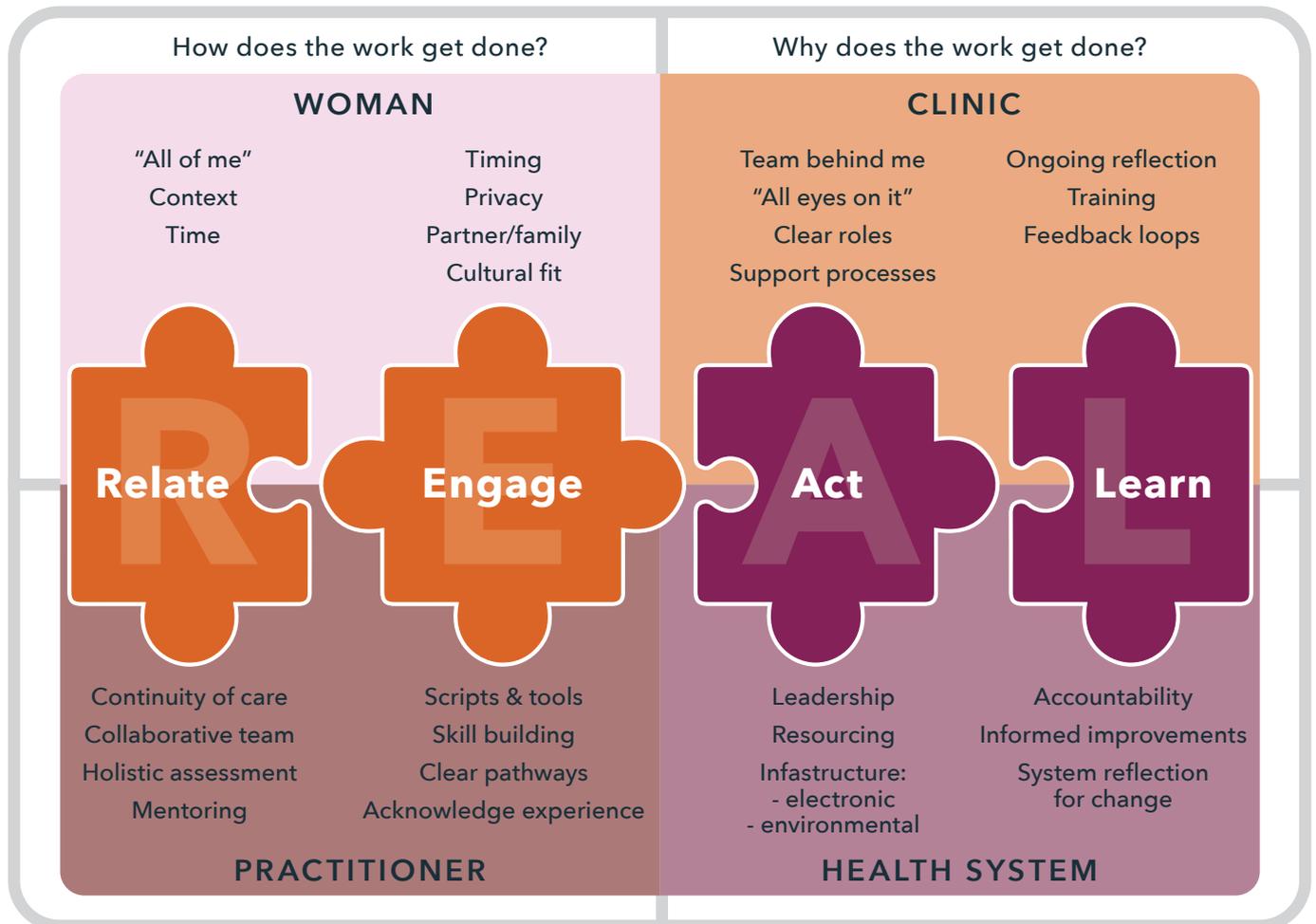
Data synthesis

The above findings were synthesised at two researcher workshops undertaken in March and May 2019, drawing on our literature review and the WITH Health System Implementation Model. Similar to this model (Hegarty, Tarzia, Rees, et al., 2016) we analysed how the work gets done and why it happens that way (May et al., 2007). This work resulted in the REAL Transformation Model (see Figure 5). The "how" pertains to characteristics of the *relationship* between women and their practitioners, and important elements that facilitate effective *engagement* of a woman. The "why" concerns practical *actions* required to be in place within the clinic and health system, as well as activities related to *learning* to enable reflection on practice and systems to build practitioners' knowledge and skills and strengthen existing systems.

We identified essential elements pertaining to four different levels of the system: the woman, the practitioners, the clinic and the health system. Overall, seven key subthemes were important to women with regards to how practitioners *relate* and *engage* with them. These included "all of me" (referring

Figure 5 The “REAL” Transformation Model: Sustainability of identification and responses to domestic violence in antenatal care

Sustainability of Identification and Response to Domestic Violence in Antenatal Care



to holistic care), *context* (consideration of women’s particular circumstances), *time* (making adequate time for care processes), *timing* (appropriate timing for identification and responses to DV), *privacy*, *partner/family involvement in care* (if safe to do so), and *cultural fit* (including provision of bilingual services). To facilitate their relationship and engagement with women, practitioners valued *continuity of care*, having a *collaborative team*, *holistic assessment*, *mentoring*, having *scripts and tools*, *skill building*, having *clear pathways* to guide clinical decisions, and *acknowledgement of their various experiences*.

At the clinic level, seven subthemes emerged to support the two overarching themes of *act* and *learn*. These were having a supportive team; “*all eyes on it*” (involvement of all professional groups in DV identification and response); and having *clear roles*, *support processes*, *ongoing reflection*,

training and *feedback loops* to improve practice. To have well equipped health systems to facilitate identification and responses to DV, *strong leadership* to support work in this area, *adequate resourcing*, *provision of infrastructure* (electronic and environmental), *accountability*, *informed improvements* and a *system reflection for change* were valued as key factors.

Implications for practice, policy and research

Implications for practice

Our task is to fulfil women’s expectations that antenatal health care provides holistic, tailored care; adequate time; and an environment conducive to relationship building and engagement. Practices such as consistent, women-only consultation time and ongoing contact with practitioners (continuity of care) are examples that facilitate woman-

centred care. Procedures for screening need to attend to timing of asking questions and building rapport with women. This focus on woman-centred care should be balanced with providing family-centred care catering to children as well as partners who may be using violence. To facilitate DV screening and response, health practitioners require a supportive workplace. Ongoing training, peer support, case discussions, team approaches and clear roles are measures that will build capability and confidence. Implementation plans need to focus on multiple health professions, as women felt both midwives and doctors were supportive, and women may disclose to a subsequent practitioner they see. Thus, there is a need for continuity of care models in antenatal care.

Implications for policy

Simply mandating screening will not produce the desired outcomes. High screening rates at NSW sites 'where a systematic screening is established', compared to lower rates at Victorian sites 'where this is only now to occur' point to the need for a comprehensive system approach. Standardised tools are required that incorporate screening and risk assessment questions, guide interpretation and referral pathways, and provide tailored information for women. Electronic record systems, bilingual workers and trained interpreters can facilitate the reach of safe implementation of tools at designated times, as well as team communication. Clinics may also require onsite social work response capacity to support practitioners; however, this may be difficult in rural areas. Finally, a means to evaluate program accountability and improvement over time to ensure value for money is paramount in any policy implementation plan. Systems to ensure ongoing and updated data collection in an area that requires further attention and resourcing across states. There is a need for sector-wide consultation to determine the best approach for such tools and the best way to support achievement of standards across systems and services.

Implications for research

Our proposed model requires testing in practice. We suggest this work be done in collaboration with women, practitioners and workplaces. Ongoing research needs to be undertaken utilising the REAL Transformation Model to evaluate whether paying attention to the factors in the model increases

sustainability of screening and response to DV in antenatal care. In testing the model in practice, there is currently no validated tool evaluating infrastructure or outcomes suited to antenatal care settings. Standardised system audit tools sensitive to improvements would support feedback loops and monitoring infrastructure, accountability, and performance.

Conclusion

We have listened to the voices of women and practitioners, examined workplace contexts and appraised the literature addressing DV screening and response in the antenatal setting. In doing so, we now have a greater understanding of how and why DV screening and response varies across health locations. Although there will always be uncertainty in practice, we propose the REAL model as a relationship-based, sustainable model to guide ongoing learning and improvement in meeting the health and safety and recovery needs of women who are experiencing DV, as well as their children and families.

Introduction

The aim of this study was to understand and support the integration of evidence-based and effective screening, risk assessment and first-line responses to DV into the complex system of antenatal care. Building on existing resources and research, the study focused on women attending health services for pregnancy, who often are at low risk of DV or in an ongoing relationship with perpetrators, and often not in contact with DV services. The main research questions of the SUSTAIN study were:

1. How can we integrate and sustain screening, risk assessment and first-line responses to DV effectively into the complex health system of antenatal care?
2. How can we overcome the specific challenges for health systems in regional and rural settings with low resources?

The specific objectives of this study were to

- a. explore how women attending antenatal care perceive the nature and timing of screening questions and risk assessment about DV, including the most effective and acceptable wording of screening questions
- b. understand the factors encouraging disclosure and acceptance of referrals from a system perspective
- c. understand how practitioners working in antenatal care perceive the process of screening, risk assessment and responses for DV
- d. understand the barriers and facilitators to introduction and sustainability of screening and first-line responses in antenatal care.

The problem

Background

A significant number of women experience DV during pregnancy, and for one quarter of women, DV commences during this time (Australian Institute of Health and Welfare, 2015). Pregnancy is an opportune time for early intervention for women to receive support, including risk assessment and safety planning for DV, due to the frequent ongoing contact with health services (Campo, 2015; World Health Organization, 2013b). The prevalence of current DV among pregnant women ranges from 3–9 percent, increasing to 16–25 percent when

prior DV is included (O'Reilly, Beale, & Gillies, 2010). For one third of women experiencing DV, pregnancy is a time when violence commences or may escalate (Australian Bureau of Statistics, 2013). Most pregnant women, whether at low or high risk of DV, are still in relationships with the perpetrator, often having no contact with DV services. Although women want to be asked, experiences of DV are identified for only a minority of women in antenatal care (O'Doherty et al., 2015). This gap in identification of DV has led to recommendations for screening and first-line responses (including risk assessment) in antenatal care (O'Doherty et al., 2015; World Health Organization, 2013b). Health practitioners are crucial to this early intervention work (Garcia-Moreno et al., 2014) given the isolation women can experience with DV, particularly in rural areas, and the adverse effects on pregnancy outcomes (e.g. miscarriage, pre-term labour) from DV (World Health Organization, 2013a).

Australian context

A 2015 review by the Australian Institute of Health and Welfare (AIHW) showed that the majority of Australian states and territories do not have a standard pregnancy screening tool in place, and there is much variability in whether screening for DV is undertaken (Australian Institute of Health and Welfare, 2015). Only in NSW is antenatal screening mandatory and in this state, screening in antenatal care has occurred for over a decade with variable rates of screening and disclosure (Australian Institute of Health and Welfare, 2015). Since 2003, NSW's antenatal program (monitored annually using one-month snapshots) shows variation in screening and disclosure rates across the state (NSW Ministry of Health, 2016). The 2015 NSW monitoring report showed that in antenatal settings, 90.1 percent of women were screened, of whom 3.4 percent were identified as having DV, with approximately one fifth of those identified accepting offers of assistance at time of screening (Australian Institute of Health and Welfare, 2016).

The 2016 Victorian Royal Commission into Family Violence recommended mandatory antenatal care screening and an update to the *Common Risk Assessment and Management Framework* in 2018 (Victorian Royal Commission into Family Violence, 2016). Although the Victorian government has introduced the Strengthening Hospital Responses to Family Violence model, the screening and risk assessment

approach is yet to be rolled out widely and requires a greater evidence base for optimal implementation (Garcia-Moreno et al., 2014; The Royal Women's Hospital, 2015; Schachter, Stalker, Teram, Lasiuk, & Danilkewich, 2008).

Health system change models are needed to shift practitioner behaviour

There has been limited development or evaluation of health system models in the area of DV research, despite recommendations from the World Health Organization (WHO) (Garcia-Moreno et al., 2015). Further, there is limited evidence about the best way to screen and undertake risk assessment for DV during pregnancy (Bacchus, Mezey, Bewley, & Haworth, 2004; O'Doherty et al., 2015), what women and practitioners think about screening processes (Spangaro, Koziol-McLain, et al., 2016; Taft et al., 2015), and how the health system should best support practitioners to undertake DV work in antenatal care (Garcia-Moreno et al., 2015). Recent reviews (Arkins, Begley, & Higgins, 2016; Australian Institute of Health and Welfare, 2015) have concluded that more qualitative work is needed to inform the screening process.

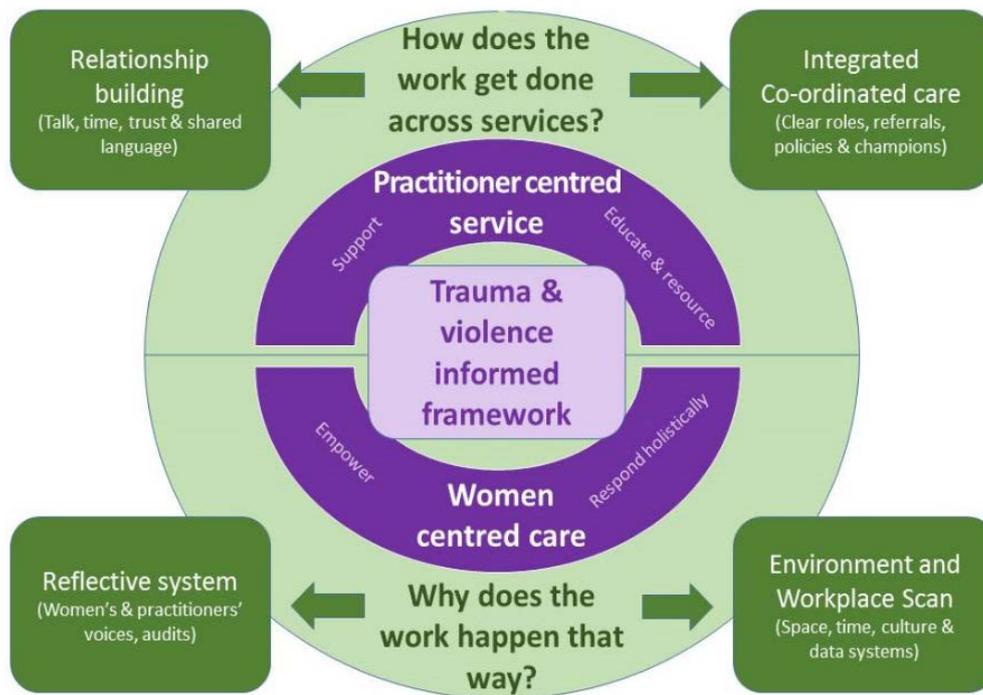
Screening is acceptable to the vast majority of women if questions are asked in a sensitive way (Feder et al., 2009; Hinsliff-Smith & McGarry, 2017; Rhodes, Dichter, & Smith, 2018; Spangaro, Zwi, Poulos, & Man, 2010; Zink, Levin, Putnam, & Beckstrom, 2007; Zink, Levin, Wollan, & Putnam, 2006), and evidence suggests that practitioners should ask on more than one occasion, as women may not be ready to disclose on the first occasion (Ahmad et al., 2009; Kataoka, Yaju, Eto, & Horiuchi, 2011; O'Reilly et al., 2010; Spangaro, Zwi, & Poulos, 2009; Webster & Holt, 2004). However, practitioners do not always take the opportunity to screen (Taft et al., 2015), as shown by the variability in antenatal screening rates across the NSW snapshot data (from 69 percent to 99.3 percent) (NSW Ministry of Health, 2016). Thus, better evidence of how services can adopt a systems approach is needed to enable effective sustained screening in antenatal care (Spangaro, Poulos, & Zwi, 2011). No trials have been identified that apply a health system implementation model to support staff and organisations to undertake DV antenatal care work (Garcia-Moreno et al., 2014; Hegarty, Tarzia, Hooker, & Taft, 2016).

Rural settings pose specific challenges

The rural setting poses unique challenges for healthcare delivery, including shortage of health practitioners, fragmented communication and distance to specialised services (Dent et al., 2016; Wendt, Chung, Elder, & Bryant, 2015). In addition, Australian women living in regional and rural areas have increased odds of reporting lifetime DV (rural: 26.1 percent; regional: 24.4 percent; major cities: 19.6 percent) (Dillon, Hussain, & Loxton, 2015). Further, many women may be reluctant to disclose DV as they may know the practitioner personally or socially (Hughes, 2010). Some of the specific challenges for implementing a DV health systems change model in a rural setting may include recruiting facilitators, access to health practitioners, absence of DV services in the community (McCall-Hosenfeld, Weisman, Perry, Hillemeier, & Chuang, 2014) and safety from perpetrators, who may also be known to the practitioners (Campo & Tayton, 2015). There has been a lack of research focus specific to this setting on how to overcome these challenges, and exclusion of rural research is detrimental, as the population becomes invisible to policymakers. Thus, we aim to fill these gaps by further developing a health system model and guidelines to integrate and sustain screening, risk assessment and responses to DV, informed by the specific experiences of urban, regional and rural health services in NSW and Victoria.

Attention to health system change is required for screening and responses in antenatal care to be effective and sustainable (Garcia-Moreno et al., 2015). A recent Australia's National Research Organisation for Women's Safety (ANROWS) project, the WITH study (Hegarty, Tarzia, Rees, et al., 2016), developed a Health System Implementation Model for trauma- and violence-informed care for women experiencing sexual violence and mental health issues (see Figure 1). This SUSTAIN study makes use of a unique opportunity to learn from the different antenatal experiences of two states about what works, for whom, and in what context (Pawson & Tilley, 1997), and applies the lens of the WITH Health System Implementation Model to inform the introduction and sustainability of screening nationally.

Figure 6 WITH Health System Implementation Model



Report structure

This report is presented in seven main parts. Part A is a literature review on screening and first line response to DV in antenatal care. Part B describes the research methodologies for all phases of the study. These include the study context and health service readiness; survey of women and qualitative interviews; and practitioners' focus group discussions, interviews and data synthesis workshops. Part C focuses on the key findings of the study context assessment and health service readiness audit. Part D is a description of women's voices, which includes findings from the survey of women and qualitative interviews. Part E outlines results from the practitioners' focus group discussions and interviews. Part F presents a synthesis of the key findings, using investigator workshops to develop the REAL Transformation Model for the SUSTAIN study using updated implementation evidence on screening, risk assessment and response, and the WITH Health System Implementation Model as a framework. Part G consists of the conclusions and forms the final part of this report. It includes the study strengths and limitations, as well as implications for health practice, policy and research for the sustainability of evidence-based, effective DV screening, risk assessment and response.

State of knowledge review

Introduction

The SUSTAIN study state of knowledge review explores the question: how can we sustainably identify and respond to pregnant women experiencing DV in complex health systems?

This review describes current evidence for screening and first-line responses for DV in pregnancy and the supports required for sustainable and effective screening and response. Early intervention in health systems is urgently needed, and sustainability of identification and first-line responses is imperative for health programs to be able to effectively address DV (Garcia-Moreno et al., 2014). For optimal universal antenatal screening, tools need to be well tested and validated with different populations, addressing varied perpetrators and types of abuse. Tools need to be flexible, short, easy to administer and acceptable to health professionals. Screening tools need to be connected to Listen, Inquire about needs, Validate, Enhance safety, ensure Support (LIVES), the first-line response recommended by the WHO (World Health Organization, 2013b). From the first-line risk and safety assessment, there needs to be clear referral pathways that address issues of confidentiality, documentation and child protection issues (Spangaro, 2016). Further, this first-line response and referral needs to be supported by a whole-of-hospital system approach.

Background

One in six Australian women report experiencing physical or sexual violence in an intimate relationship since the age of 15 years, with around two thirds (68 percent) of mothers, who had children in their care when they experienced violence from their previous partner, reporting their children had seen or heard the violence (Australian Bureau of Statistics, 2017). Additional analysis by ANROWS showed that, including in dating relationships, one in four women experience physical or sexual violence (Cox, 2015). One in five Australian women report experiences of physical and/or emotional violence by an intimate partner in the first year after having a baby, and this affects around 60,000 Australian families each year (Woolhouse, Gartland, Hegarty, Donath, & Brown, 2012). DV damages the mental and physical health of individual women, men, young people and children (World Health

Organization, 2013a) and is a leading contributor to death and disability for women of child-bearing age (Ayre, Lum On, Webster, Gourley, & Moon, 2016; Vos et al., 2006).

Health practitioners are crucial to early intervention given their pivotal role in family violence identification, safety assessment, response and referral capacity (Garcia-Moreno et al., 2015). The WHO recommends a broad systems-based approach to enable sustained change in health practitioner behaviour (Garcia-Moreno et al., 2015). The WHO has recommended that only in antenatal care may there be enough evidence for screening, although this was based on an assessment of the quality of evidence as low (World Health Organization, 2016). Evidence from a 2015 Cochrane screening review (O'Doherty et al., 2015) suggests that screening by a health professional increases identification, with no increase in referrals or changes in women's experience of violence or wellbeing.

Context for the SUSTAIN study

NSW has been screening for DV in antenatal care for over a decade, with variation in screening rates across hospitals and settings. The Victorian Government, in their recent Royal Commission into Family Violence (2016), made a key recommendation in the hospital reform space:

Recommendation 96: The Department of Health and Human Services require routine screening for family violence in all public antenatal settings. The screening guidance should be aligned with the revised Family Violence Risk Assessment and Risk Management Framework. Implementation will require targeted and continued training, the development of specific guidelines, and clinical support. (p. 72)

The SUSTAIN study is optimally placed to inform this development as there is an opportunity to learn from the NSW experience about what works, for whom and in what setting, to inform the introduction of screening in Victoria.

Below, this literature review discusses key questions for the implementation and sustainability of DV screening programs in antenatal care.

Methodology

This literature review contributes to an understanding of the current state of research on screening and first-line responses to DV. Specifically, it provides important context to current health system identification of and responses to DV as well as the availability and utility of validated screening tools in antenatal healthcare settings. In addition, it reveals existing gaps in research and practice and helps identify current priority areas and practical recommendations for screening for and responses to DV among pregnant women.

A systematic review was conducted, guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, which is a 27-item checklist developed to improve the reporting of systematic reviews and meta-analyses (Moher, Liberati, Tetzlaff, & Altman, 2009). The specific objectives of this review were to update previous systematic reviews undertaken in 2010–16 (see search strategy below) to

- find new empirical studies on DV screening and first-line responses and existing antenatal screening tools
- identify gaps in the literature in the context of DV screening and first-line responses.

Search strategy

We reviewed literature focused on screening and first-line responses to DV published in the wake of existing systematic reviews (Arkins et al., 2016; Hegarty, Forsdike, Tarzia, Schweitzer, & Vlasis, 2016; Hegarty, Tarzia, Hooker, et al., 2016; Hussain et al., 2015; O’Doherty et al., 2015; O’Reilly et al., 2010; Rabin, Jennings, Campbell, & Bair-Merritt, 2009; World Health Organization, 2013b) and the 2015 AIHW review (Australian Institute of Health and Welfare, 2015) (see Appendix A). Inclusion criteria for these reviews were systematic reviews assessing DV screening and first-line responses in healthcare settings that were published in the English language. Additional references were contributed by the research team from their expertise in the area as relevant to the research questions. We updated this evidence by using a similar search strategy as described in a recent systematic literature review (Arkins et al., 2016), outlined below. The literature search used the terms “domestic violence” or

“intimate partner violence” (IPV) or “spouse abuse” or “family violence” AND “screening” or “questionnaire” or “instrument” AND “pregnancy” or “antenatal” or “prenatal”. The search was limited to English language literature and publication year from January 2016 to May 2019 in selected databases likely to contain evidence for antenatal care (MEDLINE [Ovid], PubMed and CINAHL). We included additional studies if they contained new information relevant to the SUSTAIN study focus. For inclusion in this update of the literature, studies must have been randomised controlled trials (RCTs) or primary studies evaluating DV screening and first line responses among a population in healthcare settings. Studies were excluded if they focused on populations such as children, the elderly and perpetrators of DV; or were DV prevalence studies, commentaries, opinion pieces or policy papers.

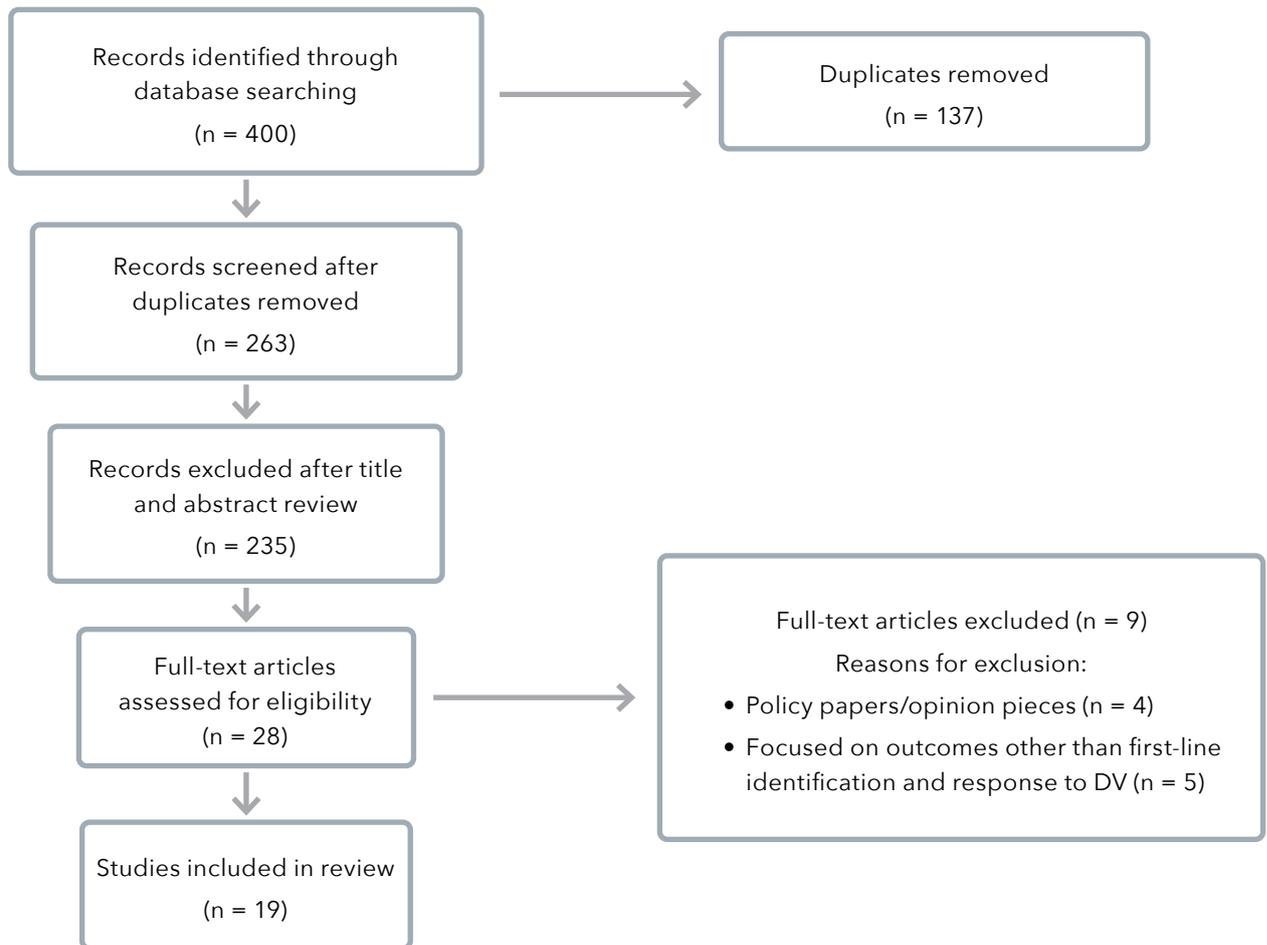
Study selection

Searches yielded a total of 400 papers: 127 from CINAHL, 83 from MEDLINE (Ovid) and 190 from PubMed from 1 January 2016 to 22 May 2019. Of these, 137 duplicates were removed, leaving 263 papers to screen. The studies were exported into Covidence online software program for title and abstract screening, guided by the eligibility criteria. Twenty-eight peer-reviewed papers remained for full text screening for relevance, following which a further nine were excluded. The remaining 19 papers were independently reviewed by two reviewers (MKO and KH) and discrepancies on inclusion were resolved by discussion. The study selection process is shown in Figure A1.

Data extraction and evidence synthesis

A summary table containing relevant column headings was developed to guide data abstraction. Data from the 19 articles meeting the inclusion criteria were abstracted based on the following items: author and country of study, study design and aims, study population and major findings on DV screening and response.

Figure A1 Study selection



Findings

Overall, the search for current literature found 19 primary studies. The main findings for each study and data abstracted are outlined in Appendix B. The succeeding subsections outline a focused series of questions to answer the overall question of the literature review: how can we sustainably identify and respond to pregnant women experiencing DV in complex health systems? Findings from our current literature search have been integrated into the discussion to add recent evidence to previous systematic reviews.

Do women want to be asked about IPV generally in health settings?

We know that the vast majority of women (abused and non-abused), including in antenatal settings, find screening acceptable if the questions are asked in a non-judgemental and sensitive way (Feder et al., 2009; Zink et al., 2006; Zink et al., 2007).

A recent mixed method study by Decker et al. (2017) described the uptake and impact of a brief, trauma-informed, universal IPV assessment and education intervention in family planning clinics. In a real-world family planning clinic setting, the intervention measures involved healthcare providers discussing healthy and unhealthy relationships with women and giving them a safety resource card. In post-test surveys, women found the clinic-based IPV assessment helpful, regardless of their IPV history. In addition, women indicated in qualitative interviews that IPV assessment was perceived as a sign of provider concern for their health and safety.

Which format of asking elicits most disclosures of DV?

There have been several studies looking at face-to-face versus distal ways of asking about DV, such as on paper or online (Ahmad et al., 2009; Chang et al., 2012; Kataoka et al., 2011; Webster & Holt, 2004). Participants in the Chang et al. (2012) study had been screened in the waiting areas using a computerised questionnaire and in the consultation verbally by

their obstetrician. On interview, they reported that they found computerised screening anonymous and non-judgemental. However, they preferred face-to-face contact with providers as this enabled tailored questioning and connection with the provider. In another study, women and home visitors who participated in the Domestic Violence Enhanced Home Visitation Program (DOVE) using mHealth technology (i.e. a computer tablet) and a home visitor-administered, paper-based method shared similar views (Bacchus et al., 2016). Authors in the Chang et al. (2012) and Bacchus et al. (2016) studies recommended that providers should use both approaches and repeat screening in person, using the computer tablet to complement and enhance the therapeutic relationship.

A previous systematic review and meta-analysis of six RCTs (Hussain et al., 2015) showed screening in face-to-face interviews is not significantly different to a self-administered, written screen. However, a computer-assisted, self-administered screen was better than a face-to-face screen (DV disclosure increased by 37 percent and written screen DV disclosure increased 23 percent). This has implications for the development of online responses to disclosure if a computerised method is used for identification. A more recent systematic review, by Pasha and Sapienza (2018), compared screening using face-to-face interviews to screening questionnaires that women self-completed. This review also showed that a written questionnaire format for screening women for IPV increased rates of identification more than face-to-face interviews. Similarly, other studies have shown that a self-completion screening tool facilitated disclosure (Hooker, Small, & Taft, 2016; Taft et al., 2015).

However, in a nurse home visitation program in the United States, both nurses and clients had an appreciation for informal opportunities to discuss personal experiences of DV. They reported that general conversations about other topics, such as personal safety, their relationships, their partner's role in parenting and their experiences in childhood, or working on an activity, such as a craft or parenting skills, were less threatening than direct questions and could help clients open up about DV (Jack et al., 2017). Client-initiated disclosures facilitated by informal discussions may be more likely to lead to higher acceptance of referrals and other support.

How often should women be asked in pregnancy?

There has been some evidence suggesting that practitioners should ask about DV more than once as women may not be ready to disclose on the first occasion (O'Reilly et al., 2010; Spangaro et al., 2009). In the nurse home visitation study by Jack et al. (2017), nurses reported that providing clients with multiple opportunities to disclose abuse over time (without an initial disclosure) was often beneficial since relationships may change over time and sometimes rapport and trust needs to be developed before disclosure can occur.

What should we ask women?

Validated tools

Screening tools mostly rely on behavioural items (e.g. hit, kicked) or emotion questions (e.g. fearful, safe), rather than labelling questions (e.g. are you a domestic violence victim?). Behavioural and emotional items are more likely to elicit disclosures of family violence than stigmatising questions that include having to identify as experiencing DV (e.g. are you experiencing domestic violence or are you experiencing physical abuse?).

Validated screening tools have predominantly been tested in the United States, Canada and the United Kingdom, with the most common tools tested being the Abuse Assessment Screen (AAS), Woman Abuse Screening Tool (WAST), Hurts, Insults, Threaten, Scream (HITS) tool and Partner Violence Screen (PVS) (Arkins et al., 2016; Australian Institute of Health and Welfare, 2015). AAS is the only tool that specifically addresses abuse during pregnancy. WAST and AAS both have the issue that they include a labelling question about physical and emotional abuse. The common items used across almost all tools were assessment of fear, physical violence and threats to harm. AAS and WAST include sexual abuse; HITS and AAS include verbal abuse. A systematic review conducted in 2009 (Rabin et al., 2009) concluded that no particular DV screening tool had good psychometric properties. For example, HITS, WAST and AAS had sensitivities ranging from 55 percent to 99 percent. A separate review published in the same year concluded that though several short screening tools are relatively valid and reliable for use in health-care

settings, the HITS scale showed the most diagnostic accuracy, concurrent validity and reliability for identifying women who are experiencing current abuse, as well as the best predictive power (Feder et al., 2009).

A more recent systematic review (Arkins et al., 2016) found 10 DV screening tools and three tools (WAST, Canada; AAS, United States; and HARK, United Kingdom) were identified as having the strongest psychometric values since they assessed all areas of DV and were validated against an appropriate reference standard. HARK is an adaptation of AAS that is validated in primary care (Sohal, Eldridge, & Feder, 2007). A variety of questions are used in tools across antenatal care in Australia that are variations on these validated tools (Australian Institute of Health and Welfare, 2015). A review by the AIHW (Australian Institute of Health and Welfare, 2015) also examined different screening tools in the context of obtaining data for the national perinatal data collection. After weighing up the pros and cons, the AIHW recommended the HITS or the HARK tool for the antenatal setting; however, neither tool has been validated in the antenatal setting, nor do they address controlling behaviour.

In our updated review, we found some studies focusing on development or validation of screening tools for antenatal settings in four countries. For instance, Doi, Fujiwara, and Isumi (2019) developed the IPV during Pregnancy Instrument, which includes eight questions to detect unmeasured IPV in pregnant women. It allows asking indirect questions about risk factors such as maternal age, multiparity, and a history of artificial abortion rather than asking directly about experience of IPV. Compared to the revised Conflict Tactics Scale, it showed moderate predictive power (area under receiver operating characteristic curve = 0.719) with a cut-off point of 2 (sensitivity = 79.5%, specificity = 47.1%). Escribà-Agüir et al. (2016) assessed the reliability, accuracy, and construct validity of the Spanish AAS among pregnant women using the Spanish version of Index of Spouse Abuse (ISA) as a reference standard. Retest agreement of AAS was high, from 96.4–100 percent, with specificity for all types of abuse above 97 percent. However, sensitivity values were low (33.3%, 22.9%, 6.9%, for severe physical abuse, minor psychological abuse, and minor physical abuse, respectively). In a cohort study, Kita, Haruna, Hikita, Matsuzaki, and

Kamibeppu (2017) developed a Japanese version of the WAST, comprising two simple questions, to examine its accuracy and validity. The tool showed sensitivity between 66.7–71.4 percent and specificity of 89.7 percent. Lastly, a brief screening tool was tested for use in women attending antenatal care in Tanzania (n = 1116) and Vietnam (n = 1309) (Rasch et al., 2018). It performed best in predicting physical IPV (identified 93% and 96% of Tanzanian and Vietnamese women, respectively). Based on previous studies, it is clear that development and testing of DV screening tools need to be done with specific cultural sensitivities of the population of interest as an important consideration. There is a clear gap in validated tools for the Australian antenatal setting.

Tools in use in Australian jurisdictions

AIHW describe that almost all Australian states are currently screening in antenatal care with a variation of the NSW Health Routine Screening program (NSW Ministry of Health, 2016). For over a decade, NSW has had a screening program in antenatal, mental health, drug and alcohol, and child and family health services that has been monitored for one month every year. The four target service streams use a common two- to four-question tool, with “yes/no” response categories for each of the following questions:

1. Within the last year, have you been hit, slapped or hurt in other ways by your partner or ex-partner?
2. Are you frightened of your partner or ex-partner?
3. Are you safe to go home when you leave here?
4. Would you like some assistance with this?

Victorian context

At the time of commencing the SUSTAIN study, the current *Common Risk Assessment Framework manual* for Victoria (Department of Health and Human Services, 2017) was in use, suggesting the following questions:

1. Are you ever afraid of someone in your family or household? If so, who?
2. Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do?
3. Has someone in your family or household ever threatened to hurt you?

4. Has someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you?
5. Are you worried about your children or someone else in your family or your household?
6. Would you like help with any of this now?

How many practitioners are likely to screen?

Findings from a review of international studies a decade ago reported a median screening rate of 19 percent of women, based on the 11 studies that examined women's self-reported data (Stayton & Duncan, 2005). A more recent review, found through our search, also reported low rates of routine screening of 10–20 percent, ranging from 2–50 percent across 35 studies (Alvarez, Fedock, Grace, & Campbell, 2016). A recent study in Canada among 49 practicing obstetrician/gynaecologists in Edmonton showed that 94 percent believed that they were inadequately screening for DV. In addition, 33 percent never or rarely screened women for DV during prenatal visits, 94 percent did not have a screening protocol, and 77 percent did not have written materials to provide to women (Long, Golfar, & Olson, 2019).

In Australia, the November 2015 snapshot of the NSW Health Domestic Violence Routine Screening program showed that 90.1 percent of women in antenatal services were screened for DV (NSW Ministry of Health, 2016). The situation varies from 43–56 percent for maternal and child health nurses, who are mandated to screen in Victoria at 4 weeks postpartum (Taft et al., 2015). In southeast Queensland, a recent study showed 90 percent of 6671 women were screened who presented to antenatal care 16 months after midwives had completed a one-day training program (Baird, Creedy, Saito, & Eustace, 2018). Another recent Australian study showed that 37.5 percent of antenatal healthcare providers in the community (general practitioners and private midwives) did not screen for DV in the six months prior to completing the survey (O'Reilly & Peters, 2018).

There are many barriers to sustained screening by practitioners. Evidence shows that only half of health professionals in two systematic reviews undertaken find screening acceptable (Feder et al., 2009; Stayton & Duncan, 2005). Some health professionals feel they lack the time or the skills to undertake

screening and response, particularly if partners are present, while others do not see it as their role or fear offending the patient (Hooker, Small, Humphreys, Hegarty, & Taft, 2015; Hooker et al., 2016). Other barriers include lack of training, referral and support services (O'Reilly & Peters, 2018). Similarly, according to Long et al. (2019), in a study of 49 obstetricians/gynaecologists in Canada, common barriers to screening included:

- a lack of time or adequate resources for women
- women being accompanied to appointments
- worry about offending women
- not knowing what to do if a patient screened positive for DV
- being unsure of mandatory reporting guidelines.

Saberi et al. (2017) have reported similar barriers based on a survey of 76 emergency department nursing and medical staff at a public hospital in Australia. In addition, 72 percent of the practitioners reported conducting case-finding that mostly favoured asking women with physical injuries, a practice that may neglect women experiencing other forms of DV without overt signs of violence. In the southeast Queensland study previously discussed (Baird et al., 2018), organisational support was perceived to be lacking in some respects. However, training, support processes and referral pathways contributed to midwives' sustained preparedness and knowledge to conduct routine enquiry and support women disclosing DV. Similarly, knowledge-based training in IPV or reproductive coercion have been found to increase provider responses such as safety card provision, discussion of healthy relationships, and provision of information about IPV resources (Zachor, Chang, Zelazny, Jones, & Miller, 2018).

How many women are likely to disclose and accept a referral?

In Australia, the November 2015 snapshot of the NSW Health Domestic Violence Routine Screening program showed that just over three percent of women screened antenatally identified as experiencing current abuse, with approximately one fifth accepting an offer of assistance at time of screening (NSW Ministry of Health, 2016). Similarly, in the southeast Queensland study (Baird et al., 2018), DV disclosure was two percent, and most women at risk of or experiencing violence declined referral. As reported by Spangaro, Koziol-McLain,

et al. (2016), Indigenous populations globally experience higher levels of DV; however, their decision to disclose may be influenced by multiple factors including, in particular, cultural safety as well as concerns of perpetrator awareness, and safety from shame and institutional control.

A United States study (Jack et al., 2017) involved home nursing clients who had all experienced DV (n = 26), yet 35 percent reported that they purposefully did not disclose DV at their intake relationship assessment, 10 percent provided a partial disclosure (e.g. of emotional abuse but not physical abuse) and 5 percent reported that their home nurse did not complete this assessment with them. Reasons for non-disclosure included a perception that the questions were asked with little introduction to help them understand why the information was being asked. Others had privacy and confidentiality concerns, fear of partner awareness and subsequent escalation of abuse, concerns child protection services may be involved, or concerns that nurses may not understand their situation or could not really help (Jack et al., 2017). A clearer understanding of the concerns of specific populations of women regarding disclosure of DV could guide the development, implementation and sustainability of DV programs.

Which response is best after identification?

A first-line response is important for all women who disclose DV; for the WHO that response consists of the processes involved in LIVES (World Health Organization, 2013b). Two areas that require a focus in training include assessing safety and risk, and tailoring responses to women's readiness to take action (Hegarty, O'Doherty, Gunn, Pierce, & Taft, 2008). Among women attending antenatal care, many may not wish to access DV support services (Hegarty et al., 2013).

Limited evidence exists about what assists women to heal from experiences of DV. There has been limited testing in antenatal care over and above empowerment and advocacy interventions, including through home visitation and peer support programs. Trauma-informed care and models to support recovery and healing need to be formally tested in RCTs (Hegarty, Tarzia, Hooker, et al., 2016).

Based on a 2018 systematic review of 30 studies (n = 14,959 women), the US Preventive Services Task Force concluded that available evidence does not support the effectiveness of brief interventions or the provision of information about referral options without ongoing supportive intervention components, especially among pregnant or postpartum women (Curry et al., 2018; Feltner et al., 2018). Decker et al. (2017) reported in a study that providers and women gave mixed feedback about provision of safety cards with DV-related resources. On one hand, some participants found the information helpful, noting that that the easily concealed size was a good feature. On the other hand, some providers felt that handing out something as small as a safety card to women with extreme DV experiences did not address the seriousness of the women's experiences. Another study (Van Parys, Deschepper, Roelens, Temmerman, & Verstraelen, 2017) assessed the impact of a referral-based intervention, consisting of three parts: a questionnaire, a referral or thank you card, and two interviews. The intervention group received a referral card and the control group received a thank you card. There were no significant differences between the two groups; however, women in the intervention group found the referral card helpful. However, the interviews with practitioners were reported to be significantly more helpful than the referral cards (Van Parys et al., 2017).

Some research has focused on equipping women with the knowledge and skills to take action that might in turn reduce DV. Some women are unable to access healthcare or are reluctant to disclose face-to-face with health professionals as they fear judgemental attitudes. An international group has developed online responses—safety decision aids and healthy relationship tools—and is testing them in RCTs (Koziol-McLain et al., 2018). A sexual violence intervention program addressing reproductive coercion assessed the effectiveness of a provider-delivered intervention involving counseling to reduce risk of partner interference with contraception and increase safety. Overall, the intervention did not impact recent DV, reproductive coercion or unintended pregnancy. However, it increased awareness of DV-related resources and self-efficacy to use harm reduction behaviours among the intervention group (Miller et al., 2016). An Iranian study on the effect of problem-solving skills training for pregnant women experiencing DV shows some promise, as the rate of physical and psychological violence was significantly

reduced post-training in the intervention group (Taghizadeh, Pourbakhtiar, Ghasemzadeh, Azimi, & Mehran, 2018).

In a recent RCT conducted over a 2.5-year period at 15 sites across eight states in the United States, 492 socially disadvantaged pregnant women were enrolled. The study aimed to determine if augmentation of a nurse home visitation program with an IPV intervention starting in pregnancy, compared to the home visitation program alone, led to improved maternal quality of life at 24 months after infant delivery. Although nurses attending the intervention group received comprehensive training specifically developed to support identification of women exposed to IPV and provision of a tailored clinical response, the intervention did not significantly improve quality of life 24 months after delivery compared to the home visitation program alone (Jack et al., 2019). Conversely, a structured, brochure-based IPV empowerment intervention (the DOVE clinical trial), delivered during six scheduled home visits (three sessions during pregnancy and three during the postpartum period), was found to be effective in decreasing IPV (Sharps et al., 2016).

Despite differing reports, studies show what many women value in the identification and responses to DV by healthcare professionals. From an interview study of 32 women who had experienced DV, Spangaro, Koziol-McLain, Rutherford, and Zwi (2019) identified factors that women perceived as having a positive impact 16 weeks after antenatal DV screening. These factors included care in asking and support and validation from the midwife, and were important regardless of whether or not a woman had made a disclosure. Further research is needed in the antenatal care setting investigating which models support women and their children in recovery from DV. There is a clear gap in reporting what responses and interventions happen for women attending Australian antenatal care.

Which whole-of-hospital response should be implemented to support screening in antenatal care?

Health systems are large and complex. A recent Lancet article showed that individual health system changes occurring in isolation (e.g. training of staff or introduction of polices alone)

are unlikely to improve patient outcomes based on existing systematic review evidence (Garcia-Moreno et al., 2015). A “whole-of-system” health service response and system change is required to support screening in antenatal care. At a workplace level, there is a need for a culture of gender equity and enactment of trauma-informed principles (respect, privacy, confidentiality, safety) as well as clear staff roles, protocols and referral pathways. At a system level, there is a need for provision of workforce support, including for staff who experience DV; appointment of champions; infrastructure, both environmental and financial; and information systems for evaluation.

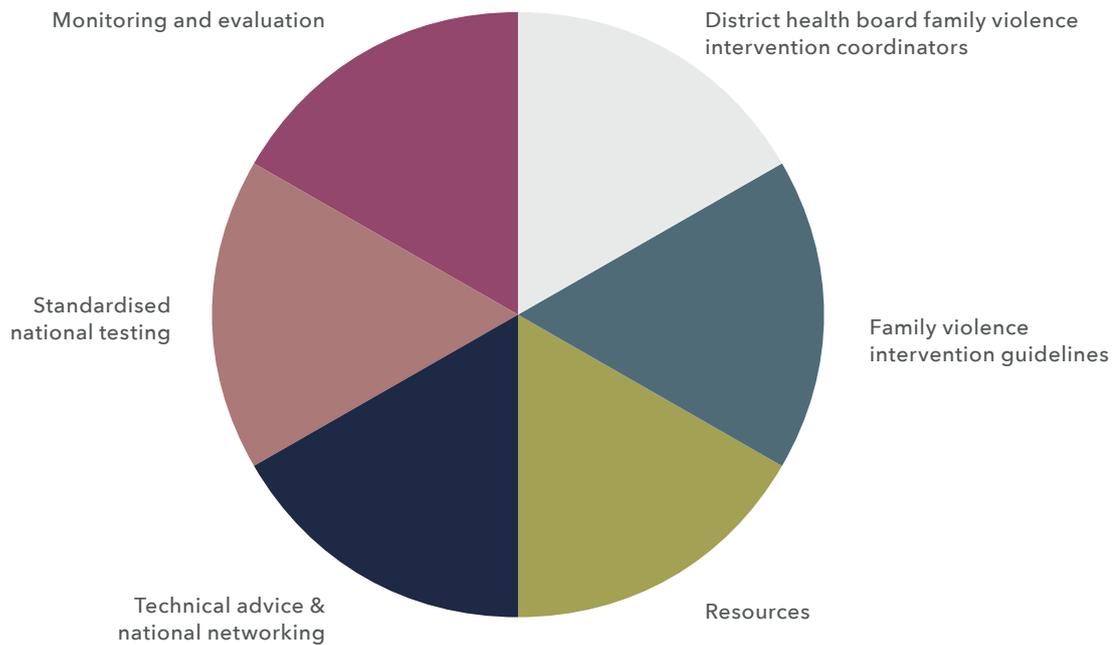
A European study of health clinics found several factors encouraged best practice including dedicated leadership, mandatory recurrent training of all staff, the availability of on-site trainers and clear referral pathways (Bacchus, Bewley, Fernandez, & et al., 2012). These findings are also supported by evidence from a systematic review of health-sector responses to DV in low- and middle-income countries, which also emphasised the connection or “linkages” between different individual factors, with all elements being implemented in a coordinated manner a key characteristic of the most integrated responses (Colombini, Dockerty, & Mayhew, 2017).

In the United States, Bright, Bagley, Pulliam, and Newton (2018) documented how policies related to DV in pregnancy in Mississippi. They suggested that shared leadership and community engagement were pivotal to the success of the process. They developed three goals: increase policies to screen for DV, increase policies for referral to services for women experiencing DV in pregnancy, and increase access to information on services available for DV. These goals were matched with clear strategies, actions, process measures and resources. After completion, all expecting mothers receiving prenatal care in the area were expected to be screened for DV.

This section highlights two examples of strong policy informing health system change in this area.

New Zealand

The Violence Intervention Program (VIP) (New Zealand Ministry of Health, 2015) is an example of a comprehensive

Figure A2 NZ Ministry of Health VIP Systems Support Model

systems approach with six program components (Figure A2). These components include:

- regional coordinators
- guidelines: Child and Partner Abuse (2015)
- resources that include a website, posters, cue cards, pamphlets and Quality Improvement Toolkit
- support provided by a national manager, national trainer and networking meetings
- national training contracts for staff, midwives and primary care providers
- monitoring and evaluation.

The New Zealand Ministry of Health suggests that set-up prior to going live with any screening program includes the following features:

- posters in waiting rooms, nurses' rooms, doctors' rooms, toilets
- resource baskets in doctors' and nurses' rooms including cards, barcodes and various referral services
- laminated screening cards
- box on front desk for cards
- pamphlets in waiting rooms
- family violence champions overseeing process and feedback to the family violence coordinator.

Evaluations of the program have shown that composite evaluation scores increased incrementally from 2004–11 in 20 district health boards (Koziol-McLain, Ritchie, & Zimmerman, 2012).

United States

Over the past 10 years, Dr Brigid McCaw and Kaiser Permanente have undertaken system changes in health (Kaiser Permanente, 2018) with a demonstrated six-fold increase in identification and referral of members affected by DV over that 10-year period (McCaw, 2011). The program is underpinned by leadership and oversight (Figure A3) and involves:

- information for participants and a supportive environment
- routine practitioner screening
- referral supported by online tools and resources, online support services 'including mental health care' and/or access to a crisis line
- community linkages to DV
- advocacy services.

What is the evidence for effective systems change in health care settings?

Organisational change in healthcare is complex and challenging, but to ensure long-term change evidence

Figure A3 Kaiser Permanente Model



suggests that some activities are better than others (Johnson & May, 2015). Best practice for “large system transformation” in healthcare involves blending designated leadership with distributed leadership, establishing feedback loops, attending to history, engaging doctors and including women and families (Best et al., 2012).

We know that focusing on *collective action* (work within and between teams, with clarification of roles and resources) and *reflexive monitoring* (appraisal with feedback of activities) has been found to be most effective (Hooker et al., 2015; Hooker & Taft, 2016; Johnson & May, 2015). Other activities that focus on individuals (such as workforce training) are less effective in isolation. A focus on doing more of the things that “are going right” builds on existing wisdom and good practice and is a recognised enabler for change (Braithwaite, Wears, & Hollnagel, 2015). Combining such interventions is most likely to result in sustained and effective health system change (Johnson & May, 2015).

Previous work we drew on for this study includes a trauma- and violence-informed Health System Implementation Model developed by Hegarty (see Figure 1) specifically for violence intervention (Hegarty, Tarzia, Fooks, & Rees, 2017). In addition to the systems-level factors described above, the model takes into account the complexities of an individual’s life, expanding the concept of trauma-informed care to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person’s life (Varcoe, Wathen, Ford-Gilboe, Smye, & Browne, 2016).

There is very limited evidence in the DV field about what works to change health practitioner behaviour (Spalding et al., 2015). The evidence below is taken from recent systematic reviews from all areas of health, with none taking place in the DV area. There are three main strategies used that are shown to have some effect on practitioner behaviour or patient outcomes: persuasive, educational and informational, and action and monitoring.

The persuasive strategy of utilising local opinion leaders has been shown to be effective, with a systematic review (Flodgren et al., 2011) finding a positive effect on professional behaviour change; however, it was difficult to ascertain the effect (if any) on patient outcomes. In contrast, local consensus processes (Fleming, Browne, & Byrne, 2013; Oxman, Thomson, Davis, & Haynes, 1995) showed no clear improvement in practice or patient outcomes. Thus, local champions or opinion leaders are recommended as part of a system change process.

Educational and informational strategies include patient mediated interventions, educational materials and meetings. These all have benefits of changing professional behaviours, with a smaller number of systematic reviews finding a benefit for women (Forsetlund et al., 2009; French, Green, Buchbinder, & Barnes, 2010). Educational outreach by peers or academic detailing (Chhina et al., 2013) is effective in changing practitioner practice. Thus, training of practitioners is a standard part of systems change. Educational outreach, although effective, is less frequently used since it has greater resource implications.

Action and monitoring activities, such as audit and feedback, have led to improvements in professional practice and patient outcomes (Ivers et al., 2012). Audit and feedback may be most effective when there is a low baseline of performance and feedback is performed by a colleague or supervisor and is recurrent verbally and in written formats. Computer-based clinical decision support, information systems and reminders have been shown to have an effect on patient outcomes through improving process of care (Arditi, Rege-Walther, Wyatt, Durieux, & Burnand, 2012; Balas et al., 1996; Kastner & Straus, 2008; Shojanian et al., 2009). When reminders provided space for the healthcare professional to enter a response and provided an explanation for the reminder, the effect was greater than when these features were not present.

In summary, multifaceted strategies (Chaillet et al., 2006; Medves et al., 2010) are of more benefit than single strategies. We recommend from the evidence that local opinion leaders, audit and feedback, and reminders should be used in any system-level intervention to address DV.

Summary and recommendations

The SUSTAIN study literature review explored the question:

How can we sustainably identify and respond to pregnant women experiencing DV in complex health systems?

This literature review described current evidence for screening and first-line responses for DV in pregnancy, and the supports required for sustainable and effective screening and response.

For optimal universal antenatal screening, tools need to be well tested and validated with different populations, addressing varied perpetrators and types of abuse. Tools need to be flexible, short, easy to administer and acceptable to health professionals. The SUSTAIN study has an opportunity to further inform the DV field and influence the current policy direction in Victoria. Below we suggest some research recommendations for the SUSTAIN study as a result of this literature review.

RECOMMENDATION 1:

Test a screening tool

As part of the SUSTAIN study, new screening questions should be trialled in the antenatal care research survey filled out by women in waiting rooms. This should include when they might like to be screened during antenatal care.

Screening tools need to be connected to a WHO-recommended first-line response (LIVES) supported by a whole-of-hospital system approach (World Health Organization, 2013b). From the first-line risk and safety assessment there needs to be clear referral pathways that address issues of confidentiality, documentation and child protection issues (Spangaro, 2016).

Recent systematic reviews (Chaillet et al., 2006; Medves et al., 2010) showed that multifaceted strategies, particularly for complex healthcare areas, are of more benefit than single strategies. For example, interventions that link local opinion leaders, audit and feedback are the most effective in overcoming barriers to change.

RECOMMENDATION 2:

Undertake system audits to understand sustainability

As part of the SUSTAIN study, system audits need to be undertaken to enable a deep understanding of the whole system.

Synthesis of this new evidence will inform local and national policy and practice. The next steps in the project are to undertake audits across six hospitals in Victoria and NSW, survey and interviews of women, and focus group discussions and interviews with practitioners.

PART B

Methodology

Introduction

This part of the report outlines, in detail, the overall research design used in the conduct of this study. It describes the rationale for selected approaches, study settings, participants involved, instruments used, and the data collection and analysis procedures. A case study methodology (Stake, 2005) was employed to thoroughly explore the multidimensional and complex issue of DV screening and responses in antenatal care. This involved a review of the study context and audits of hospital readiness, survey of women, qualitative interviews with women, and focus groups and/or interviews with staff. The final stage of the methodology included two synthesis workshops with the investigators spending in-depth time exploring the findings to develop a model for sustainable screening and responses to DV in antenatal care.

This study used a case study approach involving multiple sources and units of analysis to investigate the phenomena of DV screening, risk assessment and responses in antenatal care, within the real-life context of urban, regional and rural settings (Stake, 2005). We explored this complex area from multiple perspectives and within an existing Health Systems Implementation Model framework (Figure 6). We used this approach rather than a mixed methods approach using critical realism since we used the different units of analysis (antenatal sites) to draw together and examine system barriers and facilitators for implementing and sustaining DV screening and responses (e.g. historical background, physical setting, institutional and political contextual factors). The case study methodology involved focus group discussions with staff, surveys with women, and audits of hospital readiness to inform antenatal care guidelines nationally with a focus on low resource settings.

As this was a multi-phase study, incorporating an in-depth case study approach (Thomas, 2011), this methods section is divided into four subparts. The following elements of the study are covered below:

- the study context (study settings) and audits of health services readiness
- survey of women and individual interviews with women with experiences of DV

- focus groups and/or interviews with practitioners
- synthesis workshops.

The study context/settings

The purpose of this stage of the study was to develop a broad understanding of the study sites, with emphasis on the differences between states; regional, rural and urban areas; and health services. The methods for data collection on the study settings are presented here.

The SUSTAIN study was implemented across a total of six publicly funded health services and hospitals: three in NSW (sites N1, N2 and N3) and three in Victoria (sites V4, V5 and V6). The sites were equally distributed between regional and rural (sites N3 in NSW and V5 and V6 in Victoria) and urban hospitals (sites N1 and N2 in NSW and V4 in Victoria). All of the hospitals have designated service areas including surrounding suburbs or towns with “catchment” populations. Key demographic and socio-economic indicators are reported for each hospital including socio-economic disadvantage, birth rates and maternity unit levels of service and models of care. A discussion of the key similarities and differences between the different hospitals is provided below.

Data collection methods

The research team worked with investigators from each site and key clinical personnel to capture information providing context for each site, including models of care and clinics offered. This was augmented with Australian Bureau of Statistics (ABS) data for each local government area for participating sites. Socio-economic disadvantage, cultural and linguistic diversity and birth rates were calculated based on census data from the ABS (Australian Bureau of Statistics, 2019a). The most commonly accepted measure of socio-economic conditions by geographic area is the Socio-Economic Indexes for Areas (SEIFA), which comprises four sets of measures from census data:

- Index of Relative Socio-economic Disadvantage

- Index of Relative Socio-economic Advantage and Disadvantage
- Index of Economic Resources
- Index of Education and Occupation (Australian Bureau of Statistics, 2019a).

This report uses the Index of Relative Socio-economic Disadvantage (IRSD), a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area (Australian Bureau of Statistics, 2019a) and is an accepted measure of relative socio-economic disadvantage in Australia.

Description of study sites

Maternity unit capabilities

NSW Health and Victorian Health and Human Services work within a health services system composed of six levels of care for health service provision, aligning with a national policy framework (Australian Health Ministers' Conference, 2011). Health services are designated for level of maternity and neonatal care by the relevant state's department of health, "including the required workforce, infrastructure and equipment, and clinical support services it can continuously meet" (State of Victoria, Department of Health and Human Services, 2019, p. 3). Sites N1, N3 and V6 provide Level 3 maternity care; that is, they provide local maternity care for women and babies considered to be at low risk. Sites N2, V4 and V5 provide Levels 5–6 maternity care, with much higher capability that includes local care as well as comprehensive state-wide and regional services.⁴

Screening status

Screening status in the participating sites reflected a clear jurisdictional divide between NSW and Victoria. All three NSW sites (N1, N2, and N3) implement mandated systematic screening for DV, which has been in place in NSW since 2003. Victoria has only just started systematic screening, with sites V5 and V6 in the early stages and site V4 having not yet started systematic DV screening.

⁴ For more detail, refer to the *NSW Maternity and Neonatal Service Capability Framework* (NSW Health, 2016) and *Capability frameworks for Victorian maternity and newborn services* (Department of Health and Human Services, 2019).

Audits of screening and clinical health services readiness

The audit had two components: first, analysis of data from screening at the three NSW sites and second, an assessment of health services readiness to respond to DV. This section contributes to the following research objective: to understand the barriers and facilitators to introduction and sustainability of screening and first line responses in antenatal care.

Audit of screening

NSW collects systematic data on DV screening in public hospitals through eMaternity, an electronic medical record. Each local health district is required to report DV routine screening rates as one element of the service level agreement between health districts and NSW Health. Given the last publicly available screening data in NSW was for 2015, for this study, an audit of 12 months of screening at the three NSW sites was conducted to determine screening rates for DV and actions resulting from disclosure.

After consultation with the data users and managers at each of the NSW sites, a report was built to extract data from eMaternity, the electronic record system used at each site (see Table B1). After each site extracted their site data, duplications of records were identified and removed, and identifying data was removed before transmission of the data to the University of NSW research team in Excel format. The data was imported into and analysed descriptively using IBM SPSS Statistics (Version 25).

Audit of service readiness tool

An audit was conducted at each site using the WHO's *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence* readiness checklist (World Health Organization, 2017). Consistent with the WHO tool, capacity to respond to DV was assessed for each site's implementation of services (World Health Organization, 2017). The aid was developed by the WHO in recognition of the need for tools to support and evaluate health service delivery in response to DV and is part of their guidance manual for planning and managing health services for women subjected to violence. This checklist was adapted to meet the needs of the different hospitals and different

Table B1 eMaternity report fields used for audit

For all women who presented to the clinic in the period 1 July 2017 to 30 June 2018:
Were they screened for DV?
Did they answer yes to screening questions?
Were they safe to go home?
Did they ask for assistance?
Was DV identified by the health professional?
Where DV was identified, how many said they had children?
Actions taken in response to the DV questions
Main referrals made
If screening was not completed, what was the reason?
Was a psychosocial plan written?
What model of care was provided?
Demographics
Date of booking visit
Country of birth
Language spoken
Interpreter needed
Referred to Aboriginal and/or Torres Strait Islander services

levels of service provided, the Australian environment, and the study's focus on DV, rather than violence against women more generally. One question on availability of medication and equipment, designed for responses to crisis sexual response presentations, was replaced with a question about information available to and provided to women.

Each NSW site was visited by the research team to complete the audit in February 2019. The checklist was completed in group discussion with key informants including nurse and midwifery unit managers, midwives, educators and social workers. In Victoria, the checklist was completed by investigators associated with each study site who worked on the Strengthening Hospital Responses to Family Violence program and were familiar with current policies and practice. The WHO tool used is provided at Appendix C.

Survey of women

A targeted survey was used to gather data from a large representative population of pregnant women. This allowed collection of information on specific attributes of the

population of interest, including the prevalence of DV, women's preferences on how to be asked about DV and their particular needs. The survey of women is related to the following objective: to explore how women attending antenatal care perceive the nature and timing of screening questions and risk assessment about DV, including the most effective and acceptable wording of screening questions.

Sample size estimates

Women were recruited from sites V4 and V5 over a period of two months; both are sites where mandatory screening was to be introduced in Victoria. As pre-specified in our protocol, the NSW sites did not undertake a survey as screening is already part of antenatal care. The rural Victorian site V6 was excluded due to logistics of undertaking the survey with minimal staff. Based on the average number of midwifery appointments, site V4 recruited from an eligible pool of 3488 women attending antenatal appointments from Monday to Thursday (109 women per day). This recruitment was based on the assumption that approximately half of the women attend appointments with their partners and therefore should not be approached, to protect their safety. Further, 20–25 percent of

women request an interpreter in languages that the survey is not available in due to limits of resources. Based on a 75–80 percent response rate from a previous study (Hegarty et al., 2007), up to 1046 women were expected to be recruited. Additionally, site V5 recruited from an eligible pool of 640 women (16 women per day) and, based on the previously mentioned assumptions regarding partner attendance and response rate, could recruit up to 256 women.

Women’s eligibility and recruitment

Inclusion criteria for women

Women were included in the study if they were:

- at least 16 years of age
- attending pregnancy care appointments at either site V4 or V5
- literate in written English, Arabic or Chinese, the three major languages at site V4.

It was important to include young mothers as they are a high risk group for DV (Australian Bureau of Statistics, 2012; Jasinski, 2004; Quinlivan, 2000) and we did not want to deny young women the opportunity to provide their input into the study.

Exclusion criteria for women

Women were excluded from the study if they:

- were accompanied to the appointment by a partner and/or family member
- were too unwell to participate
- were not proficient in written English, Arabic or Chinese
- had previously participated in the study on a different day.

Procedure

Eligible women at any gestation waiting for their pregnancy care appointments in the waiting area were asked by a trained researcher to participate (see Appendix J for recruitment flowchart). As women were approached, they were asked if they spoke or read in another language, and if they were attending their pregnancy appointment alone. If the woman was

accompanied, she was asked who had come to the pregnancy appointment with her. Her response was documented, and she was then thanked for her time. If the woman was on her own, she was asked if she was interested in taking a survey on “women’s emotional wellbeing” for the SUSTAIN study. As the presence of the partner or other family member at pregnancy appointments are not otherwise documented, these steps helped to determine what percentage of women attend appointments with their partner/family members or alone, and to explore how to safely and feasibly approach women in future.

Women who agreed to participate were given introductory information to read about the study and, if they were still interested in taking the paper survey, they were given the participant information statement. Consent was implied on completion of the survey (which took approximately 15 minutes), prior to their antenatal clinic appointment. The researcher waited nearby to collect the survey or to respond to any queries. Disclosure rates of DV may be higher if questions are completed by women anonymously rather than via face-to-face screening by practitioners (Arkins et al., 2016). Where women screened positively for DV, a message prompted them to “speak to their midwife or social worker, or DV service”. A self-addressed, reply-paid envelope was also distributed with the survey for women to return the survey when completed. At site V4, for women speaking Arabic, Mandarin or Cantonese (Chinese dialects), recruitment sheets were provided in these languages, as they are the most frequently requested languages for translation. All women approached were given a resource card with information on DV support services embedded within other health service information. This resource was translated into Arabic and Chinese.

Study tool

The survey had six sections (see Appendix D). These included questions about the woman’s:

- pregnancy and pregnancy care
- health and wellbeing
- relationships and safety
- supports

- personal and household details
- views about the survey.

Within the relationship section were questions that included the screening tool in various forms; the CAS (Hegarty, Bush, & Sheehan, 2005); questions exploring perceptions about the nature of questions about DV at their pregnancy visits and optimal timing of questions; risk assessment and response quality; factors encouraging disclosure and acceptance of referrals from a systems perspective; and demographic items. The survey screened participants for IPV using four screening items relating to partner or ex-partner behaviours. These four items were presented in two ways to participants. The first set required a binary response, and response options for each item were “yes” (scored 1) or “no” (scored 0). The second set required participants to select how often the behaviours occurred (frequency format) and responses for each item were on a five-point Likert scale (Never = 0, Rarely = 1, Sometimes = 2, Frequently = 3, Very frequently = 4). The purpose of using various forms of the screening tool was to help explore the acceptance of these two approaches to responding. The survey was translated into Arabic and Chinese.

At the end of the questionnaire women indicating they had experienced recent DV were also invited to participate in the next part of the study by including their first name, safe contact details, and the best time of day for contact. This step helped the research group to identify women who reported DV but were not referred to social work or did not attend social work appointments. It also helped the research group to understand barriers and facilitators for acceptance of referrals within the hospital system. Based on another study conducted by the group, we anticipated that fewer than 20 women would be eligible and express interest for these interviews (O’Doherty, Taket, Valpied, & Hegarty, 2016).

Data coding and analysis

Data were entered into Microsoft Excel and uploaded into STATA (Version 13.0) for cleaning and analysis. Data were summarised using frequencies and percentages for categorical data, means and standard deviations for continuous data that was normally distributed, and median and interquartile

ranges for continuous data that was not normally distributed. Open text items were uploaded into NVivo (Version 12.0) for content analysis (Vaismoradi, Turunen, & Bondas, 2013).

Participants were classified as being abused if they answered “yes”, “sometimes”, “frequently”, or “very frequently” to any of the four screening questions and/or met criteria for abuse on the CAS (Hegarty et al., 2005). Participants met criteria for abuse on the CAS if they had a total score of at least three (a recommended cut-off), or if their subscale scores placed them in a specific category of abuse (i.e. Severe Combined Abuse, Physical Abuse, Harassment/Emotional Abuse or a combination of Physical and Harassment/Emotional Abuse). Some participants could not be classified, as they did not complete abuse screening questions or the CAS.

Individual interviews with women with experiences of DV

This element of the study relates to the following objective: to understand the factors encouraging disclosure and acceptance of referrals from a system perspective.

The use of individual interviews with women enabled researchers to generate a rich understanding of attitudes, perceptions, and useful and relevant insights into women’s views regarding DV screening and responses. This data collection technique also allowed investigators to probe for additional information, where necessary. The semi-structured interview comprised open-ended questions exploring women’s experience of being asked about DV, disclosing DV, and accepting a referral to social work because of the disclosure to DV, with the aim of developing a description of their pathway to safety and care (Appendix F).

Eligibility and recruitment

Interviews for this part of the study were conducted only in NSW as researchers were unable to successfully recruit eligible women at the Victorian site within the study period allotted. Recruitment of participants in Victoria was conducted by social workers, who were encouraged to identify eligible patients

(women with experiences of DV) and refer them to the research team for the duration of the study. Recruitment materials, including scripts to guide social workers' discussions about the nature of the study, modes of contact of the research team and flyers advertising the study were provided or displayed in the waiting area. However, the social work department at V4 was undertaking an audit at the time of recruitment and were unable to concentrate on this task. Research personnel also changed during this time so there was less attention paid to the task than was optimal.

In NSW, women referred, for DV, to social work from pregnancy care were approached and invited to participate in the study. Inclusion criteria were that women must be:

- at least 16 years of age
- attending pregnancy care appointments at the participating site
- literate in English, Arabic or Chinese.

In the consultation phase, it was identified that social workers were well placed to safely and privately raise participation in the study with eligible participants. Over a four-month period, women referred to social work from pregnancy care for DV were invited during their social work appointment to speak to a member of the research team about participating in a single, short interview.

Social workers were provided with resources that included an overview of the study and interview aims, scope and purpose; suggested script to discuss the study with women; cards to give women with the free call number; and re-contact forms. To maximise uptake and flexibility, three options were provided for women to make contact. First, the social worker could telephone the research associate conducting the interviews with the woman present, allowing the research associate to explain the study directly to the woman, and conduct the interview then or make a time to do so. The second option involved completing a re-contact form and passing on the woman's details and preferred dates and times for the research associate to call. If neither of these options was preferred by the woman, a card was provided to her with the free call number enabling her to make contact if she chose to. (The social work protocol is available at Appendix E.)

To include women who may not have disclosed their experiences of abuse or met with a social worker, flyers were placed on the back of women's bathroom doors in the antenatal clinics of participating sites. These invited women who have experienced recent "relationship issues" to participate in a telephone or face-to-face interview at the clinic. A dedicated 1800 number was also provided for women to call without cost. As recruitment yielded low numbers, recruitment was extended during this phase to midwives providing the high-risk clinic at one site, and at a second site with the Arabic-speaking antenatal educator.

Conduct of interviews

Interviews could be conducted either face to face at the clinic or by telephone, depending on participant preference. Consent to participate was sought at the time of the interview once the research team had explained the nature of the study and allowed potential participants to ask questions. For interviews conducted by telephone, a verbal assent process was used (provided in Appendix E). Interviews were conducted by Jeannette Walsh, a senior social worker and member of the research team with extensive counselling experience with women who have experienced DV; all were telephone interviews. Bilingual interviewers able to conduct interviews in Arabic and Mandarin were recruited, briefed and provided with a procedures document. Each bilingual interviewer developed translated versions of the interview guide and were provided with audio recorders to conduct telephone interviews in their own right. Interviews were audio-recorded with the woman's consent, and transcribed. The interview guide included an embedded distress protocol (see Ethics section), and prior to commencing the interview a code phrase was given to the woman to allow her to indicate to the interviewer that she could not continue by saying, "I have everything I need for the baby", which would alert the interviewer to end the call.

Interview guide

The semi-structured interview consisted of open-ended questions exploring women's experience of being asked about DV, disclosing DV, and accepting a referral to social work with the aim of developing a description of their pathway to safety and care (see Appendix F).

Participants

Five interviews were conducted with women who had experienced abuse and were referred to social workers at NSW sites. An additional eight women were approached by social workers. Of these, four declined to participate, and two were considering participation but were not subsequently seen by the social worker, so consent to be contacted by the research team was not secured. A further two women initially agreed to participate, but no contact could be made by the research team. The interviews were conducted from August to November 2018 and averaged 29.6 minutes (range 23–34 minutes). Of the five women, four were from the rural site and one (who spoke Nepalese) was from the metro, middle-income site. None of the women identified as Aboriginal or Torres Strait Islander peoples, however one of the women from the rural site had an Aboriginal partner and as a result was eligible for antenatal care from the local Aboriginal Maternal Infant Health Service where she was referred by the midwifery team later in her pregnancy.

Data analysis

Audio recordings were transcribed verbatim. The transcripts were uploaded into NVivo (Version 12.0) for thematic analysis (Vaismoradi et al., 2013). Thematic analysis is an approach that identifies, analyses and reports patterns or themes, and was undertaken to answer the research questions. Definitions and inclusion criteria for themes and creation of new subthemes occurred through a series of team discussions and the pathways to safety for each woman were mapped.

Focus groups and/or interviews with practitioners

This part of the study relates to the following objective: to understand how practitioners working in antenatal care perceive the process of screening, risk assessment and responses for DV.

This qualitative component facilitated the collection of detailed information on the perceptions and opinions of practitioners about DV screening and response. The semi-structured focus groups or interviews explored views and attitudes

towards workplace processes for screening, risk assessment and responses, and views on system elements that need to change to further enable effective and sustained screening. The offer of both interviews and focus groups enabled us to include staff who were not available to meet at the same time.

Practitioners' eligibility and recruitment

Practitioners were eligible to participate if they were a midwife or doctor working in an antenatal clinic or a social worker employed at one of the participating sites providing pregnancy care. Even though social workers do not screen for DV, they provided valuable information through participation in focus groups and/or interviews about what builds sustainable processes for screening. Practitioners were excluded if they were working in other areas of hospital care (e.g. neonatal services, gynaecology or oncology services, imaging centre, allied health or emergency departments) as they were not the target group for this research. The practitioners and other key informants were informed of the study via email broadcasts, staff e-newsletters, site intranets, and brief presentations at staff meetings.

Practitioners were approached through regular team meetings and those who expressed interest in participating were asked to read an information sheet. They were then asked to sign and date a consent form and given a resource card prior to the focus group or interview. Each focus group took place in an enclosed meeting room for privacy and was facilitated by a project team member with a research assistant. The project team member followed the focus group/interview guide and the field notes were recorded by the research assistant, including notes on the participants' responses, non-verbal behaviour, mood of discussion, and the setting and atmosphere of the focus group/interview. The research assistant gave each participant an ID number or pseudonym, drew a map of participant seating and recorded which participant made which contributions. This map helped to match the participant's contributions to the transcript of the focus group afterwards. The focus groups were expected to take approximately an hour and telephone interviews approximately half an hour. The focus groups/interviews were audio-recorded. Participants were also asked to complete a brief survey requesting demographic details (e.g. gender

[female/male], age, profession/position within the organisation [midwifery, nursing, medical, other], clinical area typically worked [maternity, neonatal, gynaecology, women's health, other], years working within the organisation, years worked as a health professional, any training on family violence and/or DV). Personal information collected was not identifiable and the data were reported in aggregate.

The research team planned to conduct one or two focus groups with 8–12 participants in each hospital health setting across the Victorian and NSW sites. Recruiting at least 12 participants is recommended as data saturation would most likely be reached for a range of themes (Guest, Bunce, & Johnson, 2006). Focus groups were designed to maximise privacy and confidentiality for health practitioners with an information sheet provided to each participant informing them of the study and their right to withdraw from the study at any time.

Focus group/interview guide

All investigators contributed to the development of the focus group interview schedule (see Appendix G), comprising open-ended questions exploring views and attitudes towards workplace processes for screening, risk assessment and responses, as well as views on system elements that need to change to further enact effective and sustained screening. The questions could be asked in a flexible sequence depending on the participant's responses. Prior to commencing the focus group or interviews, the questions were piloted for face validity with a convenience sample of midwives and/or doctors to ensure appropriate wording of questions.

Data analysis

Audio recordings were transcribed verbatim. The transcripts were uploaded into NVivo (Version 12.0) and analysed for key themes using the framework analysis approach. Framework analysis displays data in a matrix, uses case and theme-based approaches, reduces data through summaries and synthesis, retains links to the original data and allows for comprehensive and transparent data analysis (Smith & Firth, 2011). A coding tree was developed by Jeannette Walsh and Jo Spangaro in consultation with the chief investigators. The analysis was informed by the WITH framework (Figure 6) that was

developed to map key elements of a system approach for gender-based violence in health settings, but is not specific to antenatal care or DV.

Each transcript was read closely after the development of the coding tree. Transcripts were coded against each of the codes. Each code was reviewed, and a subsequent decision was made to focus on three overarching domains as identified by Garcia-Moreno et al. (2015): woman-centred care, healthcare practitioners supporting women, and health systems supporting healthcare practitioners. Elements of the WITH framework were incorporated under these major domains.

The key focus was on exploration of enablers of good practice for identification of DV and on the similarities and the differences between experiences in the different sites. Each code was reviewed, and transcripts were compared for similarities and differences with the following conditions for screening:

- sites with well-established DV screening processes in place
- sites with no DV screening processes in place or those who are newly screening.

Additionally, attention was paid to rural contexts to identify differences in rural settings compared to urban or regional settings.

General ethical considerations

In Victoria, approval for the SUSTAIN survey was sought and granted by the Human Research Ethics Committees for sites V4 and V5 where this aspect of the study was undertaken. Approval for the focus groups and interviews with practitioners was granted by the Human Research Ethics Committee for sites V4, V5, and V6. In NSW, multi-site approval was sought and granted from South Eastern Sydney Local Health District Human Research Ethics Committee, with site-specific approval granted by local districts.

The sensitive nature of DV requires that any study involving the topic pays particular attention to the ethics of unequal relationships, safety of participants, potential for distress and perpetrator awareness.

People in unequal relationships

Women or health practitioners could feel obliged to participate in the study. Women were assured that their participation in the survey or interview was voluntary and that choosing not to participate would not adversely impact on their pregnancy care at the hospital. Further, those women recruited from social work were reassured that their participation would not affect their counselling, and social workers would not know if they participated. Health professionals were assured that choosing whether to participate or not would not affect their work at the hospital.

Potential risks of distress and perpetrator awareness

Maintaining the safety of women and their children and practitioners was the primary concern in this study. The research was conducted in line with ethical and safety guidelines for research on women experiencing DV (World Health Organization, 2001). Potential risks for participants included distress and perpetrator awareness. Women or health professionals could feel distressed when completing the surveys, focus group discussions or interviews. Our experience is that this distress is usually minimal and the women perceive that undertaking research in this area is extremely valuable (Valpied, Cini, O'Doherty, Taket, & Hegarty, 2014). Previous studies have reported no increased DV or adverse patient outcomes following screening (O'Doherty et al., 2015). We followed a distress protocol with all research assistants trained in this protocol (Appendix H).

The research team were highly skilled at conducting research on sensitive topics such as DV. Research assistants were provided with appropriate training and could refer to more senior team members for guidance. The researchers aimed to uphold women's and practitioners' dignity and wellbeing by ensuring that they felt like a valuable part of the development

process, and that their expertise and experience were guiding the service response.

We carefully aimed to decrease the likelihood that perpetrators were made aware that the study is about DV. Apart from not approaching women who were closely accompanied by a partner and/or family member, we made sure in our initial approach and in the study materials that the study is called a "women's emotional wellbeing study". In contacting women, we only used safe emails and safe telephone numbers given to us by women once they were aware of what the study was about. We had a telephone protocol that if a woman did not answer, we did not reveal anything about the nature of the study, and if she was interrupted on the phone, we stated that we were calling from the University of Melbourne about a generic women's study.

Plain language statements (i.e. participant information and consent forms) were provided to all participants who were informed that they could opt out at any time without adversely affecting their quality of pregnancy care. All participants were also provided with resource cards with details of services they could access, if necessary. Participants were referred for support where required, either from members of the research team, or from the social services through which they were recruited.

Practitioners could also feel distressed during the focus groups or interviews; hence, practitioners were reminded that they could access counselling through the Employee Assistance Program. Women and practitioners at site V4 could also access the Consumer Advocate for any complaints about how the research was conducted.

Synthesis workshops

The SUSTAIN study investigated the research questions:

- How can we integrate and sustain screening, risk assessment and first-line responses to DV effectively into the complex health system of antenatal care?
- How can we overcome the specific challenges for health systems in regional and rural settings with low resources?

To answer these questions, we employed a range of research methods to gather data from various sources. This approach of triangulation facilitated a deeper understanding by allowing researchers to capture different dimensions or perspectives of the research problem and to cross-validate data that emerged across a range of contexts, where possible.

The synthesis process involved a series of investigators' workshops carried out in March and May 2019, in Melbourne and Sydney, respectively. The first was a one-day workshop and the second a two-day workshop. Given the volume of study findings obtained, the purpose of the initial investigators' workshop was to develop a broader familiarity with the various data sources, then assess and summarise the evidence relating to the research question. This workshop involved presentation of study findings by investigators from various study sites as well as small group discussions to work on various exercises and draw together the system barriers and facilitators for implementing and sustaining DV screening and responses (e.g. historical background, physical setting, and institutional and political contextual factors). Subsequently, we created a matrix of the SUSTAIN domains, data sources and themes based on the WITH Health System Implementation Model. Following the initial workshop, the research team refined and streamlined the findings based on further discussions.

The second workshop allowed investigators to integrate components or elements of the study to develop the REAL Transformation Model for the SUSTAIN study. During this workshop, investigators reviewed summaries of the different units of analysis of the study and held a series of discussions to develop the REAL Model using the matrix developed from the initial workshop. We sought to understand what works for whom and in what context, using a collective instrumental design with cross-case analysis to illustrate similarities and differences. The workshop also allowed investigators to review the ANROWS deliverables and share views for finalising the draft report. After the workshop, the new model was refined by the team, as needed, to reflect the findings.

PART C

Findings: Study context and health services readiness assessment

Introduction

This section of the report outlines the first part of the key findings from the SUSTAIN study, beginning with the study context, specific hospital characteristics that may influence practice, a description of screening practices, and a description of the audits of health services readiness that were carried out as part of the SUSTAIN study. The next two sections provide a description of findings using women's voices (based on the SUSTAIN survey and individual interviews of women with experiences of DV) and practitioners' voices (based on focus groups and/or interviews with practitioners).

The study context

To understand the variation in screening and first-line responses in antenatal care across different sites, it is important to have an understanding of the context in which the NSW and Victorian hospitals are working. The two states operate under very different policy contexts, and variability in antenatal screening rates and quality exists across Australia generally (Australian Institute of Health and Welfare, 2015). In NSW, screening has occurred for over a decade with mixed success, while in Victoria providers will be mandated to screen, risk assess and respond using the Multiagency Risk Assessment and Management Framework (see <https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management>) beginning in 2019/2020. The SUSTAIN study presented a unique opportunity to learn from the two states' antenatal experiences about what works, for whom and in what context.

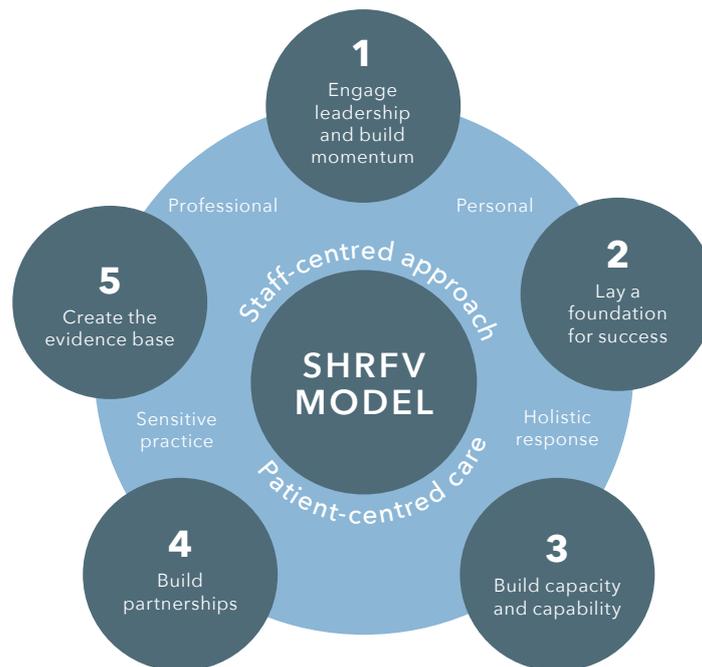
In NSW, a primary health model of care has been in place since 2009, with at-risk women being referred to a multidisciplinary case discussion called SAFE START. The key objective of SAFE START is to identify and support women and families with a range of social and emotional issues during pregnancy and following birth. This is achieved by early identification through psychosocial assessment as a component of routine antenatal and postnatal care, followed by referral to multidisciplinary case meetings that determine which health services should respond. The SAFE START psychosocial assessment covers seven factors identified as highly significant in contributing to poor maternal and child mental health outcomes, including

lack of social or emotional support; recent stressors in the past year; low self-esteem; history of anxiety, depression and other mental health problems; couple relationship problems; adverse childhood experience; and DV. Several other factors (including drug use) are acknowledged to contribute to poor mental health outcomes in children and families and are part of the broader obstetric and child and family assessment processes in NSW Health.

Subsequent to psychosocial assessment, women with significant risk factors are referred for discussion in multidisciplinary case discussion meetings (which include representatives from midwifery, child and family health nursing, alcohol and other drugs, social work, mental health and other relevant specialist services). Discussions in these meetings review initial assessments and decision-making about appropriate referral pathways, and are followed by development of a management plan, identification of a key worker and appropriate updating of the medical record. For women identified as experiencing current DV or having a history of DV, the specific aim is to ensure coordinated care, ongoing review and referral to specialist services.

In Victoria, based on recommendations made by the Royal Commission into Family Violence (2016), the Victorian Government has made commitments to preventing family violence including progress on Recommendation 95: strengthening hospital responses to family violence, and Recommendation 96: antenatal screening for family violence.

More recently, three interrelated reforms were introduced in Victoria to reduce family violence and promote child wellbeing and safety. The first two are the Child Information Sharing Scheme (CISS) and the Family Violence Information Sharing Scheme (FVISS). The third is the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM), which sets out responsibilities of different workforces in identifying, assessing and managing family violence risk across the service system. It will also guide information sharing. The roll out of the FVISS reform commenced in 2018 and it is expected that additional organisations and services will be authorised in 2020 under all three reforms (Victorian Government, 2019).

Figure C1 Strengthening Hospital Responses to Family Violence model

The Strengthening Hospital Responses to Family Violence (SHRFV) model, developed by Royal Women's Hospital (RWH) and Bendigo Health, addresses key elements of health system reform (Figure C1). However, capacity to implement the SHRFV initiative will be influenced by barriers and enablers at all levels, with the additional complexity of patient factors at individual (shame, understandings of family violence, fear) and social levels (cultural differences, disadvantaged or vulnerable populations) (Hegarty, Feder, & Ramsay, 2006).

Hospital characteristics

In addition to the state context, each of the hospitals has a variety of socio-demographic factors that will influence their ability to implement or sustain screening, risk assessment and responses to DV in antenatal care. We outline each in turn below.

Births

The annual number of births per hospital highlights the size of each hospital and the population of their respective catchment areas: site V4 is the largest, with 7765 births for a population of 135,959, whereas site V6 covers 330 births for a population of only 12,906.

In NSW, teenage fertility rates (<15 and 15–19 years) for sites N3 and N2 areas are in line with the state average of 2.17 percent. In contrast, rates for site N1 are very low (0.14 percent). This may reflect the significant Muslim population in this

area and associated, relatively conservative, social values. In Victoria, the regions in which the two rural sites are located have the two highest fertility rates for the state. In comparison, the region covered by site V4 has a fertility rate that is approximately one fifth of the state average.

Low birth weight is an indicator of poor birth outcomes due to complications during pregnancy for vulnerable populations (such as women living with DV) when compared to the general population (Australian Health Minister's Conference, 2011). In terms of low birth weight, site N2 in NSW was comparable to the state average of 6.7 percent, whereas the regions covered by sites N1 (3.7 percent) and N3 (4.4 percent) had lower rates of low birth weight relative to the NSW average. For Victoria, the region covered by site V5 had a comparable rate to the Victorian state average of 6.7 percent. Site V4 (7.1 percent) had only a slightly higher rate in comparison with site V6 (7.8 percent). Sites V4 and V6 covered regions with higher than average rates of babies born with low birth weight in Victoria.

Socio-economic disadvantage

Five of the research sites were in areas of relative socio-economic disadvantage according to IRSD data. A low IRSD score indicates greater disadvantage and a higher score a relative lack of disadvantage (Australian Bureau of Statistics, 2019c). Nationwide, the score ranges from 121 (Binjarri Aboriginal Community in the Northern Territory) to 1156 (HMAS Cerebus, the Royal Australian Navy's training base in

Victoria). The average ISRD score across the six sites ranged from 924 to 1033. According to IRSD scores, five of the six study sites fell within the bottom 40 percent of disadvantaged areas. As indicated in Table C1, in terms of disadvantage, the population of site V5 lives in the third lowest ranked region in Victoria, and the populations of sites N1 and N3 lie within the bottom 30 percent for NSW. However, some variations in socio-economic status existed between suburbs within study site areas of coverage. A good example is site V4,⁵ which provides healthcare across suburbs whose populations mostly live in some of the least disadvantaged areas in Victoria. The exception is a suburb within the inner city with an IRSD score of 995, placing it in a comparable position to suburbs within the other five study sites. The difference between this suburb and others within the area covered by site V4 is the high number of people born overseas from culturally and linguistically diverse (CALD) backgrounds (50%) when compared to the state average of 35 percent.

Overall, NSW hospitals in this study tended to provide services to areas of higher disadvantage than Victoria. The most notable site in NSW was N1, where 50 percent of the population live in suburbs with high levels of disadvantage. In Victoria, the region covered by site V6 had more than one third of the resident population living in highly disadvantaged areas. Site V5 nearly equalled this with 31.4 percent of surrounding suburbs being highly disadvantaged. By contrast, less than one quarter of the population were considered disadvantaged in suburbs covered by site V4.

The percentage of low-income families with children also highlighted differences and similarities between different sites and states. Site N3, a NSW rural hospital providing healthcare for a larger local government area (LGA), has a much higher percentage of low-income families with children (23%) compared to the state average of 16 percent. By contrast, areas covered by sites N1 and N2 were similar to the NSW state average. In Victoria, the area around sites V5 and V6 stood out as having more than the average number of low-income families. By comparison, site V4 service area had a much lower percentage of disadvantaged families with children (5.8%) when compared to the state average of 8.7 percent.

⁵ Average score across suburbs within site V4 catchment area, range 995-1087.

Aboriginal and Torres Strait Islander background

The number of Aboriginal and Torres Strait Islander peoples living within hospital service regions is also relevant when considering the scope and coverage of the different hospitals. The two large urban sites in NSW, N1 and N2, serviced areas with very low numbers of Aboriginal and Torres Strait Islander peoples (close to 1% each) compared to a state average of 2.9 percent. Rural areas have higher percentages of Aboriginal and Torres Strait Islander peoples, as typified by site N3 (5.6%) and its LGA (6.8%), which both have nearly double the number of Aboriginal and Torres Strait Islander peoples than the NSW average. In Victoria, the divide between rural and urban sites is also clear, with site V5 region's population made up of 2.3 percent Aboriginal and Torres Strait Islander peoples, compared to a state average of less than 1 percent. In site V6, 3.5 percent of the population identified as Aboriginal and/or Torres Strait Islander, which is more than four times the state average (0.8 percent). In site V4, which services suburbs within the inner city, 0.5 percent of its population identified as Aboriginal and/or Torres Strait Islander peoples, a little more than half the state average. In NSW, areas with higher Aboriginal populations are serviced by a network of Aboriginal and Maternal Infant Health Services that provide antenatal care, but not delivery services. These are provided in the community either via health district operated services or through Aboriginal Community Controlled Health Organisations (ACCHOs). Some do their own booking-in and screening and others receive referrals from women after the booking-in and screening processes at the local hospital.

Cultural and linguistic diversity

The percentages of people born overseas also highlights differences in demographic composition across the sites. In NSW, sites N1 and N2 stand out with more than two-thirds of their populations being born overseas—double the NSW average. This highlights the CALD populations covered by these health services. Site N3's area of coverage, on the other hand, has less than one quarter of its population born overseas, much less than the NSW average of 34.5 percent. In Victoria, despite a large Aboriginal and Torres Strait Islander population, site V5 region has only 9.2 percent of people born overseas, the lowest in Victoria. The other rural health service, site V6, also had low numbers of people born overseas (15%),

less than half the state average (35.1%). By contrast, site V4 service area includes nearly double the number of people born overseas compared to the state average.

Maternity unit models of care

The differences between maternity units at each hospital are set out in Table C1, which shows what is provided, the models of care used, antenatal clinics on offer, and the booking-in/referral process. One issue of note is the lack of Aboriginal-focused services at site N1, where Aboriginal women are referred to the Aboriginal Liaison Officer at the nearest Level 6 hospital—this may be understandable given the low numbers of Aboriginal and Torres Strait Islander peoples living in the site N1 area.

The booking-in process for women varies according to each hospital site. However, the first booking-in visit is typically much longer than subsequent ones and can take one to two hours to complete due to the comprehensive assessment undertaken which, in NSW, usually includes DV screening. In Victoria, it varies from 45 minutes to one hour as screening for DV has not yet been incorporated. Most hospitals ask that women book in for their first appointment with a midwife sometime between 12 and 17 weeks into their pregnancy.

Summary

The study sites varied by several characteristics. For instance, in NSW, site N1, in an urban region, had the lowest teenage fertility rate while sites N2 (urban) and N3 (rural) had teenage fertility rates comparable to the state's average. In Victoria, the two rural sites had higher teenage fertility rates than the urban site. Five out of the six study sites fell within the bottom 40 percent of disadvantaged areas, with the most disadvantaged being site N3 with an IRSD of 924 and the least disadvantaged being site V4 with an IRSD of 1033. Also, rural sites tended to have more Aboriginal and Torres Strait Islander peoples compared to urban sites, while the percentages of people born overseas were much higher in urban sites than rural regions. The next section describes the hospital audits of sites' readiness to undertake work in screening and responses to DV.

Table C1 Summary of contextual data for all sites

	Criteria	N1	N2	N3	V4	V5	V6
Maternity Unit Capabilities	Level of service	Level 3 ⁶	Level 5 ⁷	Level 3	Level 6 ⁸	Level 5 ⁹	Level 3 ¹⁰
	Screening Status	Systematic mandated screening Since 2003	Systematic mandated screening Since 2003	Systematic mandated screening Since 2003	Not yet systematically screening	Early screening using systematised questions	Early screening using systematised questions
Births	Annual births	1310 (1.4% of NSW births)	2483 (2.6% of NSW births)	297 (0.3% of NSW births)	7765 (11.7% of VIC births)	1486 (1.9% of VIC births)	330 (0.4% of VIC births)
	Low birthweight babies	3.7% Nearly half NSW average of 6.7 percent	6.6% Comparable to state average of 6.7 percent	4.4% Lower than NSW average (6.7%)	7.1% Close to Victorian average of 6.6 percent	6.7% Comparable to state average (6.6%)	7.8% Slightly higher than state average (6.6%)
	Teenage fertility rates (<15, 15-19 years)	0.1% Low compared to state average of 2.2 percent	2-3% Comparable to state average of 2.2 percent	2.7% Slightly more than average (2.2%)	0.3% Low for state average of 1.5 percent	1.9% More than state average of 1.5 percent	2.1% More than state average (1.5 percent)

6 NSW Level 3 services provide “immediate care for newborns ≥ 34 +0 weeks gestation, where the mother had no identified risk factors or was identified as being at risk but did not require transfer of care for birth” (NSW Health, 2016, p. 30).

7 NSW Level 5 services provide, neonatal care at a “Supra Local Health District” level including “comprehensive neonatal care for all newborns, within a multidisciplinary management model (excluding surgical, cardiac and metabolic services)” (NSW Health, 2016, p. 34).

8 Victorian Level 6 services provide all Level 5 services plus more complex clinical services such as onsite pathology, imaging, pharmacy and drug and alcohol treatment services (Victorian Health and Human Services, 2019, p. 18).

9 Victorian Level 5 service “provides maternity care of any risk level for women living within the local community; state-wide access to specialised maternity care for women experiencing a high-risk pregnancy, labour and birth; specialist on-site services for all levels of maternal complexity; maternal foetal medicine service; Level 6 newborn care; full range of expertise to support critically ill woman and all unexpected maternal emergencies” (Victorian Health and Human Services, 2019, p. 16).

10 Victorian Level 3 service “provides comprehensive maternity care for women with uncomplicated, low-risk and normal-risk pregnancies” (Victorian Health and Human Services, 2019, p. 14).

Criteria	N1	N2	N3	V4	V5	V6	
Demographics	IRSD/SEIFA	IRSD = 971 Pop. 116,009 Bottom 25% for NSW (NSW IRSD=997)	IRSD = 977 Pop. 277,754 Bottom 40% in NSW (NSW IRSD=997)	IRSD = 924 Pop. 37,232 Bottom 30% in NSW (NSW IRSD=997)	IRSD = 1033 Pop. 135,959 Top 10% in Victoria (Victoria IRSD=1010)	Average IRSD = 975 Pop. 316,487 Bottom 10% in Victoria (IRSD=1010)	Average IRSD = 969 Pop. 12,906 Bottom 30% in Victoria (IRSD=1010)
	Percentage of population disadvantaged	50% ¹¹	33%	40%	22%	31.4%	35.9%
	Percentage of low-income families with children	16% Same as NSW average (16%)	16% Same as NSW average (16%)	23% Higher than NSW average (16%)	5.8% Much lower than state average (8.7%)	10.9% Highest in the state	10.8% Higher than state average of 8.7%
	Percentage of Aboriginal and Torres Strait islander people	0.9% Well below NSW average population of 2.9 percent	1% Well below NSW average population of 2.9 percent	N3 = 6.8% LGA = 5.6% Approx. double average for NSW (2.9%)	0.5% Well below the Victorian average of 0.8 percent	2.3%, highest in state Nearly three times Victorian average of 0.8 percent	3.5% More than four times Victorian average of 0.8 percent
	Percentage of people born overseas	70.5% Double state average of 34.5%	69% Double state average of 34.5%	22.3% Low compared to state average (34.5%)	67.3% Nearly double state average of 35.1%	9.2% Lowest in Victoria	15% Less than half Victorian average of 35.11%

¹¹ Percentages and measures have been averaged across the different state suburbs or local government areas within each hospital's catchment area. Please note that there may be significant differences between suburbs within each of these hospital catchment areas.

Criteria	N1	N2	N3	V4	V5	V6	
Maternity Unit models of care	Models of care offered	<ul style="list-style-type: none"> • GP Shared Care • Continuity of care¹² available for majority of women dependent on staffing • Referral to <i>Multidisciplinary Case Discussion</i>¹³ for at-risk women 	<ul style="list-style-type: none"> • GP Shared Care • Continuity of care is team-based apart from high-risk women seeing complex care midwives • Referral to <i>Multidisciplinary Case Discussion</i> for at-risk women 	<ul style="list-style-type: none"> • GP Shared Care • Continuity of care only available for a small number of low-risk women (Midwifery Group Practice) due to resourcing/staffing constraints and unfunded continuity of care proposal • Referral to <i>Multidisciplinary Case Discussion</i> for at-risk women 	<ul style="list-style-type: none"> • GP Shared Care • Continuity of care for women using one-to-one midwife care and Midwives in Small Teams MIST (8 midwives caring for woman work in shifts) • Women's Community clinics 	<ul style="list-style-type: none"> • GP Shared Care • Continuity of care provided under Mamta Caseload program for low-risk women • High Risk Obstetric Care • Low Risk Care (midwives) 	<ul style="list-style-type: none"> • GP Shared Care • No continuity of care due to resourcing/staffing constraints (Level 3) • Enhanced Maternity Care Program (EMCP) by specialist midwife & social worker • EMCP outreach for vulnerable mothers & babies
	Antenatal clinics offered	<ul style="list-style-type: none"> • Doctors' antenatal clinic • Midwives' antenatal clinic • Gestational diabetes clinic • Early pregnancy assessment (<20 weeks gestation) 	<ul style="list-style-type: none"> • Doctors' antenatal clinic • Midwives' antenatal clinic • Gestational diabetes clinic • Outreach clinics • Twins clinic • High body mass index clinic • Genetic referral service • Foetal medicine clinic • Risk-associated pregnancy clinic • Obstetric medicine (renal physicians) • Caesarean clinic 	<ul style="list-style-type: none"> • High-risk midwives' antenatal clinic 	<ul style="list-style-type: none"> • Doctors' antenatal clinic • Women with individual needs clinic • Women's alcohol and drug service • Young women's health program 	<ul style="list-style-type: none"> • Doctors' antenatal clinic • Midwives' antenatal clinic • Gestational diabetes clinic 	<ul style="list-style-type: none"> • Doctors' antenatal clinic • Midwives' antenatal clinic

¹² Continuity of care refers to antenatal care provided by the same midwife. Note: at no sites was the booking-in visit part of any continuity of care provision.

¹³ Also referred to as SAFE START in NSW.

Criteria		N1	N2	N3	V4	V5	V6
Maternity Unit models of care	Booking-in process (screening visit in screening sites)	<ul style="list-style-type: none"> • Referral by GP • Booking-in by midwives • Appointment confirmation states women should attend alone 	<ul style="list-style-type: none"> • Referral by GP • Booking-in by midwives 	<ul style="list-style-type: none"> • Self-referral • Booking-in by midwives 	<ul style="list-style-type: none"> • Referral by GP • Booking-in by midwives 	<ul style="list-style-type: none"> • Referral by GP • Booking-in by midwives 	<ul style="list-style-type: none"> • Self-referral • Booking-in by midwives
	Responses for Aboriginal women	<ul style="list-style-type: none"> • No specific Aboriginal Maternal Infant Health Service • Support of Aboriginal Liaison Officer at closest Level 5 hospital (12 km) 	<ul style="list-style-type: none"> • Aboriginal Maternal Infant Health Service does own bookings with backup from generalist midwives as needed 	<ul style="list-style-type: none"> • Aboriginal Maternal Infant Health Service (antenatal and post-natal care) • Aboriginal women managed via Aboriginal Health Team 	<ul style="list-style-type: none"> • <i>Badjurr-Bulok Wilam</i> Aboriginal and Torres Strait Islander Women and Families Place • Caseload for A&TSI women and babies—all risk model (Baggarrook) • Shared care with Victorian Aboriginal Health Service 	<ul style="list-style-type: none"> • Aboriginal Hospital Liaison Officer 	<ul style="list-style-type: none"> • Aboriginal Hospital Liaison Officer • Njernda Aboriginal Corporation, a local ACCHO

Table C2 NSW and study site domestic violence routine screening rates

	NSW Health (all antenatal: November 2015) n (%)	N1 July 2017–June 2018 n (%)	N2 July 2017–June 2018 n (%)	N3 July 2017–June 2018 n (%)
Eligible women	6353	1596	2443	374
Screening rate	5726 (90.1%) CI ^a 89.8–90.2%	1578 (98.9%) CI 98.7–99%	2345 (96%) CI 95–97 %	308 (82.4%) CI 81–83%
Disclosure rate	192 (3.4%) CI 3.2–3.5%	15 (0.1%) CI 0.8–1.1%	36 (1.5%) CI 0.5–2.6%	17 (5.5%) CI 5–6%
Report made to child protection	23 (12%) ^b CI 11.8–12.2%	0	0	1 (5.9%) ^b -
Notification to police	6 (3%) ^c -	0	0	0
Women not screened Reason:	627 (9.9%) CI 9.3–10.5%	18 (1.1 %) CI 0–2.4%	98 (4 %) CI 3–5%	66 (17.6 %) CI 15.3–20%
Partner present	193 (32%) ^d CI 29.1–32.5%	1 (5.5%) ^b -	8 (8.2%) ^b -	35 (53%) ^d CI 48.7–57.3%
Others present	84 (13.4%) ^d CI 6.3–20.5%	4 (22.2%) ^d -	1 (1%) ^d -	5 (7.6%) ^d -
Declined to answer	5 (1%) ^d -	1 (5.5%) ^d -	0 -	1 (1.5%) ^d -

Notes: ^aCI refers to confidence interval

^b As a percentage of those identified

^c As a percentage of those disclosing

^dAs a percentage of those not screened

Audits of screening

Screening for DV

New South Wales

At NSW sites, screening for DV has been in place in public hospitals since 2003, under NSW Health policy (NSW Department of Health, 2006). As a result, the approach is consistent across all sites, sitting within a broader psychosocial assessment completed at the first antenatal appointment. Screening occurs when the woman is alone and includes a preamble (e.g., "We ask everyone because it is common but can be serious"). Women are given the choice to not answer. Screening consists of two questions, asking about the past 12 months (violence by their partner or ex-partner, frightened of their partner or ex-partner). If she answers "yes", a woman is then asked about her safety and her children's safety and if she would like assistance. All women are offered an information card about DV that includes key messages about the nature of abuse and a free call hotline number. The card uses a "z card" format, presenting as a wallet sized resource that folds out to A4 paper size and has no violence-related text or material on

the cover, instead with a design similar to a female hygiene product to reduce the likelihood of it drawing attention. All sites had conducted comprehensive training at the rollout of screening and each local health district is required to have an ongoing training strategy for screening.

Experiencing or being affected by DV is considered a form of child abuse that may require a statutory child protection report in NSW. To determine this, health providers must consider whether an incident of DV (whether child/young person was present or not) has occurred where a parent/carer or other adult household member used a weapon; attempted to kill a household member; seriously injured an adult; caused physical injury to a child/young person; and/or seriously threatened to harm a child/young person/adult/self, as well as whether DV was persistent or there has been a significant increase in the pattern/level of violence (NSW Department of Justice, 2014).

Table C2 sets out the screening rates for NSW sites for the period 1 July 2017–30 June 2018. The overall rate is also

Table C3 SUSTAIN sites, demographics and actions taken during antenatal care: domestic violence identified

	Site N1 n (%)	Site N2 n (%)	Site N3 n (%)
Women identified experiencing DV	15	36	17
Women born in country where English is not first language ^a	13 (87%)	14 (39%)	0
Interpreter required ^a	4 (26.7%)	3 (5.4%)	0
Referred to multidisciplinary case discussions ^{a,b}	6 (40%)	27 (75%)	14 (82.4%)
Psychosocial care plan written ^c	6 (100%) ^c	25 (92.6%) ^c	14 (100%) ^c
Child protection report made during antenatal care ^a	0	4 (11.1%)	3 (17.6%)
Referred to social work ^a	7 (46.7%)	15 (41.7%)	7 (41.2%)
Referred to drug and alcohol services ^a	0	8 (22.2%)	5 (29.4%)
Referred to mental health services ^a	0	3 (8.3%)	6 (35.3%)
Referred to Aboriginal Maternal Infant Health Services ^a	0	0	4 (23.5%)

Notes: ^a Of women who reported DV

^b Also known as SAFE START

^c Of those referred to multidisciplinary meetings

reported for NSW publicly funded antenatal hospitals from November 2015, which is the most recent data available. Confidence intervals (CI) at the 95 percent level are also reported, where available.

All three NSW sites have very high rates of routine screening for DV ranging from 82.4–98.9 percent. Two sites were above the state screening rate for antenatal care of 90.1 percent. Despite robust screening rates, not all sites had equally high rates of DV disclosure, ranging from 0.1–5.5 percent compared to the NSW 2015 disclosure rate for antenatal services of 3.4 percent as reported in Table C2. It should be noted that the disclosure rate is for the point of screening only. It does not include disclosures made in subsequent visits, which are not captured in eMaternity. Elements outlined in the contextual information (Table C2) may contribute to the relatively lower disclosure rate at sites N1 and N2—in particular, the high number of women born overseas.

Table C3 reports on the women who disclosed DV at screening at NSW sites from 1 July 2017–30 June 2018. First, as noted, sites N1 and N2 had a high proportion of women who were born in a country where English was not the first language. At sites N1 and N2, of women who disclosed abuse, a higher proportion spoke a language other than English (87 percent

and 39 percent respectively), with 26 percent and 5 percent requiring an interpreter, respectively. At site N3, all women who disclosed abuse were born in Australia, reflecting the demographics of the rural location, and 23 percent of women were referred to the Aboriginal Maternal Infant Health Service. In examining referrals or actions once DV was identified, for sites N2 and N3, most women were referred for discussion at multidisciplinary case meetings (SAFE START), while at site N1, 40 percent were referred to multidisciplinary meetings. At sites N1 and N3, all women referred to multidisciplinary meetings had plans developed to address psychosocial needs, while at site N2, two women did not have plans developed. During antenatal care, child protection reports were noted as being made for women at sites N2 and N3 (compared to no reports made at screening at site N1). At all sites, approximately 40 percent of women were referred to social work; smaller numbers were referred to drug and alcohol and mental health services. Anecdotally, the reason that not all women are referred to social work includes the fact that some abuse reported is no longer current; further, at all NSW sites, referral to the SAFE START meeting is used as a mechanism for non-urgent referrals. Data available is only from screening or multidisciplinary meetings and does not include all referrals made during antenatal care. Multiple referrals may have been made for each woman.

Status of screening in Victoria

There is variability of screening across Victoria, as it was only mandated in 2018 in some pilot sites; for all sites, screening is mandated for 2019/20. Site V4 has not yet introduced systematic implementation of screening but is closely involved in developing and piloting tools for state-wide use. At site V5, routine antenatal DV screening is recommended but not yet compulsory. At V5 all midwives are recommended to ask women about safety in their home environment at the first appointment where the woman is alone, as well as at a second time later in pregnancy care, and re-screening occurs for women who have not previously disclosed, but for whom risk is suspected. Screening consists of four questions about the past 12 months (fear, control/humiliate/put you down, threatened to hurt, or hurt) with additional questions about children and if women would like help.

At site V6, it is recommended that screening for DV occurs at booking-in appointments. Each patient completes the Antenatal Psychosocial Risk Questionnaire, which asks about emotional support from their partner, stresses, changes or losses in the past 12 months and associated distress, and sexual or physical abuse. These questions are scored but there is an additional unscored question that asks if they feel safe with their current partner (five-point response range). If women disclose DV in response to any of the above questions, the practitioner is supposed to sensitively enquire further.

Mandatory reporting requirements for children exist across all states in Australia. Victoria differs from NSW in that where a child has been or is currently at risk of significant harm from physical or sexual abuse, registered medical practitioners, nurses, midwives and registered psychologists have mandatory reporting requirements. Social workers are not currently mandated to report suspected cases of child abuse, although they have a duty of care in this area.

Health services readiness

Hospitals demonstrated a high level of readiness to capture the issues related to women living with DV. Hospitals answered in the positive for the majority of issues related to service readiness. The only exceptions were responses to one question related to healthcare provider training at NSW sites

and two questions regarding information, monitoring and evaluation for Site V4. See Table C4 for items and responses from each site.

NSW service readiness

Of the three NSW sites, each scored “Yes” on all items except for one question regarding staff training. Two of three NSW sites scored “No” on this item, which asked, “Have health-care providers received training on responding to violence against women/family violence?” When screening for DV was introduced by state-wide health services in NSW in 2003, it was accompanied by a comprehensive training program, with each local health district subsequently given responsibility to maintain training. Although training occurred at each site initially, coverage of training for new staff has not been maintained at all sites. At sites N1 and N2, it was noted that some training occurs for social work and nursing but there was no specific DV training for medical officers. However, both hospitals conduct mandatory child protection training for medical staff that included DV. At site N3, the clinical nurse educator for the area did not provide training on DV. Although a dedicated DV training workshop was held at the hospital half an hour to the north in the previous three months, it was unclear whether any of the site N3 hospital midwives attended. One of the issues raised was a lack of resourcing/staffing required to adequately train staff. Neither site N1 nor N2 had a dedicated budget for training on DV, with both having to rely on the child protection educator funded under the Health District’s SAFE START program. Site N3, however, does have a dedicated Domestic Violence and Child Protection Educator who can provide staff with DV training.

At all NSW sites, the main mechanism for support for women identified at risk of DV was referral to SAFE START meetings, the fortnightly multidisciplinary team meetings that include representatives from mental health and social work who determine optimal referral pathways. Options for immediate follow-up to disclosure were limited at each site due predominantly to lack of staff required to respond to the needs of women.

Table C4 Service readiness to respond to domestic violence

Service Areas	Questions	VIC sites			NSW sites		
		Site V4 (metro, high income)	Site V5 (rural, low income)	Site V6 regional health (rural, low income)	Site N1 (metro, low income)	Site N2 (metro, middle income)	Site N3 (rural, low income)
Service delivery	Written protocols	Yes	Yes	Yes	Yes	Yes	Yes
	Minimum care package	Yes	Yes	Yes	Yes	Yes	Yes
Health workforce	Healthcare provider responsibilities	Yes	Yes	Yes	Yes	Yes	Yes
	Healthcare provider training	Yes	Yes	Yes	Yes	Yes	No
	Mentoring, supervision & support	Yes	Yes	Yes	Yes	Yes	Yes
Infrastructure and resources	Consultation space	Yes	Yes	Yes	Yes	Yes	Yes
	Reader-friendly written information	Yes	Yes	Yes	Yes	Yes	Yes
Leadership, governance and accountability	Providers & managers supportive	Yes	Yes	Yes	Yes	Yes	Yes
	Confidential feedback mechanisms	Yes	Yes	Yes	Yes	Yes	Yes
	Workplace policy for healthcare providers	Yes	Yes	Yes	Yes	Yes	Yes
Budget/finances	Budget allocation for care/service provision	Yes	Yes	Yes	No	Yes	Yes
Multisectoral coordination/ community engagement	Referral system across services/sectors	Yes	Yes	Yes	Yes	Yes	Yes
	Services/organisations informed	Yes	Yes	Yes	Yes	Yes	Yes
Information, monitoring and evaluation	Monitoring indicators/ data collected, collated and used	No	Yes	Yes	Yes	Yes	Yes
	Intake forms/registers	No	Yes	Yes	Yes	Yes	Yes

Victoria service readiness

Of the three Victorian sites, V5 and V6 scored “Yes” on all items. Site V4 scored “Yes” to all items except the two questions under information and monitoring: “Are indicators and data to monitor the health responses to violence against women or family violence being collected, compiled and used to improve services?” and “Are there intake forms/ registers and confidentiality mechanisms (for example, secure storage and removal of identifying information) for recording information about patient’s experience of violence and care received?” Site V4 noted that data to monitor the health responses to violence against women or family violence was collected as part of a social work survey and at the time they were working on confidentiality mechanisms with the University of Melbourne.

- Does it assess the reliability (self versus external) of audit processes?
- Does the use of scales allow for “partial” ratings?
- Is this the best way to support achievement of standards across systems and services?

Summary

Although screening for DV has not yet been formally introduced in Victoria, responsiveness to this issue is demonstrated across each site in Victoria and NSW, indicating that considerable planning and service reform has been undertaken at a system level to improve responsiveness to DV. Systems to ensure ongoing and updated training and data collection are areas that require further attention and resourcing across systems and states.

The checklist demonstrated a readiness to respond across all sites; however, the tool used, intended for use in countries with less developed health services, proved to be too simplified to effectively evaluate gaps in service provision across the six sites. The tool used did not provide capacity for a “partial” response option and addressed responsiveness at a broad level without specific measurement notes. There is a need for sector-wide consultation to determine the best approach for such tools, including questions regarding the purpose of the tool:

- Is it intended to guide change/to monitor change over time/to provide accountability?
- Should the standards be “visionary” reflecting “ideal” versus “minimum” standards?

Findings: Women's voices

This section consists of findings from surveys conducted at two Victorian sites (V4 and V5) and a small number of interviews with antenatal women where DV was identified (N1 and N3 sites).

Survey of women

Background

The SUSTAIN survey was a survey of women conducted before routine DV screening in antenatal settings commenced in Victoria. The survey was completed by 1067 and 152 pregnant women at sites V4 and V5, respectively, while they were in the waiting room before appointments (see Tables D1 and D2 for demographic data). Below key findings are presented for the overall group, and then either by clinic or abuse classification (abused or non-abused), as applicable. Participants classified as “abused” were those who screened positive for abuse on at least one screening item or on CAS (with a score of at least three overall or having met requirements for one of the abuse categories on the CAS). A small number of participants were unable to be classified, due to not answering screening and CAS items. Where study results for sites V4 and V5 are similar, the findings are presented together.

Sociodemographic characteristics

The average age of participants in the V4 study site was around 33 years, with nearly half of the women (49%) expecting their first child. Around 97 percent of the women had a current partner and more than two thirds were married (70%). Approximately one percent of respondents were Aboriginal and Torres Strait Islander peoples, nearly half were born outside Australia (45%) and over one quarter (27%) did not speak English as a first language. Most respondents (92%) had completed at least Year 12 of school and 72 percent had completed a degree or a higher degree (Table D1).

The mean age for participants at site V5 was 30 years, with 45 percent of women expecting their first child. About 92 percent had a current partner and 50 percent were married. Nearly 4 percent were of Aboriginal or Torres Strait Islander descent, 6.5 percent were born outside Australia and only 1.5 percent did not speak English as a first language. Sixty-

eight percent had at least a Year 12 level of education and 30 percent had completed a degree or higher degree (Table D2).

Rates of domestic violence and abusive behaviours experienced by participants

The SUSTAIN survey screened participants for DV using four screening items relating to partner or ex-partner behaviours. These four items were presented in two ways: the first set requiring a simple “yes or no” response, and the second set requiring participants to select how often the behaviours occurred. Further details about DV experienced by participants was also collected via the CAS (see Methodology section). Participants were also asked whether they had experienced abusive behaviours from other family members.

Domestic violence in past 12 months

Overall, 14.2 percent (n = 170) of the survey sample were positive for DV in the past 12 months on the screening items or the CAS. When using screening items that asked for a “yes or no” response, 8.3 percent of the survey sample screened positive for DV in the past 12 months; that is, they had experienced fear-inducing, controlling, threatening or physical behaviours from a partner or ex-partner (Figure D1). When also using the same screening items that asked how often the behaviours had occurred, 9.3 percent screened positive for DV in the past 12 months (Figure D2). The most common type of behaviour experienced was behaviour that made the participant feel afraid. On the CAS, approximately 1 in 10 women were classified as experiencing DV if using a cut-off score of 3, and 1 in 20 if using a cut-off score of 7 at both survey sites.

Types of partner/ex-partner abuse experienced in past 12 months

Similar trends were observed in the types of abuse occurring among participants at sites V4 and V5, with emotional abuse or harassment being the most common type and physical abuse only being the least prevalent (Figure D3).

Table D1 Demographic data for site V4 participants, N = 1067^a

	Mean	SD
Age in years (n = 942, min = 18, max = 48)	33.2	4.5
Weeks pregnant (n = 991, min = 6, max = 41)	27.0	7.6
	N	Percent
First baby	515	49.2
Has current partner	1008	96.6
Married	707	69.8
De facto (living with partner)	263	26.0
Type of care received		
Hospital care	462	54.7
Shared care	204	24.2
Midwifery care	154	18.3
Medical care	43	5.0
Specialist clinic	63	7.0
Community clinic	2	0.2
Attending first appointment	218	21.0
Aboriginal or Torres Strait Islander person	10	1.0
Born outside Australia	455	45.0
English not first language	273	27.1
Finished school to Year 12	931	92.4
Completed a degree or higher degree	729	72.2
Has a Health Care Card	289	28.6
Ease of managing on current income		
Easily	411	40.3
Not too bad	404	39.7
Difficult some of the time	175	17.2
Difficult all of the time	26	2.6
Impossible	3	0.3

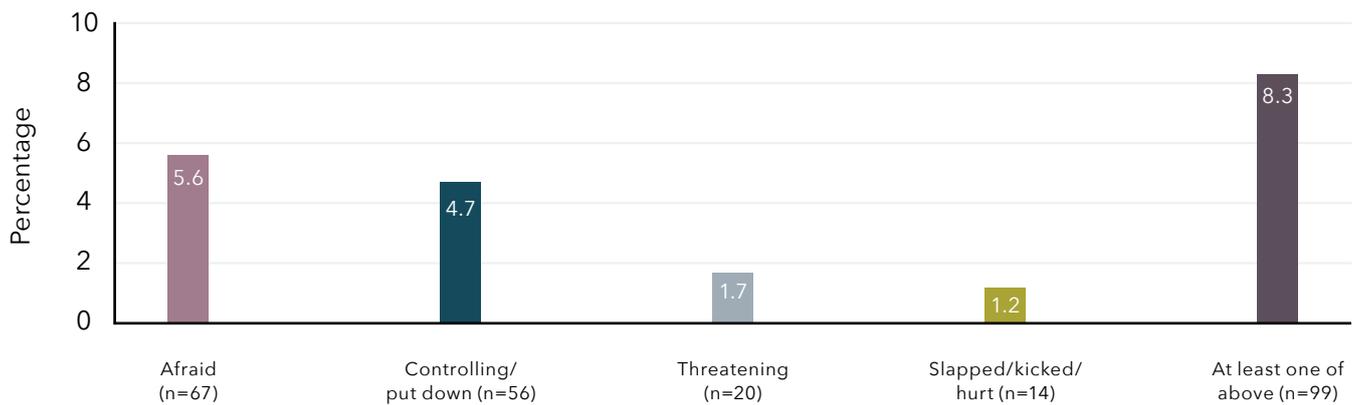
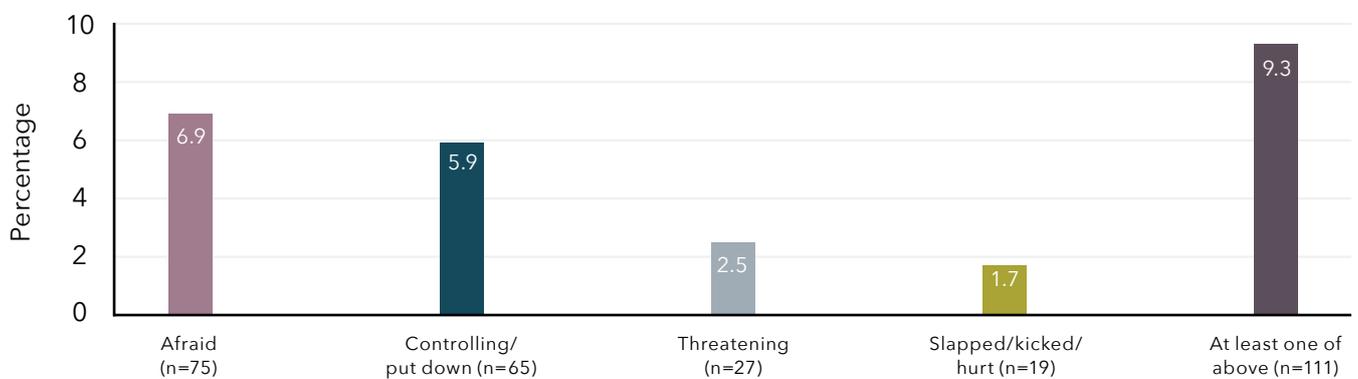
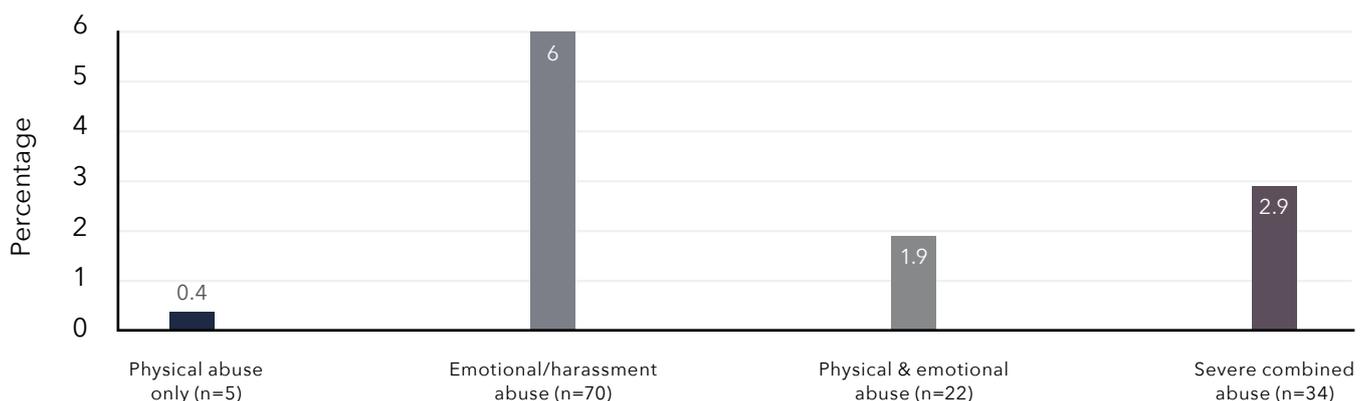
Note: ^a Denominators vary due to missing data.

Table D2 Demographic data for site V5 participants, N = 152^a

	Mean	SD
Age in years (n = 118, min = 19.7, max = 41.6)	30.0	5.0
Weeks pregnant (n = 151, min = 6.3, max = 45.0)	31.1	7.4
	N	Percent
First baby	45	29.8
Has current partner	136	91.9
Married	69	49.6
De facto (living with partner)	54	38.9
Clinic attended		
Antenatal doctors	121	80.1
Diabetes in pregnancy	12	8.0
Diabetes	10	6.6
Midwives & booking-in	9	5.9
Type of care received ^b		
Hospital care	80	57.1
Shared care	27	19.3
Midwifery care	14	10.0
Medical care	11	7.9
Specialist clinic	17	12.1
Community clinic	0	0.0
Attending first appointment	13	8.6
Aboriginal and/or Torres Strait Islander person	5	3.7
Born outside Australia	9	6.5
English not first language	2	1.5
Finished school to Year 12	94	68.1
Completed a degree or higher degree	41	29.9
Has a Health Care Card	48	34.5
Ease of managing on current income		
Easily	35	25.2
Not too bad	68	48.9
Difficult some of the time	29	20.9
Difficult all of the time	7	5.0
Impossible	0	0.0

Notes: ^a Denominators vary due to missing data.

^b Some participants received more than one type of care. Total number of participants who answered this question = 140.

Figure D1 Percentage of participants who screened positive for DV based on “yes/no” screening items only (N = 1192)**Figure D2** DV behaviours experienced based on frequency screening items (N = 1194)**Figure D3** Types of abuse (N = 1175)

Abusive behaviours from other family members

Overall, four percent of participants experienced abuse from other family members. The most common perpetrators were parents (n = 33), siblings (n = 8) and parents-in-law (n = 8). Abusive behaviours were also perpetrated by siblings-in-law, uncles and aunts, and children.

Fear of partner/ex-partner or other family member

Participants were asked if they had experienced fear of their partner, ex-partner or someone in their family (see Appendix D, item B1). Approximately 5 percent (n = 57) of participants had been afraid of a partner, ex-partner or other family member at least a little of the time in the past 12 months. About 26 percent (15/57) of participants who had been fearful of a partner had ever talked to a doctor or midwife about it.

Table D3 Fear of partner/ex-partner or other family member and disclosure of fear ^{a,b}

	Total (N = 1190) n (%)	Abused ^c (N = 168) n (%)	Non-abused (N = 979) n (%)
Experienced the following in last 12 months:			
Fear of partner/ex-partner or other family member			
A little or some of the time	57 (4.7)	41 (24.4)	15 (1.5)
Most or all of the time	7 (0.6)	7 (4.2)	0 (0.0)
Feeling down, depressed or hopeless			
A little or some of the time	758 (63.7)	130 (77.4)	598 (61.1)
Most or all of the time	41 (3.4)	12 (7.1)	27 (2.6)
Worrying a lot about everyday problems			
A little or some of the time	699 (58.7)	99 (58.9)	575 (58.7)
Most or all of the time	138 (11.6)	47 (28.0)	87 (8.9)
Alcohol and/or drug use			
A little or some of the time	60 (5.0)	12 (7.1)	48 (4.9)
Most or all of the time	26 (2.2)	7 (4.2)	18 (1.8)
Talked to midwife or doctor about these issues (ever):			
Fear of partner/ex-partner or other family member	15 (1.3)	13 (7.7)	2 (0.2)
Feeling down, depressed or hopeless	258 (21.7)	49 (29.2)	200 (20.4)
Worrying a lot about everyday problems	184 (15.5)	40 (23.8)	136 (13.9)
Alcohol and/or drug use	22 (1.8)	5 (3.0)	17 (1.7)
Would consider using help from a midwife or doctor if available for:^d			
Fear of partner/ex-partner or other family member	192 (16.1)	62 (36.9)	122 (12.5)
Feeling down, depressed or hopeless	705 (59.2)	125 (74.4)	556 (56.8)
Worrying a lot about everyday problems	586 (49.2)	112 (66.7)	456 (46.6)
Alcohol and/or drug use	179 (15.0)	34 (20.2)	139 (14.2)

Notes: ^a Denominators vary due to missing data.

^b Forty-three participants could not be classified, as they did not complete abuse screening questions and also did not complete the CAS.

^c Screened positive for abuse on C2 screening items or CAS.

^d Response option, "I have not experienced this issue" was also provided.

Similarly, there were disproportionately more participants who had experienced depression, worrying or used alcohol or drugs than those who had actually spoken to a doctor or midwife about these issues. Asked if they would consider using help from a doctor or midwife for these issues, a relatively high proportion of all participants responded in the affirmative (16%, 192/1190) (Table D3).

Participants' comfort to discuss issues ("abused" category only)

The SUSTAIN survey also included items about participants' feelings about discussing various issues, including social and emotional issues with a midwife or doctor. Participants at sites V4 and V5 health facilities were similar in terms of how comfortable they felt about discussing issues. Overall, just over one quarter (n = 43) of participants were comfortable or very comfortable about speaking to a midwife or doctor about fear of partner or ex-partner, more than half (n = 100) were neutral or indicated this was not applicable to them, and about 15 percent were uncomfortable or very uncomfortable (n = 26). Participants were generally more comfortable talking about feeling down or depressed or worrying about problems and least comfortable talking about alcohol and/or drug use (Figure D4).

Perceptions about talking to a midwife or doctor about emotional /social issues

Tables D4 and D5 show respondents' views about talking to a midwife or doctor about emotional and social issues. Over one third of all participants felt they could talk to their midwife about emotional and social issues, and that the midwife was very supportive. Around one third of participants (34.5%) also believed the midwife would give them help if needed, and 24 percent reported that the midwife asked them questions that helped them talk about emotional and social issues. Almost one quarter of abused participants thought the midwife was only there to look after their pregnancy care (24%), while only 11 percent of non-abused participants held this belief. A small percentage of participants felt that the midwife was often busy and did not have time to listen (4% of participants overall). This issue was more common among abused participants than non-abused women (7% for abused participants versus 4% for non-abused participants).

Almost one third of all participants felt they could talk to their doctor about emotional and social issues, and that the doctor was very supportive. About 30 percent of participants also believed the doctor would give them help if needed, although only 14 percent reported that the doctor asked them questions that helped them talk about emotional and social issues. Twenty-three percent of abused participants thought the doctor was only there to look after their pregnancy care, while 12 percent of non-abused participants held this belief. Twenty percent of abused participants thought the doctor was often busy and did not have time to listen, while only 10 percent of non-abused participants held this belief.

Nearly one third of participants in the abused group found both doctors and midwives very supportive; however, about 24 percent thought the health professionals were there only for pregnancy care. Compared to midwives, more participants found the doctor to be busy and appeared to not have time to listen. Also, more midwives asked questions that helped participants to talk about emotional and social issues ("helped me open up") compared to doctors, and a few participants thought that health professionals might do something that could make their situation worse (Figure D5).

When do women want to be asked about DV?

In relation to how often women thought they should be asked about DV at site V4, 48 percent preferred to be asked at every visit, 35 percent at some visits, 14 percent at first visit only and 4 percent not to be asked at all. At site V5, 50 percent preferred to be asked at every visit, 35 percent at some visits, 11 percent at first visit only and 3.5 percent not to be asked at all.

Health practitioners' enquiries about safety of women and their children

Participants were asked whether practitioners had enquired about safety in their relationship and, if so, whether the practitioner referred the participant to other services at the hospital. Approximately 40 percent (n = 407) of women at site V4 were asked about their own safety. Of these, 46 percent (n = 64) were among the abused group and 39 percent (n = 335) in the non-abused group. Among those asked, the highest number of relationship safety enquiries were made

Figure D4 Comfort to discuss issues (abused category only, N = 169)

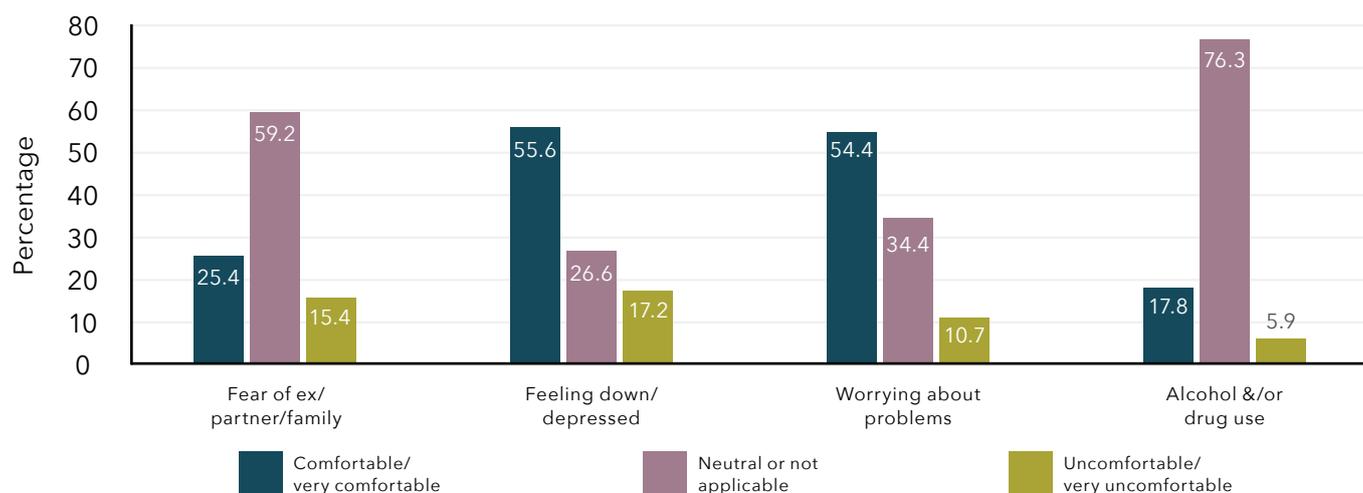


Table D4 Participants' feelings about talking to a midwife about emotional/social issues of concern^a

	Total (N=1215) n (%)	Abused ^b (N=171) n (%)	Non-abused (N=992) n (%)
Positive or neutral perceptions of taking to midwife:			
I could talk to the midwife and they were very supportive	478 (39.3)	49 (28.7)	408 (41.1)
I could talk about some, but not all of my problems to the midwife	326 (26.8)	46 (26.9)	265 (26.7)
The midwife asked me questions that helped me to talk about emotional and social problems	286 (23.5)	34 (19.6)	238 (24.0)
I thought the midwife would give me help if it was needed	419 (34.5)	47 (27.5)	356 (35.9)
I found it easier to talk to the midwife because she was female	256 (21.1)	41 (24.0)	205 (20.1)
Negative perceptions of talking to midwife:			
The midwife was often busy and didn't seem to have time to listen	53 (4.4)	12 (7.0)	39 (3.9)
I was concerned the midwife might tell someone else	34 (2.8)	7 (4.1)	23 (2.3)
The midwife might have wanted to do something that would make the situation worse	17 (1.3)	3 (1.8)	12 (1.2)
Perceptions of role of midwife:			
I thought the midwife was only there to look after my pregnancy care	159 (13.1)	41 (24.0)	113 (11.4)
I don't think any of my problems are serious enough to tell the midwife	142 (11.7)	21 (12.3)	113 (11.4)
There wasn't anything about my emotional wellbeing that I wanted to tell the midwife	281 (23.1)	32 (18.7)	242 (24.4)

Notes: ^a Denominators vary due to missing data.

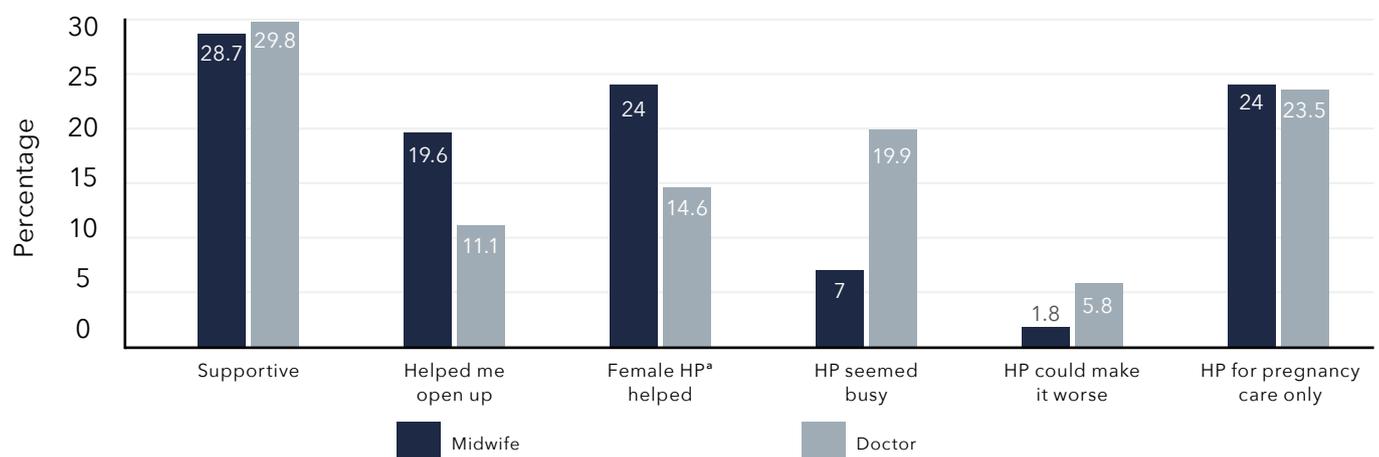
^b Screened positive for abuse on C2 screening items or CAS.

Table D5 Participants' feelings about talking to a doctor about emotional and social issues of concern^a

	Total (N=1215) n (%)	Abused ^b (N=171) n (%)	Non-abused (N=992) n (%)
Positive or neutral perceptions of talking to doctor:			
I could talk to the doctor and they were very supportive	383(31.5)	51 (29.8)	313 (31.6)
I could talk about some, but not all of my problems to the doctor	269 (22.1)	44 (25.7)	211 (21.3)
The doctor asked me questions that helped me to talk about emotional and social problems	172 (14.2)	19 (11.1)	143 (14.4)
I thought the doctor would give me help if it was needed	361 (29.7)	45 (26.3)	305 (30.7)
I found it easier to talk to the doctor because she was female	160 (13.2)	25 (14.6)	126 (12.7)
Negative perceptions of talking to doctor:			
The doctor was often busy and didn't seem to have time to listen	132 (10.9)	34 (19.9)	95 (9.6)
I was concerned the doctor might tell someone else	27 (2.2)	7 (4.1)	16 (1.6)
The doctor might have wanted to do something that would make the situation worse	28 (2.3)	10 (5.8)	17 (1.7)
Perceptions of role of doctor:			
I thought the doctor was only there to look after my pregnancy care	163 (13.4)	40 (23.4)	121 (12.2)
I don't think any of my problems are serious enough to tell the doctor	145 (11.9)	26 (15.2)	112 (11.3)
There wasn't anything about my emotional wellbeing that I wanted to tell the doctor	263 (21.6)	27 (15.8)	228 (23.0)

Notes: ^a Denominators vary due to missing data.

^b Screened positive for abuse on C2 screening items or CAS.

Figure D5 Comparison of participants' views on discussing issues with doctors or midwives (abused category only, N = 171)

Note: ^a HP refers to health professional

Figure D6 Practitioners who made safety enquiries at site V4 (N = 407)

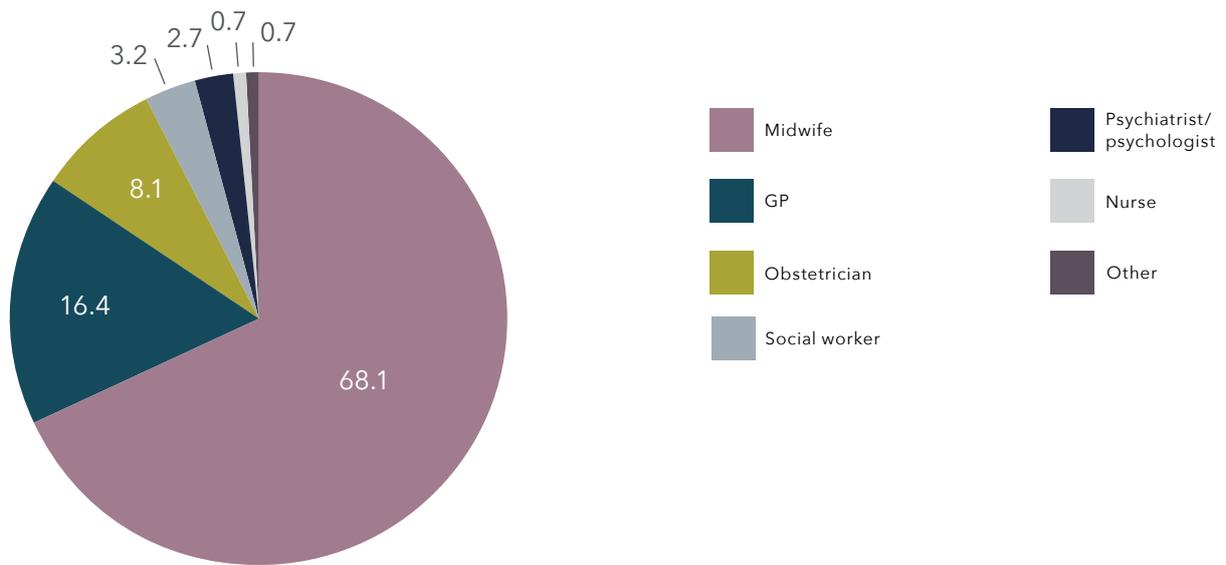
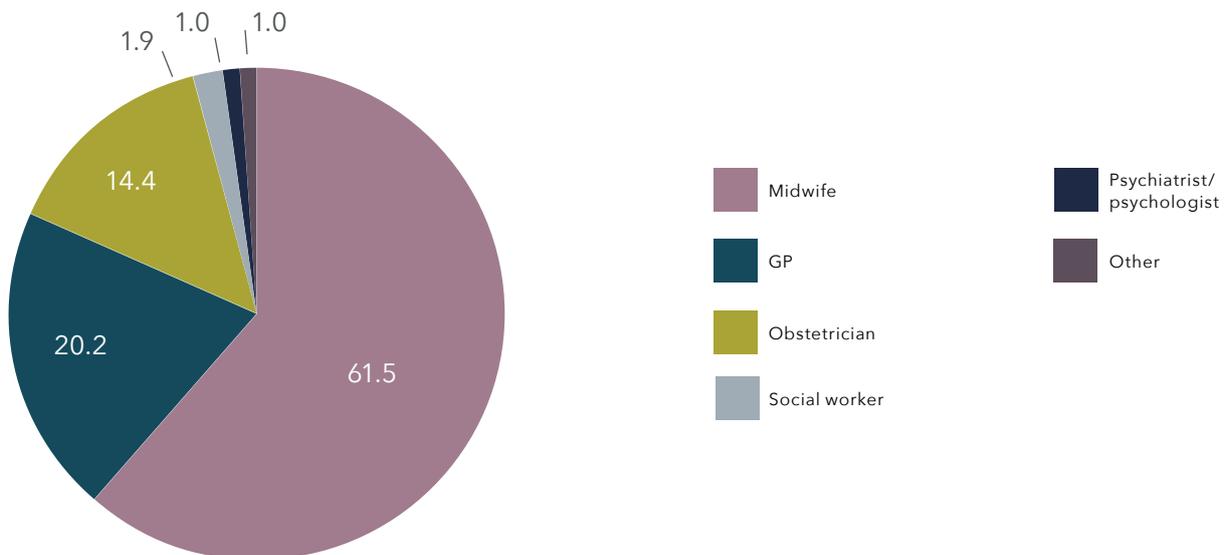


Figure D7 Practitioners who made safety enquiries at site V5 (N = 104)

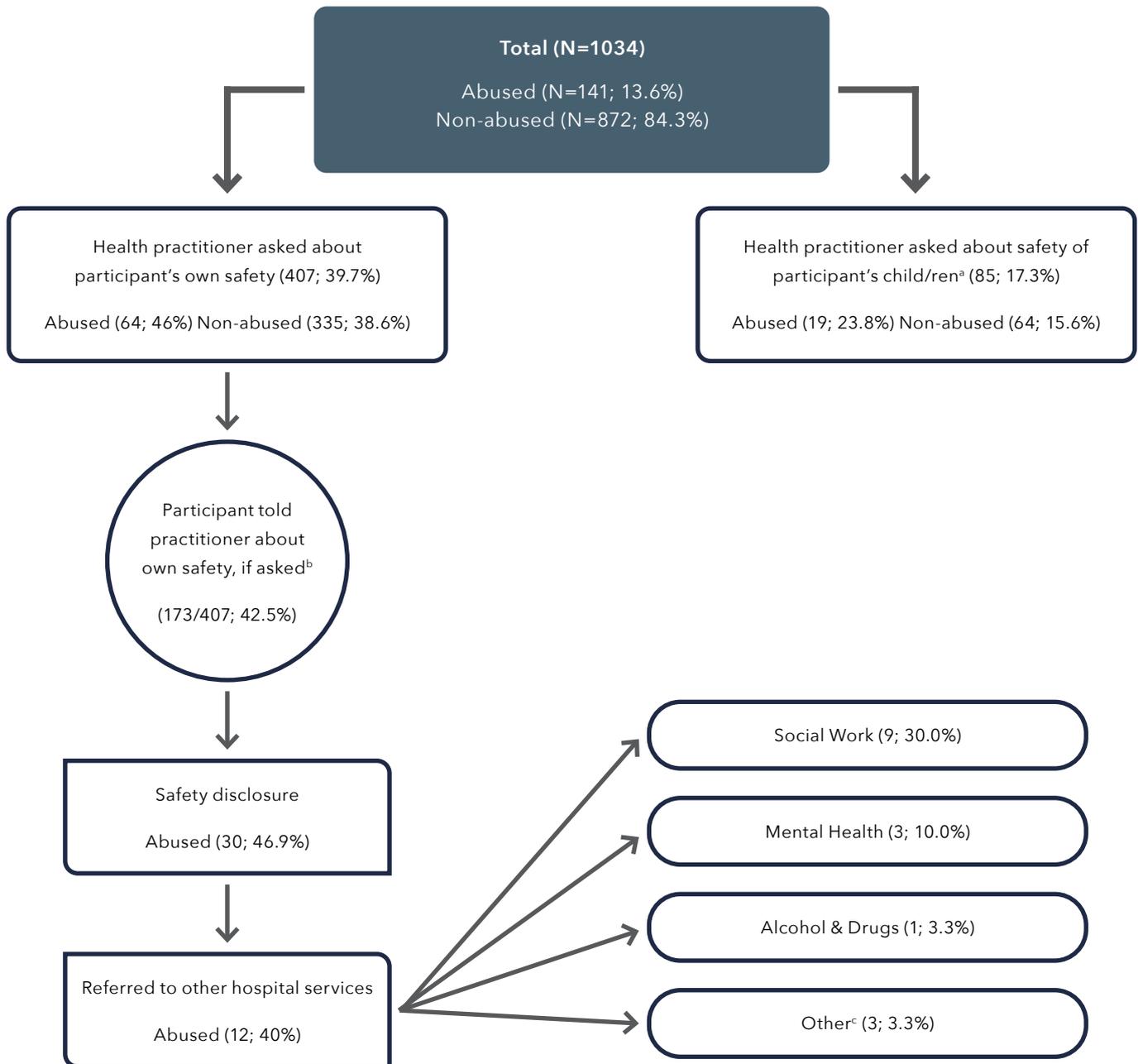


by midwives (68 percent), followed by general practitioners (16 percent) and obstetricians (8 percent) (Figure D6).

At site V5, 52 percent of participants had been asked by a health practitioner about relationship safety or DV (50% of participants in the abused group and 52% in the non-abused group). Similar to results from site V4, among those asked, the highest number of safety enquiries were made by midwives (62%), followed by general practitioners (20%) and obstetricians (14%) (Figure D7).

With regards to the safety of their children (if participants had a child under 18 years), only 17 percent (n = 85) of participants at site V4 were asked about their child’s safety. Comparatively, more abused participants (n = 19; 24%) than non-abused participants (n = 64; 16%) were asked about safety of their children. At site V5, about 18 percent of women were asked about their children’s safety and more non-abused participants (n = 16; 21%) than abused participants (n = 2; 8%) were asked about their children’s safety.

Figure D8 Safety enquiries and referral pathways (site V4)



Notes: ^a Denominator only includes participants with a child under 18 years.

^b Denominator only includes participants who were asked by practitioner about their own safety.

^c Other includes endocrinologist, emergency nurse, and doctor (not a GP or obstetrician).

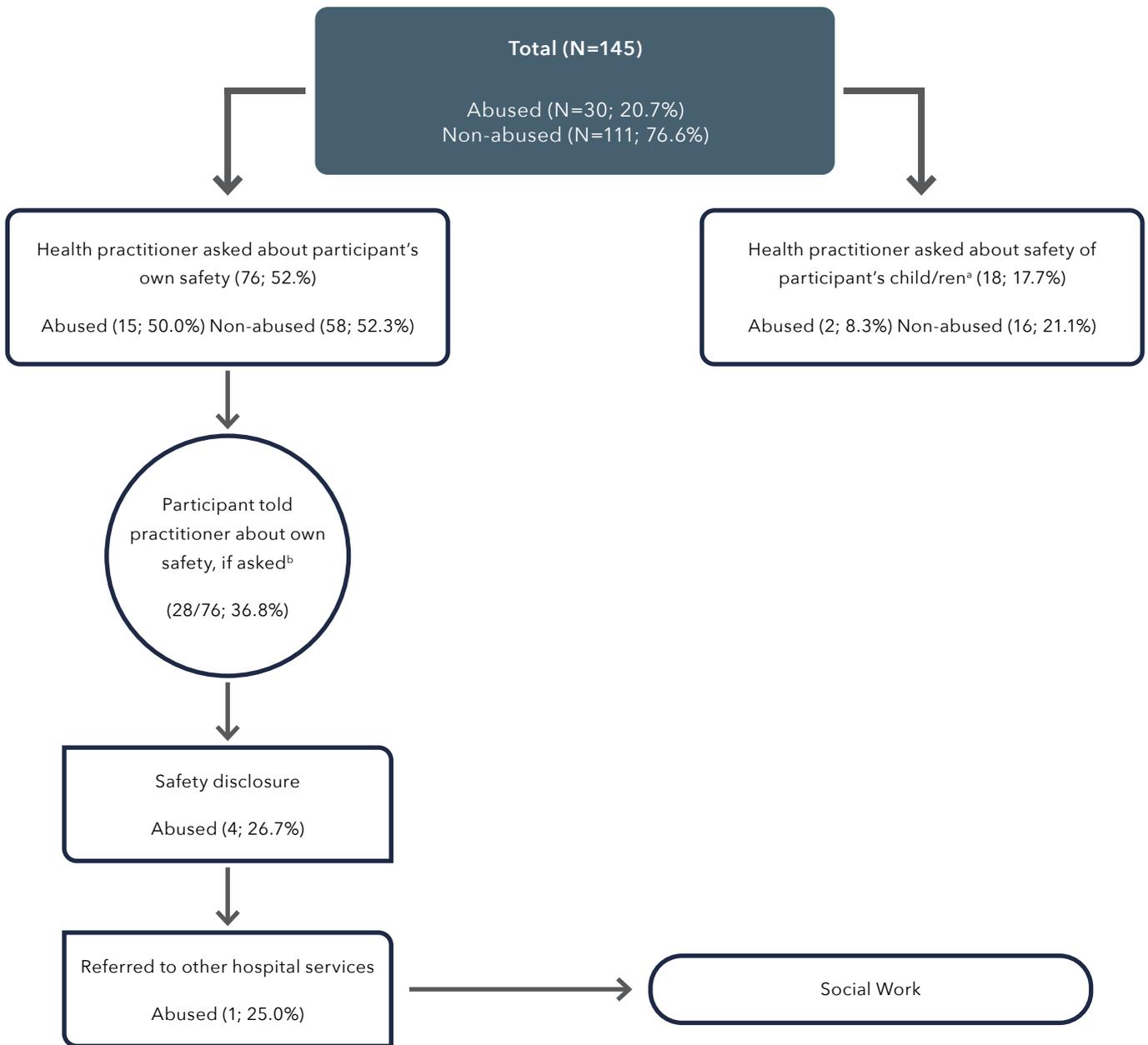
Flow charts (Figures D8 and D9) show the percentage of safety enquiries made, resultant disclosures and referral pathways at sites V4 and V5, respectively.

Among those in the abused category at site V4 who were asked about their relationship safety or DV, 47 percent ($n = 30$) told a health practitioner about it. Forty percent of abused participants who had told the health practitioner

about DV were referred to other services at the hospital. The most common services the participants were referred to were social work (30%) and mental health (10%) (Figure D8).

Twenty-seven percent of abused participants at site V5 told a health practitioner about their relationship safety when asked about this. One out of the four abused participants who had told the health practitioner about their relationship

Figure D9 Safety enquiries and referral pathway (site V5)



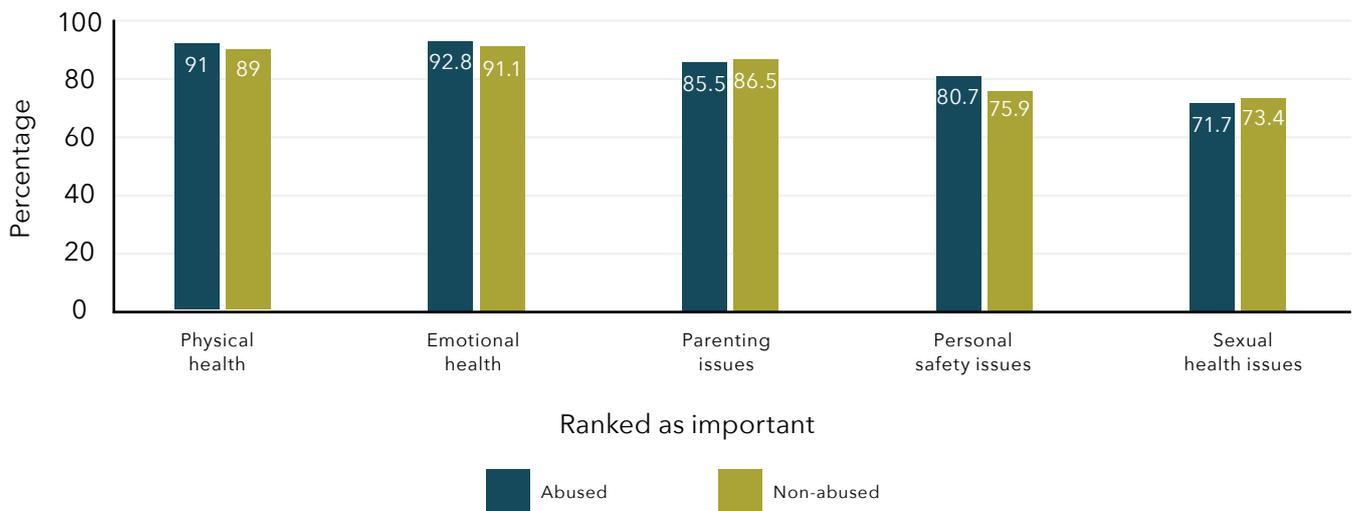
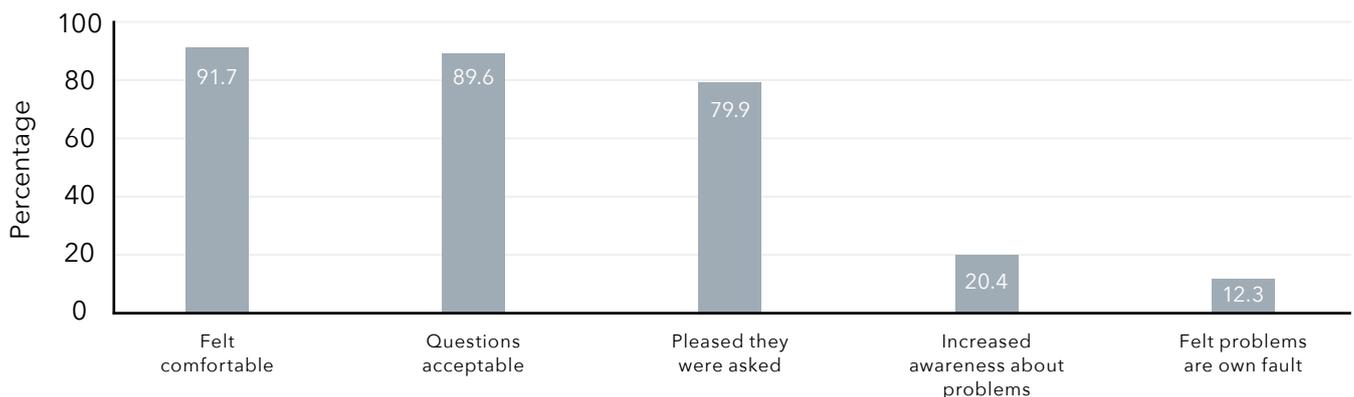
Notes: ^a Denominator only includes participants with a child under 18 years.
^b Denominator only includes participants who were asked by practitioner about their own safety.
^c Other includes endocrinologist, emergency nurse, and doctor (not a GP or obstetrician).

safety was subsequently referred to social work services at the hospital (Figure D9).

Importance of support for physical, emotional, parenting, safety and sexual health issues during pregnancy

Participants were asked how important they thought it was to get support for physical health, emotional health,

parenting issues, personal safety and sexual health issues during pregnancy. The trend in responses was quite similar in health facilities across sites V4 and V5 and across abused and non-abused groups. Overall, getting support for physical and emotional health were rated highest (ranging from 89% to 93%) as being important, while sexual health received the lowest rating (72% to 73%) across both hospitals (Figure D10).

Figure D10 Importance of getting support for issues during pregnancy (N = 1128)**Figure D11** Participants' views on the survey (N = 1151)

Participants' perceptions about completing the SUSTAIN survey

Participants were also asked for their perceptions about responding to the SUSTAIN survey items. Across both health facilities, most participants felt comfortable or very comfortable answering questions about DV in the survey (92%), 90 percent found the questions acceptable or very acceptable and about 80 percent were pleased that they had been asked these questions. About 20 percent of participants indicated that responding to the SUSTAIN survey increased their awareness about possible problems in their relationship and 12 percent of participants indicated that the survey made them feel that the problems in their relationships were their own fault (Figure D11).

Summary

Overall, the SUSTAIN survey showed that 14.2 percent of participants at the two survey sites had experienced IPV in the past 12 months. When using screening items that asked for a "yes or no" response, 8.3 percent of the survey sample screened positive for DV in the past 12 months, indicating that they had experienced fear-inducing, controlling, threatening or physical behaviours from a partner or ex-partner. Emotional abuse/harassment was the most common type of abuse experienced and physical abuse only (i.e. physical abuse without other forms of abuse) was the least common. Apart from partners or ex-partners, abusive behaviours were also sometimes experienced from other family members.

Midwives tended to make enquiries about participants' relationship and safety issues more often than other

Table D6 Attributes of interviewed antenatal women who had experienced abuse

Pseudonym	Site	Age in years	Weeks gestation / postpartum	Order of child	Disclosure at screening?	Nature of abuse	Current status of relationship with partner
Dhriti	Middle-income metro	34	31 weeks	Second	No	Unclear	Still with partner, "things are good"
Anna	Rural	27	37 weeks	First	No	Control, verbal	Separated—didn't live together
Beth	Rural	36	6 weeks postpartum	Third	No	Control, verbal	Separated—some contact
Chloe	Rural	19	6 weeks postpartum	First	Yes	Emotional/verbal abuse, possibly physical/threats	Separated—no contact
Joni	Rural	31	5 weeks postpartum	Fifth	Yes	Unclear	Separated but contact for children

categories of health professionals. Approximately 41 percent of participants were asked about their own safety. However, only about 17 percent of women with children under 18 years of age were asked about the safety of their children. Of women asked about their safety, 40–50 percent were among the abused category. Referral rates differed at the two survey sites. At site V4, 40 percent (12/30) of women in the abused category were referred to other hospital services for assistance. At site V5, one out of four (25 percent) was referred to social work for further support.

Participants expressed various perceptions and levels of comfort regarding talking to a midwife or doctor about emotional and social issues. Generally, participants in the abused category were less comfortable talking about fear of a partner/ex-partner or alcohol and drug use than they were expressing their feelings about depression or worrying. Regardless of their abuse category, participants viewed getting help for physical and emotional health, parenting issues, personal safety and sexual health issues as important. They also indicated that both doctors and midwives were supportive; however, they expressed that midwives helped them open up more and seemed less busy compared to doctors. Overall, about 13 percent of respondents also thought that the health professionals were there for only pregnancy care; however, this perception was more prevalent among abused than non-abused participants.

It is important to note that the exclusion of women who were accompanied by their partners or other family members and those who were not fluent in English, Arabic or Chinese may have lowered the overall prevalence of DV obtained in the survey.

Experiences of screening by women who have experienced DV

The interviews with antenatal women who had experienced abuse addressed the second and fourth aims of the study:

- to explore how women perceive the nature and timing of screening questions and risk assessment about DV, including the most effective and acceptable wording of screening questions
- to understand the barriers to and facilitators for the introduction and sustainability of screening and first line responses in antenatal care.

Interview participants

Five interviews were conducted with women who were antenatal patients and had also experienced abuse. The interviews were conducted from August to November 2018 and averaged 29.6 minutes (range 23–34 minutes). No women responded to the flyers on the bathroom doors and so none were recruited via this method. We were unable to recruit in Victoria because of staff issues at the time of the study. Due to the small sample, we have elected to describe the participants as individual cases that illustrate particular points rather than thematically analyse such a small sample.

Participant attributes are outlined in Table D6. Of the five women, four were from the rural site and one from the metro middle-income site. This participant was also the only one who spoke a language other than English at home. Her language was Nepalese, and she was born in Nepal. None of the women were Aboriginal or Torres Strait Islander peoples;

Figure D12 Dhriti's pathway

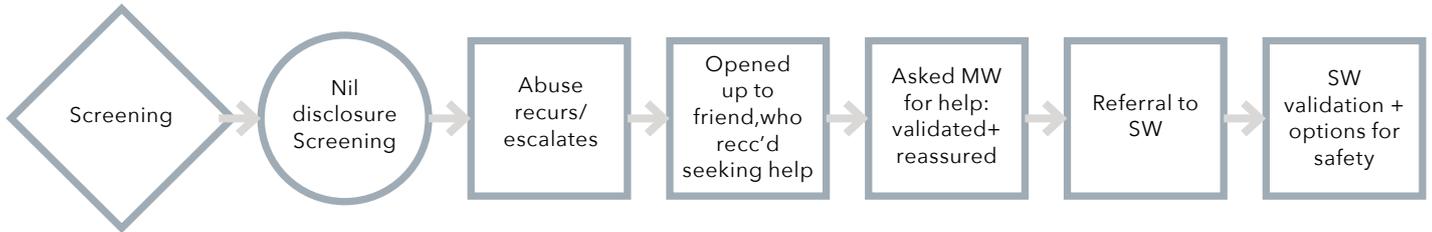
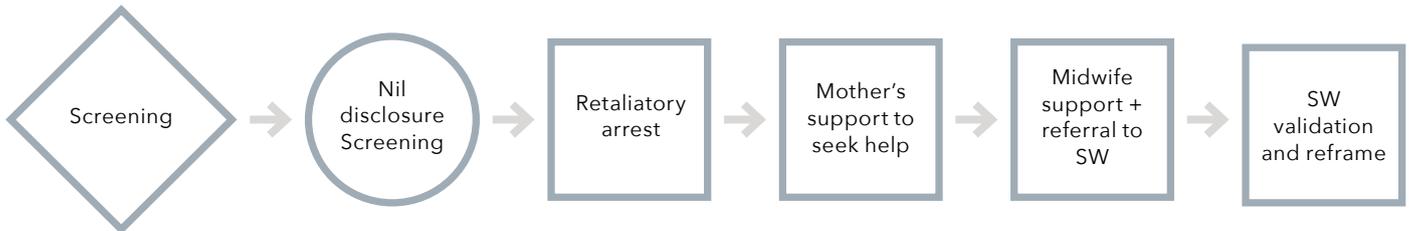


Figure D13 Anna's pathway



however, one woman had an Aboriginal partner and as a result was eligible for support from local Aboriginal services, where she was referred by the social worker after the birth of her baby. As indicated in Table D6, two women disclosed their experiences of abuse to the midwife in response to DV screening questions, and three did not. One woman (Anna) disclosed to the midwife later in pregnancy, and another (Beth) disclosed to the social worker she was referred to by the midwife for other issues.

Pathways to safety and care

Pathways to safety are outlined for each woman in Figures D12–D16, with decision points (i.e. disclosure/ending the relationship) and other elements mapped in a linear form.

Dhriti, a Nepalese woman with limited English, did not disclose any abuse at time of screening, apparently because there were no current issues: “At time I was quite happy because I thought it’s going to be settled now, so I didn’t share.” Her situation deteriorated, and she became fearful and disclosed to a friend who advised her to seek counselling. Dhriti is isolated with no family in Australia. At her 24 weeks’ visit she was asked by the midwife how her social situation was, at which point Dhriti disclosed concerns. The midwives reassured Dhriti that she had done nothing wrong and they would help. A referral was made to a social worker, who responded the same day and continued to maintain contact at the time of the interview. Dhriti’s connection to the social worker was an important resource: “I have someone to listen to me, and [tell me] how to handle the situation, or where to go if something happens, they call me, they counsel me, they are very good.” Dhriti continues to live with her partner, but reports feeling more confident that she has options (Figure D12).

The remaining women were from the rural site.

Anna, aged 27, seen at the rural service, did not disclose when asked the screening questions by the midwife, relaying in the interview that she “had been in denial at that stage”. The abuse, which was predominantly verbal and emotional, started with pregnancy. She realised that the relationship was unsafe when she was arrested by police for damaging his car and pushing him. The arrest and charges were a turning point, as was the intervention of her mother, to whom Anna disclosed more of the abuse at that time. The advice of the solicitor engaged to represent her was also important in framing her experiences with her partner as abuse.

With her mother’s encouragement, Anna went to see the midwife nurse manager and “got it off her chest”. The midwife nurse manager referred her to the social worker. Anna has compassion for her partner, but her friends do not accept this. She now recognises, through the social work intervention, that he has experienced trauma, as a result of accidentally killing a friend in a motor vehicle accident. Of the social worker, Anna reported “it was good to be able to just speak to someone who’s not biased on the situation” (Figure D13).

Beth experienced complex grief issues, arising from the imprisonment two years ago of her former partner for sexual abuse of their son, subsequent to which her partner committed suicide in jail. Her new partner began to be controlling and abusive from the start of the pregnancy. She did not disclose the abuse and says she has no recall of being asked the questions, though in the interview it was relayed that guilt, fear of judgement and continuing to care about their partner often silence women. The midwives aware of

Figure D14 Beth's pathway

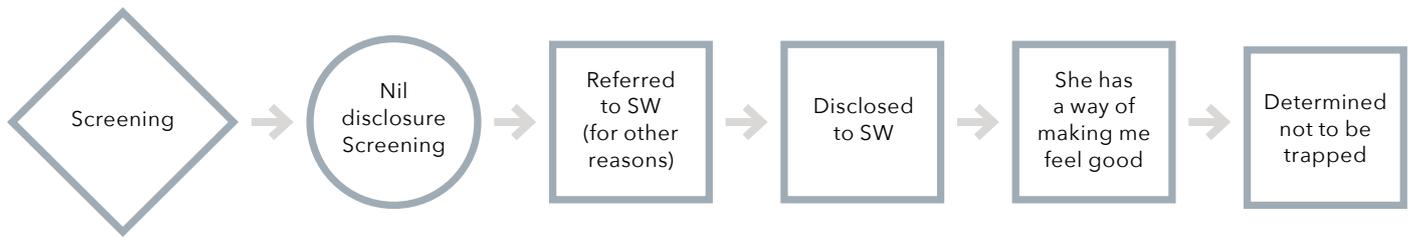


Figure D15 Chloe's pathway

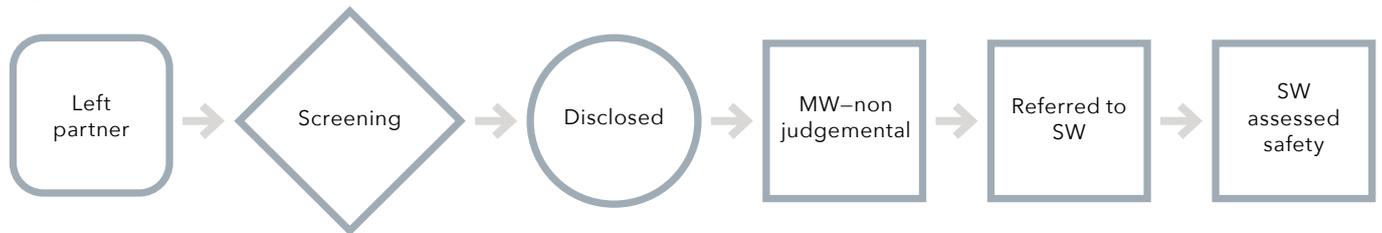
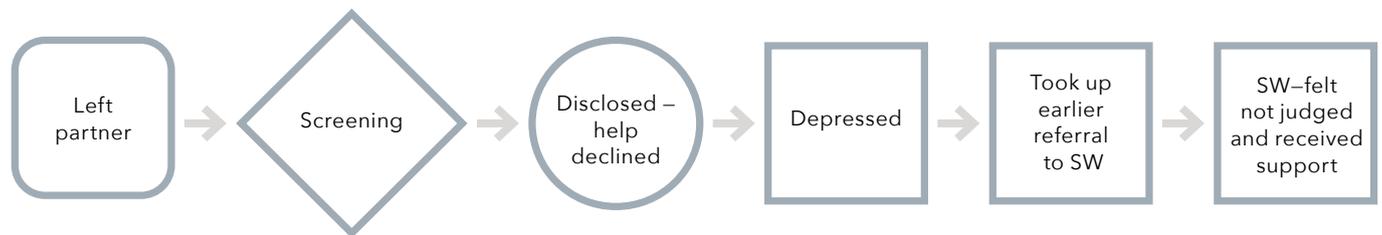


Figure D16 Joni's pathway



her prior experiences “reached out to her” and referred her to the social worker for other reasons. She was prompted to speak up “because of the trauma I’ve been in, and I don’t want to be stuck in something, like, you know, I don’t want to be the victim of a bad relationship, I want to be strong and yeah. So, I’m not embarrassed to open up and get help.” (Figure D14).

Chloe is a young woman aged 18 years whose partner is Aboriginal but no longer involved with Chloe. She disclosed her experience of abuse to the midwives in response to the screening questions, a disclosure which may have been made more likely by the presence of her mother at the antenatal booking-in. This is not consistent with state policy, which requires that the questions are to be asked when women are alone. Chloe indicates that she had already made a decision to end the relationship as her partner indicated that she needed to choose between keeping the baby or the relationship with him and she chose the baby. She felt supported by the midwife’s response to her disclosure because she was not shocked or judgemental but moved smoothly to referring her to a social worker who she described as “very understanding and just made sure I didn’t feel um ... sort of scared by him, or that I didn’t think he’d do something drastic” (Figure D15).

Joni was interviewed five weeks after delivering her fifth baby and had previously disclosed abuse in response to antenatal screening, as well as disclosing on this occasion, but she

indicated that “when I do answer it, I still downplay it”. She gave little detail in the interview but had clearly previously separated from her partner on more than one occasion, including prior to the screening. She declined assistance at the time of the screening but later followed up with the social worker when she reached a very low point. The social worker arranged for practical assistance and responded without judgement which was important in her sense of not being seen as a “bad mother or not coping” (Figure D16).

These five pathways illustrate that the process of becoming safe from DV for these women was diverse and not uniform. The experience of being asked about abuse is not always the first point in this pathway. Some women had already ended their relationship at the point of screening, although this is not the same thing as being safe or a cessation of ongoing effects. The pathways also illustrate the importance of an open door—on the part of both midwives and second line service providers—so that women can disclose or seek help at whatever point they are ready. Having a small team of midwives and also a social worker with continued availability throughout the perinatal period, as was the case at the site where most of the women were seen, are likely important elements. These pathways also illustrate women’s diverse needs, for which they seek assistance from social work services. These range from practical support to validation and unburdening and referral to other services. There is considerable value in second-line responses, such as a social work services, which are able to respond to women’s multiple needs.

Table D7 Selected quotes from interviews of women

Experience of screening <ul style="list-style-type: none"> • agreed with practice 	<p>If they're not going to ask it, most women aren't going to offer the information just off the top of their head just for the sake of it. (Joni)</p> <p>It is very important because you ... like they're having a baby, they're having more responsibility, and you have experience ... like that, help they can get, and then they will know what to do if something happen in future. (Dhriti)</p> <p>I think it's important, because I wasn't aware I was a victim of domestic violence. (Anna)</p>
Wording of questions <ul style="list-style-type: none"> • broader than physical 	<p>Like a lot of people put that category into getting hit. Well for me it wasn't like that. Like he doesn't hit me or hurt me, but it's verbal sort of, you know what I mean, like you don't realise it's domestic violence when it is sometimes ... So, I think maybe having a broader, I don't know ... like controlling and all that, like maybe that's the start of it. (Beth)</p>
Decision to disclose <ul style="list-style-type: none"> • denial or minimises 	<p>You don't really want to say it. You don't really want to answer it or you—when I do find myself sometimes, like when I do answer it, I still downplay it, like it's not as bad as it seems. (Joni)</p>
Midwife's response <ul style="list-style-type: none"> • caring non-judgemental approach • continuity of care 	<p>When I first got there I was very nervous. I don't like hospitals and doctors. I don't like talking to people, so she was very relaxed and calm. (Joni)</p> <p>They were very helpful for me, still very nice and then say don't worry, we can help you how we can ... You didn't do any wrong. (Dhriti)</p> <p>She didn't judge me, or like I didn't have to feel embarrassed, because it wasn't my fault. (Beth)</p> <p>I actually connected with her and she helped me a lot and she was at every appointment. (Chloe)</p>
Referral response <ul style="list-style-type: none"> • understanding ambivalence about practical support; validating women's choices and agency; providing a space for women to unburden themselves 	<p>It has been helpful. She's also then helped refer me on to others, like Family Support ... With this whole time being pregnant, the house I'm living in is—it reeks, it has mould in it, my kids have been sick ... After seeing her the first time, and then I've just felt more at ease after seeing her and speaking with her. I didn't have that feeling that she was looking at me or thinking, oh ... she's not a good mother, she's not coping, she's falling apart. I feel now that I'm starting to climb out of that dark hole. I'm starting to see a light, it's there. (Joni)</p>

We highlight the below summary with some quotes in Table D7 to provide context for these five women.

Summary

For three of five women, the screening itself was not the occasion for disclosure. Rather, these three women denied the abuse at that time but sought help subsequently. For a fourth woman, though she disclosed at the time of screening, she did not want help then. It appears, however, the DV screening process flagged that the health service was a potential source of help for women, who could follow up when they were ready. It also appears that for the women interviewed here, access to prompt social work follow-up provided important access to safety assessment and referrals for safety, practical support and validation of their experiences. Ongoing access to these supports throughout pregnancy and beyond can

optimise the chances of being able to respond to a woman at the point at which she is ready to accept help. Continuity of midwifery care was also seemingly important for these women in building relationships of trust that allowed them to talk about their experiences. Disclosure subsequent to screening points to the need to keep the possibility of DV in mind throughout antenatal care. It also highlights the fact that disclosure at screening is not the most salient outcome indicator for screening.

What does a woman-centred response look like?

These women's accounts provide insights into what woman-centred care involved for them. It included the recognition that disclosure of abuse in the antenatal setting is not an easy choice for women, and that the caring and non-judgemental

approach of midwives is central to supporting these decisions. We suggest that woman-centred care also recognises that women may downplay their disclosure and tell more over time, or in fact choose to disclose at a later point in the perinatal period, so that the issue of abuse needs to be kept in mind throughout pregnancy care, with opportunities for further discussion and/or inquiry. Further, accepting that women may not initially want help but providing an open door to follow this up at a later point is important. Continuity of midwifery care is identified here, as in other literature (Eustace, Baird, Saito & Creedy, 2016; Jones, Lattof & Coast, 2017; Kildea et al., 2016; Spangaro et al., 2019), as providing a greater level of trust and rapport that increases the likelihood of later disclosure.

Access to rapid responses by an onsite social work service that is flexible and open-ended appears to have been important to these women. The diverse needs the women experienced and the capacity of a single service to respond holistically to these needs—from baby clothes, to counselling and risk assessment—seemed important to these women. A non-judgemental response on the part of midwives and social workers was also a key element of woman-centred response. Acceptance of women's ambivalence towards an abusive partner and desire to protect them is also central.

Rural issues

Four of the five interviewees were recruited from the one rural NSW site and were asked about whether this creates particular issues. Three themes were identified: access to services; lack of privacy; and advantages to rural locations. Two women identified that rural areas have fewer services and that getting around created challenges, particularly given lack of public transport and distance, which exacerbates the isolation some experience. The local social worker provided home visits, which was acknowledged by one woman as being extremely helpful, given her lack of a motor vehicle.

Lack of privacy is often raised as an impediment to service use for women experiencing DV in rural areas. This was raised by only one interviewed woman, Anna, whose ex-partner's mother worked at the local hospital. Conversely, the same woman also spoke of the advantages of being in a small

community, knowing some of the service providers already and the comfort this provided. Another woman, Chloe, also knew some of the midwives prior to her pregnancy through her mother's work as a nurse and spoke of the comfort this provided to her. This was an unexpected finding, as we had anticipated that rural locations would pose only barriers to disclosure and service use. It is important, when considering women's experiences in rural settings, to appreciate some of the advantages they identify.

PART E

Findings: Health practitioners' voices

This section presents an overview of the findings from focus groups and interviews conducted with midwives, doctors and social workers at the participating sites. Focus groups and interviews were conducted to contribute to the following objectives related to understanding:

- the barriers and facilitators to the introduction and sustainability of screening and first-line responses in antenatal care
- how antenatal care practitioners perceive the process of screening, risk assessments and responses for DV
- the factors encouraging disclosure and acceptance of referrals from a system perspective.

Focus group participants

Twelve focus groups and eight interviews were conducted with midwives, social workers and doctors at the six sites, with a total of 91 health professionals participating, as reported in Table E1.

The focus groups and interviews were conducted in Victoria from March 2018 to March 2019 and in NSW from November to December 2018. The mean length of focus group discussions was 52 minutes (range 22–75 minutes), and the mean length of interviews was 40 minutes (range 8–75 minutes). As discussed in the methodology, the analysis was organised according to three questions (Figure E1):

- What does woman-centred care look like in antenatal care for women who have experienced DV?
- How do health practitioners in antenatal care support women who have experienced DV?
- How do health systems support health practitioners to do this work?

The inclusion of sites that have been screening for over 15 years, as well as those newly starting this practice and those that have yet to introduce systematic screening, provided opportunities to consider responses on a continuum of experience. Accordingly, sites N1, N2 and N3 are defined as well-established screening sites; V5 and V6 are defined as sites that have recently commenced screening and V4 is a site that is not yet screening systematically. Further detail on the state of practice at each site was outlined in Part B.

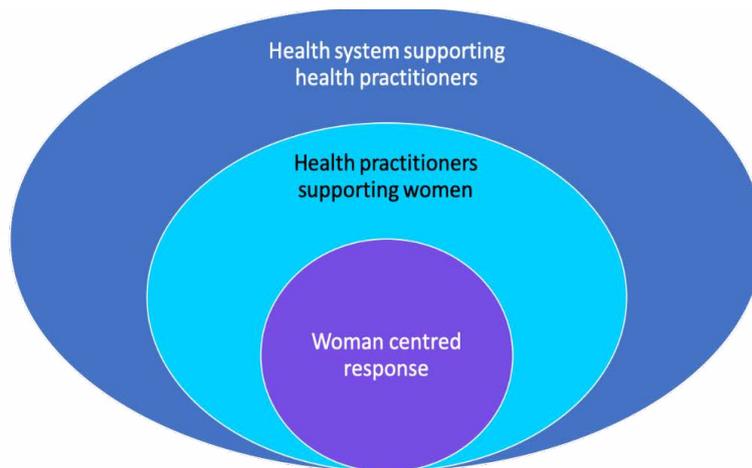
This first section examines participants' views on elements of woman-centred care that would support the introduction and sustainability of screening and first-line responses in antenatal care.

What does woman-centred care look like?

Figure E2 provides an overview of the themes developed from the analysis that related to the concept of woman-centred

Table E1 Focus group/interview participants at each site

SITE	V4	V5	V6	N1	N2	N3	TOTAL
Midwives	23	13	3	4	5	4	52
Social workers	5	1	1	1	5	1	14
Doctors	16	8	1	0	0	0	25
Total participants	44	22	5	5	10	5	91

Figure E1 Major domains for SUSTAIN study based on World Health Organization model

Source: Garcia-Moreno et al., 2015

Figure E2 Themes identified for woman-centred care

care. In examining how to strengthen health systems to respond to women subjected to DV, the WHO identifies that woman-centred responses are “organized around women’s health needs and perspectives” (World Health Organization, 2017, p. 8). In approaching this concept in the analysis, themes that focused on centring women in the provision of antenatal care were identified as “woman-centred care”, and included being able to see women in their context and respond to women holistically. A distinction was drawn between woman-centred care and woman-centred responses that focused on screening for DV (asking) and responding to disclosures of DV. Each of these themes are examined in the following section.

Asking: Relationship, time and privacy

At the time of asking women about DV, themes focused on centring women and identified screening as being relational, while requiring time and privacy. A dominant theme at all sites was the importance of the need to develop rapport in a very short time frame to raise the issue of DV effectively with women: “I work really hard on trying to connect in that time and trying to support them to feel safe ... all that psychosocial stuff that we ask, that’s really deep and heavy”. (Site N3, MW2)

There was an understanding across all sites that screening was more than just asking the screening questions. Rather, participants agreed that screening was carried out within the context of building supportive relationships that build safety for women, exemplified by this participant:

You don't want her to feel like you're just there asking questions, you want her to feel like she's being cared for and nurtured so that she can disclose information to you. (Site V3, FG1, MW1)

If midwives are feeling pressured for time, screening can become less relational, as described by one participant: "There are some midwives who say they stick to the format because they know they're going to get bogged down in the detail and follow-up". (Site N3, MW1)

Participants at all sites recognised that screening is not a one-off event but requires an ongoing relationship and constant awareness of how DV may be impacting on women and their openness to changing situations: "Not just screening them once but just checking all the time as how life is at home". (Site V5, FG1, MW1)

Caution was raised about the danger for women if a caring approach was not foundational to screening for DV:

I've had re-referrals come back, because women have been traumatised by the way they've been asked that question, then they've gone and disclosed everything and then they've been given nothing, and they've left. (Site N2, SW1)

Different approaches to creating privacy for women were taken at screening sites, usually by managing the presence of the partner when screening for DV. One site sent letters to women prior to the booking-in visit, informing them they were expected to attend the first appointment on their own (an interpreter may be present, if needed). Midwives at the other screening sites had a variety of approaches to see women on their own. At some sites they asked partners to leave briefly or used creative ways to be alone with the woman (e.g. to provide a urine test, ultrasound, body mass index [BMI] or height check). Some sent the partner to complete a task, such

as to make the next appointment at the reception desk or call the GP to get some information. One participant talked of her expectation that she would always see a woman on her own during antenatal care but would find a way to do so without asking the partner to leave. Participants identified that, at times, the presence of other family members apart from the partner also needed to be managed: "It's not just the partner, it's about asking the mother-in-law to leave, or the mother to leave or making sure that the child's not old enough". (Site N2, MW4)

Participants at all sites talked about how helpful they would find it to have a uniform process that provided systemic support to create privacy for women, such as the expectation that there will be a time in every interview when the partner leaves. Some sites reported how they have already implemented positive practice:

You ask the woman to leave first and then you talk to the partner about some parenting and how he feels about being a dad and then you switch the roles so they think, you know, she's just going to be asked the same questions and then you ask about the DV. Sometimes we make just a whole different appointment just to ask those questions. (Site N2 MW4)

Discussion at sites that were not yet systematically screening or newly screening showed that there was not always a focus on creating private time for women when asking about DV. Additionally, women who had separated from partners were not always asked about DV.

At rural sites, participants discussed the complexity of ensuring privacy and confidentiality for women, requiring health practitioners to manage and respect boundaries in closely connected communities:

People know each other. They're not anonymous here. (Site V6, MW2)

You're working in health but you're also part of the community and most people are aware of who's who. You've seen them at the coffee shop, or you've got kids in the same school. ... You talk about confidentiality but

the reality is, it must be hard for women to sit here and talk about things when they know that you're connected to other parts of their life. (Site N3, SW)

Even while juggling these boundaries, participants at N3 talked very positively about the way they work with their community:

We feel ownership, in a positive way, for the women in our community. Well, we've got them, all of us have them for this whole length of time, and we will see them again. (Site N3, MW2)

When you're working in a rural area and you're doing everything, every shift, every day, it becomes more common practice to look at the whole picture. (Site N3, MW1)

Asking: Ask directly

A woman-centred health response provides women with information and supports them to make informed choices and decisions (World Health Organization, 2017). Asking clear, direct questions at the time of screening supports women to understand what is being asked and gives information about DV. In examining responses to the theme of asking directly, anxiety was expressed at all Victorian sites about screening tools, with practitioners expressing preferences for explicit and direct questions. At sites V4, V5 and V6, where screening is not yet systematically implemented or is in the early stages of implementation, midwives and doctors talked about the need for standardised approaches to screening, including direction about how to ask to support screening:

We need some guidance on how to screen, what to say. (Site V4, FG2, MW9)

If you don't have anything to guide you it makes it really difficult and you're more likely to avoid the conversation. (Site V5, MW)

One of the questions favoured at non-screening or newly screening sites was: "Do you feel safe at home?" This sometimes elicited unexpected responses: "I said, 'Do you feel safe at

home?' ... This woman said 'Yeah, we live in a really good neighbourhood.' That's what she said." (Site V4, FG1, MW8).

A number of participants described the value of using explicit screening questions:

I would think that it's probably a reasonable thing to ask somebody directly, "Are you being hit?" Because it takes maybe the stigma of saying, yes, whereas if you ask, "Do you feel safe and, supported?" It's a woolly question. (Site V5, FG3, D5)

In NSW, the protocol specifies two questions about the past year, related to hitting/slapping or hurting and fear of a partner. Midwives and social workers expressed concern about aspects of the questions. Some described them as not always understood by women from CALD backgrounds and saw the timeframe as limiting what information may be shared:

The question does actually say, 'Have you ever been hit, slapped or hurt by your partner in the last 12 months?' And I think that's when they go, 'Okay, well it hasn't been 12 months'. I don't like the 12 months. If he choked you two years ago, I'd still like to know that. (Site N2, MW3)

Some participants suggested that the focus on physical violence in the first question directed women's thinking towards this form of abuse, leaving coercion and control unexplored:

I do ask directly but I've never really thought actually about the controlling emotional side that doesn't cover so, once again, I would see that as a barrier, that perhaps a clinician without a lot of experience would miss those cues. (Site N2, MW1)

Asking: Seeing all of me

Participants at five of the six sites commented on the importance of understanding the woman's context in providing healthcare. We named this theme "seeing all of me" to describe practices associated with responding to the whole person at the time of screening, when women may be juggling caring for children and breastfeeding: "I was looking at the whole situation, I could see that she was overcome and flabbergasted by the fact she was attending to all this" (Site N2, MW3).

Alternatively, women may present with nebulous concerns (or, as this participant named it, “abstract things”) when the midwife needs to be alert to abuse occurring:

Women frequently attend our antenatal clinics or delivery suite with abstract things and you’ve always got to wear that hat. Why are they, are they calling out for help? So, it’s that process of just making your thinking a bit more broad because you know that domestic violence and all sorts of abuse can affect the physical. (Site N2, MW5)

Concern was expressed at a non-screening site that the whole person could be overlooked if DV screening became the focus of engagement:

I did have a comment [from a patient] who went to their maternal child health nurse and all they focused on was whether she was in a domestically violent relationship, which she wasn’t, and she felt very disregarded for the other stuff. (Site V4, FG2, MW9)

At screening sites where questions about DV are included in a broader psychosocial assessment, midwives recognised the interconnections between the different elements of the assessment, such as mental health and DV.

When you’re asking the other questions about relationships or about your mental health, or about your drug use, then you get a response about domestic violence out of that. So, when you’re screening it’s not when you get to the two questions around domestic violence. (Site N2, MW4)

Responding

Participants identified ways of responding when women disclosed DV that the research team identified as woman-centred, namely focusing on women’s health needs and perspectives. These responses were holistic and supported women’s choice and agency.

Respond holistically

Similar to the theme of “seeing all of me” at screening is the theme of responding holistically to women when they disclose DV. At screening sites, participants showed high awareness of the skills required for responding to disclosures.

Our skills have to be more than screening there because the screening and a woman says “No it’s fine”, but a screening and a woman says “Yes”, we need more skills. ... You’ve got to respond to that conversation in the moment. (Site N3, MW2)

It’s my responsibility to ask those questions and to make sure that that person is safe, in a safe environment. (Site N2, MW2)

Participants at all sites emphasised the importance of responding holistically to develop pathways that fit with women, subsequent to a woman’s disclosure of DV. Participants also understood the complexity for women managing a pregnancy and experiencing DV. Thinking of leaving a violent relationship is challenging: “If you’re preparing for birth, you’re not really preparing to move out of your house and separate from your partner.” (Site V5, FG3, MW3)

In responding to women’s needs, the role of health practitioners was identified as complex and broad:

Holistic assessment, looking not just at the details of physical abuse, but all the other factors that play into family violence like financial issues, health issues, social isolation and all of that, and trying to address family violence in a holistic way. (Site V4, SW3)

Supporting choice and agency

A woman-centred health response shows respect for women’s human rights—this theme was evident in the discussion of participants at sites with long-established screening. Participants understood that women were constantly evaluating their own safety, and that the role of practitioners was to focus on and enhance safety and support women’s choices, agency and timing:

Provide a safe journey for them into motherhood in some way, so that they then can be set up with the confidence to know that when the time’s right for them if it is, that her and her baby are safe, and she’s got a pathway to go. (Site N2, MW1)

Supporting women's choices, however, was not without tensions for participants:

We work with women's choice, and I think with domestic violence, even when people are in very violent situations, they've made choices of how to keep themselves safe, and so I think it is about checking, are you safe? Are you going to be able to get food? If she's got no money ... It's quite challenging for us to let somebody go home when they go, yeah, we're going home and we think it is safe and it's all under control. (Site N2, MW4)

In NSW, social workers at two sites discussed their role in advocating for women with the statutory child protection agency (Family and Community Services, or FACS):

If we have to call in FACS due to child protection ... they don't care about the mum. It is about the child for them, whereas I care about both. So, it's actually building that relationship and supporting that woman through what is probably a terrifying ordeal for them. (Site N1, SW)

I find a lot of our work is safety planning, because it isn't the right time for them to leave and sometimes there are expectations from FACS that that will be the outcome, but it's not necessarily in her best interest at that particular time. (Site N2, SW1)

Social workers at this site recounted how women felt the loss of agency and choice in their experiences with FACS:

She likened the interventions with [a] feeling [of] powerlessness and that lack of control that she does experience with her relationship ... which I thought was really telling. Having to support her around that was very difficult. (Site N2, SW2)

Summary

The healthcare practitioners who participated in interviews and focus groups at the SUSTAIN study sites revealed that a mode of practice that we identify as woman-centred care was valued at all sites. The core theme fundamental to woman-centred care in the context of screening for DV was ensuring that asking occurred in the context of a relationship, rather

than being process-driven. Time and privacy were required to build this relationship, but key support for practitioners also involved having clear questions and processes for screening. This enabled practitioners to feel confident to ask the relevant questions and, in doing so, provide women with information about DV. Establishing privacy for women and maintaining safety in this process was a tension across screening sites, and a concept that was not always understood at non-screening sites. Creative practice was identified at a number of sites to establish a private space for women where partners were persistent in attendance and to document actions discreetly. One site had developed a process where women were asked to come to their first appointment on their own, with the risk of taking away women's choice (about attending alone, or otherwise) at the very start of their engagement with antenatal services.

Responding holistically to women who disclosed was important and connected to the theme of "seeing all of me". Participants identified ways in which they supported women's agency and choice, which at times required standing with the woman and advocating for her choices about safety with child protection staff. At the same time, participants expressed how this can be fraught, in instances where women minimised the likelihood of abuse recurrence or its impact on them and their baby. Rural sites identified complexity in managing confidentiality and privacy for women where health practitioners' and women's lives are intertwined. The overall focus of participants was on providing women with a "safe journey into motherhood" with women's needs centred and respected.

What do health practitioners need to provide woman-centred care in the context of domestic violence?

To provide woman-centred care, health practitioners need to be supported by the health system in this work. Figure E3 provides an overview of the themes that we identified from the analysis as supportive of health practitioners: practitioners needed to be supported to develop confidence to screen and respond. This confidence developed over time but foundational to feeling confident was having clear roles; "having a team behind me"; and initial and ongoing training, mentoring and

Figure E3 Themes identified for health practitioners supporting women

support in responding to DV. All of these themes enabled practitioners to feel they were not on their own in responding to DV. These subthemes are examined below.

Experience builds confidence

Participants at two well-established screening sites (N3 and N2) reflected on how midwives' confidence in screening had grown, as they came to see its value for women. Screening was described as a challenge to begin with, particularly when women disclosed DV, but over time this shifted for midwives, and collaboration with social workers in this work had increased:

I found it was a little bit daunting and a bit confronting, when we first started ... but now that I've been doing it for a while, I've seen the benefits of asking those questions. You might get many, many Nos but then you get a Yes. And then when that woman opens up, then I find it's quite worthwhile and quite valid. (Site N3, MW3)

I don't know whether they're [midwives] just more comfortable with it, whether there's more disclosures as well and they find it more important, you know, they're feeling that's an important question. So, culture and whether they've had more training, more discussions, I think we probably work a bit more collaboratively as well these days than maybe historically. (Site N2, SW1)

Strong confidence for participants at sites with well-established screening practices contrasted with understandable anxieties from participants at newly established screening sites. One participant had anxieties about new processes, while at the same time, understanding the focus on women's wellbeing: "I know it's all part of their wellbeing and so forth but it's not something that we're used to doing." (Site V6, MW1)

Becoming comfortable to screen is dependent on practitioners knowing what to do if someone discloses, as this participant identified:

I think the thing is making people comfortable enough to ask those questions, because it's actually quite confronting for someone to ask, especially younger midwives, they ask it and then they cringe, because it's like, if I get a yes, what am I going to do? (Site V5, FG3, MW6)

Another anxiety was concern that a difficult conversation about DV may impact on their ongoing connection with women:

You worry, are they going to come back? Particularly for women who are vulnerable in other ways in their pregnancy, it might be difficult to get them to attend in the first place and you kind of worry about offending them and getting them to engage in the services. (Site V5, MW)

Despite participants having more confidence at well-established screening sites, it was also acknowledged by participants from five of the six sites that having conversations with women about DV is not easy for all midwives, as this quote typifies:

“Some midwives are more comfortable having those deep conversations with women.” (Site N3, MW2)

Knowing my role with domestic violence

A clear emergent theme from the discussion by midwives, doctors and social workers was the need for clear role delineation between these three professionals with respect to asking screening questions and responding to disclosures, including assessing safety.

Debate about whose role it was to ask the screening questions was a particular pre-occupation at sites where screening is not yet or has only recently been introduced. Doctors and midwives suggested screening was best suited to the midwifery role, as those with first and regular face-to-face contact with women. Midwives saw it as integral to their role of building trust with women during antenatal care.

Midwives are the first people they see in this hospital. ... We're the first people who have really detailed discussions with them. (Site V4, FG2, MW9)

Screening is an integral role really because we're the ones that are building trust with women and having regular contact with them. (Site V5, MW)

Doctors acknowledged that in most instances, raising the issue of abuse is left to midwives:

I think we're very poor at asking about domestic violence, to be honest. ... We rely on the midwives having done it. I probably only ask if I have suspicion. (Site V5, FG3, D3)

Doctors identified that it was difficult to ask about abuse, as they did not have sufficient ongoing contact with women. The preference of many doctors was to use case finding rather than routinely screen, meaning they would ask about DV when indicators were present.

Midwives at well-established screening sites also saw screening as a good fit with their role, which provided opportunities to build rapport and support later disclosures:

I think midwives do it really well. We're great communicators and it's everybody's responsibility and it is time consuming, but it just gives that woman that opportunity to disclose, or the next time she may disclose, or that she's heard. (Site N2, MW5)

Where women were receiving shared care, midwives suggested that it may be unsafe for women to disclose to their GP: “If the GP is her and her partner's GP, then they don't necessarily want the GP to know this is going on.” (Site N2, MW2)

In terms of responding to disclosures, midwives tended to see their role as primarily referral, relying on social workers to provide expert knowledge, as well as “knowing how to escalate and who to escalate it to and how to, the best people to get involved to deal with it” (Site V4, FG2, MW7).

Doctors similarly saw their role as referral, wanting appropriate referral pathways if women did disclose to them:

I don't mind asking the questions, but I feel a bit powerless to do anything about it. I'd like to be able to ask the question, knowing that if somebody said yes ... that I can get them help straightaway. (Site V4, FG1, D3)

A minority of practitioners took a different view. One midwife from a screening site identified that initial risk assessment and management were part of the midwives' role, particularly if social workers were not available:

If a woman makes a disclosure then if you can't get hold of social work, or it's not safe to get hold of social worker that day, then I think the midwife needs to be able to do a basic assessment of: Is that woman safe to go home? Because if she's not, then you need to come up with a plan. (Site N2, MW2)

A participant at another screening site made the point that midwives need skills to be able to assess urgency:

When a woman is disclosing to you, you get a sense of what she's going through and how worried you are about her and if you think you need to act on it straight away or not. (Site N1, MW1)

A rural GP who participated in antenatal provision noted the role GPs played in providing ongoing care, and how this could be a linchpin for DV enquiry because “they’re the ones that follow-up and see these patients on a regular basis” (Site V6, D).

There was a high degree of agreement among social workers at all sites about the role they are able to play with women who have disclosed abuse: providing assessment, safety planning, education, exploring with women their options and linking them to services.

Social workers highlighted the ways they are able to advocate for women with other hospital services:

Domestic violence is overshadowed because she has mental health concerns and then some of their practices where they have to involve the partner in safety planning around her mental health obviously place her more at risk ... we’ve got a bit of an advocacy role there. (Site N2, SW3)

They also described their capacity to work with women where ambiguous disclosures are made, including providing psychoeducation:

It’s very rare that it’s just a clear-cut disclosure from the screening. We have to do a lot of education with that and a lot of counselling to, first initially engage them and build that rapport and also help them to have an understanding that it’s not normal, you know, that this it’s domestic violence. (Site N2, SW1)

Social workers stressed the value of a referral to their service for all women when DV is identified, regardless of whether this was requested:

We would expect that if a doctor or a midwife identified that there was family violence ... a referral would be made to us, whether or not the woman consents, so that some safety planning and risk assessment can be done. (Site V4, SW2)

At some sites, processes have been established to help midwives prioritise referrals. For example, at V5, social workers and midwives jointly identify whether an immediate response is

required. At two other sites (V4 and N1) social workers found it useful for midwives and doctors to have done some initial risk assessment to assist with triaging. This remains a tension for most sites—that is, determining how far the midwife/doctor should pursue safety and referral, particularly in settings where a social work response is not easily accessed.

Social workers described how flexibility to see women at different points in her pregnancy assisted engaging with women: “When she gave birth and she was at the ward, they rang me ... Can you come to see her while she’s in the ward.” (Site N3, SW) At one well-established screening site, the social worker ensured her meetings with women coincided with antenatal appointments, to minimise any risk of partners finding out they were seeing a social worker: “They don’t have to give an explanation as to why they’re coming in on another day.” (Site N2, SW3)

Having a team behind me

Regardless of how roles were defined, it was clear that the sense of back-up from a team with expertise and capacity was important to midwives who identified DV.

Participants from all sites valued having a social work response that was on-site and immediate:

If she’s agreeable we ... straight away advise the social worker, or they will come to her. (Site V4, FG2, MW11)

If I had a real problem, I’d ring our maternity support worker [social worker] and get them to come down. (Site V5, FG2, MW1)

At all sites, participants spoke of the value to their practice of collaboration. Doctors at two Victorian sites valued the expertise that multidisciplinary teams bring to the work:

We’ve got a great multidisciplinary team and therefore we can attack it from multiple angles. (Site V4, D1)

It has to be a joint collaborative experience, because ... one person is not going to be able to solve the complex problems of these patients. (Site V6, D3)

At NSW sites, the state-wide SAFE START program involves formalised regular multidisciplinary meetings attended by government and non-government services, including mental health, social work, drug and alcohol, and child and family health. Participants identified the support and value they experience from being able to discuss women with complex needs at these meetings:

A lot of the people that identify domestic violence or psychosocial needs come up at the SAFE START meetings, and then we develop a plan, and then we enter that on the e-Maternity system. (Site N3, MW1)

Participants at these sites valued the opportunity at these meetings to collaborate in relation to women referred for other risk indicators, where there is a high index of suspicion in relation to DV (“something’s not quite right”; “I’ve got this feeling”). It was observed, however, that when referrals for social work responses are made through the SAFE START meetings, delays can ensue that result in lost opportunities to engage women:

The screening happens, they go home, they come through our multidisciplinary case discussion meeting and then we attempt to contact them which is where some of the difficulties can be—re-engaging these women at that point after the initial disclosure. They might retract what they said or minimise by the time you actually get in contact. (Site N2, SW1)

Training, mentoring and support in responding to domestic violence

Training is associated with the confidence to screen and talk with women about DV. All sites identified gaps in availability of training in that it was either not available or not offered regularly. Many participants had received some education at the time of their professional training but have not been able to access training at their site in an ongoing way:

If we could have something outside of university when you come and start working in a hospital setting. ... We should have more domestic violence training because we are dealing with it all the time. (Site N1, MW1)

There’s no training for the young ones to feel comfortable about it and what to do.

(Site V5, FG1, MW1)

As well as generic training on the nature and extent of DV, participants identified the need for training to ask screening questions at the newly screening sites of V5 and V6:

Not everyone feels comfortable to ask those questions. It is a learned skill. (Site V5, FG1, MW2)

I think training is really important, because when you get comfortable with those questions, then you feel empowered to be regularly asking. If you know referral processes, and what is a good thing to do, then we’ll adhere to that. (Site V5, IV1, MW)

A third discrete area in which participants identified the need for training was in responding to disclosures. This seemed related to confidence in asking screening questions at non-screening sites or newly screening sites:

Knowing what to do after the screening too, I mean you come across it and then what? (Site V5, FG1, MW2)

People are worried about, “Well, what do we do though then, what do we do if someone says yes?” Well, I don’t know what to do. (Site V6, MW1)

Nurse educators at site N2, in collaboration with the social work team, had developed a supportive role-play scenario for midwife training that provides mentoring and practice for asking screening questions as well as responding to disclosures.

Participants suggested that training could be made more accessible through online courses; they also suggested mandatory training or backfill to allow all team members to attend training. The site V6 doctor described the value of social workers educating junior doctors:

The social work department in the hospital here is very, very strong in educating the junior hospital staff as soon as they start, to try and address the issues of missing quite significant domestic violence, sometimes, or child abuse. (Site V6, D)

Midwives identified ways in which they receive important support to respond to DV, through both formal and informal processes, an issue not identified by social workers and doctors. For well-established screening sites, it was more common that formal processes had been instituted. For example, one well-established screening site (N2) has introduced complex care midwives, tasked with mentoring other midwives on issues which include DV responses. Staff from a newly screening site (V5) talked of the value of mentoring and case discussion for midwives; however, this process was not formalised:

My colleague, we just debriefed on the phone that night, but nothing formal. I think if you wanted to sit down and make a time with someone, no one would say no, but there's nothing formal. (Site V5, FG1, MW1)

Having team champions—midwives who are more experienced in working with DV—was another support identified by midwives from V5, which is a site that is newly screening:

Having the ability to discuss with your colleagues as well is really helpful. Somebody who is more experienced, for example, who has done lots of those things before, being able to ask them, how do you talk about this? (Site V5, MW)

The complex care midwives at N2 commented on how other midwives relied on their experience: “If a midwife was uncertain about what she should do next, she would call either of us.” (Site N2, MW2)

Summary

To provide woman-centred care, health practitioners need to feel confident to screen for and talk with women about DV. Established screening sites identified that experience builds confidence to screen, engage with women experiencing DV and ensure an adequate response. Not surprisingly, for sites where screening was not established or was in the early stages of being established, participants expressed anxiety about screening, with concerns that the questions may impact on their relationship with women. Concerns were also expressed about not knowing how to respond when women disclosed DV.

There was consensus across sites and practitioners that the task of screening best fitted with midwives. Social workers

were identified by all three professional groups as best placed to provide a comprehensive response to women where abuse was disclosed, taking into account women's varying needs and levels of risk and the time taken to assess and respond to these. Participants from all sites valued having an immediate onsite social work response. Midwives at established screening sites identified that they had an initial role in risk assessment and management, particularly if they were unable to access an immediate social work response. Ongoing opportunities to discuss working together and clarify roles are integral to managing potential tensions.

All sites valued having “a team behind them” so they could work together in the interests of supporting women. Apart from a social work response this may involve informal collaboration with other practitioners. In NSW, participants valued formal collaboration through SAFE START multidisciplinary meetings to plan services for women and provide support to practitioners. Practitioners valued being supported in their work with DV through both formal and informal processes. Similar to having “a team behind them”, established screening sites were more likely to have formal processes to provide this support, while early screening or non-screening sites relied on more informal processes. Onsite champions for consultation were valued, particularly when a site is in the early stages of implementing screening.

Gaps in accessing training, both initial and ongoing, were identified across all sites and created more anxiety at sites that were in the early stages of screening. Participants identified three areas of training that would support them in providing woman-centred care when screening and responding to women experiencing DV: general training about DV, training to ask the screening questions and training in how to respond to disclosures. Innovative practice had been developed at a well-established screening site involving supportive role-plays with mentoring of participants.

Figure E4 Themes identified for health system supporting health practitioners

What does the health system need to provide to support practitioners to work with women experiencing domestic violence?

To support woman-centred care, the health system needs to provide structural support to enable practitioners to respond to DV. Figure E4 provides an overview of the themes developed from this analysis, including providing a safe and private physical environment, ensuring an adequate response capacity and access to services external to the hospital, clear policies, electronic systems that support ongoing care and models of care that support ongoing engagement of health practitioners with women (such as continuity of care). A focus on providing bilingual responsiveness supports working with women from diverse cultural and language backgrounds. Each of these themes will be examined in the following section.

Safe and private physical environment

Ensuring safety and privacy are key to woman-centred care and to support health practitioners providing care. Of interest is that participants at only two sites commented on safety and security:

Security wasn't an issue in the old building but when you're isolated and in a different building, it is a big problem. (Site V5, FG1, MW2)

There's been a disclosure for domestic violence out in the community clinics, then we ask that those visits are now done back in the hospital for the safety of the staff and that they're not out there with potentially an aggressive partner. In the hospital we have security. (Site N2, MW4)

Additionally, staff at V5 raised concerns about privacy: "We've got a new hospital, but an assessment room that probably is half the size of what it should've been. It's got four spaces; private questions are very difficult." (Site V5, MW)

Adequate response capacity

As identified earlier, key to asking about DV is having "a team behind me". Practitioners identified that this supported them in working with women who disclose DV, with the usual pathway identified as referral to social work. Anxiety about adequate social work staffing was expressed at non-screening and newly screening sites: "We're supposed to be screening ... but what happens when they screen positive? There's a flow-on effect. So, it needs to be equally supported in social work." (Site V5, FG3, MW3)

This was confirmed by established screening sites as a valid concern, based on their experience. Participants from the rural NSW site with a part-time social worker covering both the hospital and community health expressed concern at this

staffing level and anxiety about the consequences:

We don't have enough social work service, really, to go with the demand. (Site N3, MW3)

It worries me that someone could easily slip through, because there's not enough of me. (Site N3, SW)

A positive about this position, however, was its location within community health, which meant that the social worker was able to continue to support women postnatally, including through home visits, which increased women's access: "I am so embedded in community health, the relationships that I've built up with the family and community nurses is really valuable and they're going into the family." (Site N3, SW)

One established screening site (N1) contrasted the difference made by an adequate social work response: "If you've got good social work support it makes the clinic far easier to work in" (Site N1, MW2), comparing this with their current situation of staff vacancies:

The other barrier we've got is we don't have very much, if any, support or backup if they have major problems. At the moment we have no social worker, we have two in the hospital; nobody is allocated to maternity. ... We have no mental health support whatsoever. (Site N1, MW2)

This is in direct contrast to N2, which has a dedicated antenatal social worker along with 24-hour social work crisis response. Midwives valued this back-up and found it bolstered their practice:

Whilst it's tricky to ask the questions, it's trickier when you get a positive response. But knowing that there's pathways and support that you can offer a woman, does make it easier to then ask initially. (Site N2, MW1)

Mental health staffing was a second consistently raised area of staffing inadequacy, in particular at two NSW sites (N1 and N3). It is possible that the increased identification of DV arising from screening shines a spotlight on related needs, such as mental health issues, highlighting gaps in services.

Access to services outside the hospital

All sites commented on the importance of being able to access specialist services outside the health setting. Some spoke highly of the responses provided by specialist services:

Having the legal service has been amazing. Women can come for an appointment and no-one knows she's coming in to see a lawyer as well. She's just coming in for a maternity appointment. (Site V4, SW3)

We worked really well with a DV service and I think they're a community group that's pretty good for that sort of thing. (Site V5, FG1, MW1)

There was widespread acknowledgement, however, of a common picture of highly constrained services, particularly those providing longer-term responses. Additionally, the criminal justice system was recognised as being a very difficult option for women to pursue:

There is so much responsibility on a woman having to be able to face charging their spouse and the police's focus is on charge and prosecution and naming it as a criminal offence, as opposed to actually keeping the person safe. So, that process is really daunting and hard and frightening. (Site V4, SW5)

Lack of resources was heightened in rural areas—in particular, accommodation for women leaving violence, exacerbated by long distances, isolation and women's lack of access to transport.

The refuge is in T [a regional town 98kms from the site] and a lot of the women will not want to go that far from family. There's a few motels here that are the cheaper motels that are used. ... They're known hangouts for drug deals. ... The police won't go there unattended basically. They're not safe places. (Site V6, MW2)

The services having capacity to take those people on. That's the biggest thing in this area. (Site N3, MW1)

A lot of the women that we're seeing are living in really isolated areas ... which just adds that next level of complexity sometimes onto their situation. (Site V6, MW1)

For them to get away—it's hard. I don't think we have enough resources here really.

(Site V5, FG2, MW1)

Clear policies: Sufficient time and timing

Midwives at four of the six sites described how the systems for patient allocation created time constraints associated with time to meet with women, particularly for booking-in, or initial visit, when screening questions are typically asked:

They allocate an hour to an hour-and-a half but ... what used to take an hour and a half is taking us two to three hours if you've got someone with high psychosocial needs. (Site N1, MW2)

Sometimes we find that the midwives wrote, you know, "Psychosocial—DV not done or didn't have time", and so, there's that prioritising it down, whereas potentially that woman could be in a really severe situation.

(Site N2, MW4)

Increasing complexity, as well as working with women from CALD backgrounds, was reported to exacerbate pressures of time:

We've tried to identify complex women and see them early in the day, not at the end of the day. But we have women [for whom] English is a second language, so we have to use phone booking interpreters. Give me an hour and a half, I can probably do my job really well. (Site V5, MW)

An additional issue raised by midwives at established screening sites is whether the first appointment is the appropriate point to ask these questions, as prescribed in the NSW protocol:

I think a lot of midwives find it hard to confront that topic on the very first appointment ... that's where continuity comes in. (Site N3, MW4)

You're less likely to divulge things on your first appointment, let alone a booking-in appointment. We ask them everything in the one go, and I feel like that is not fair. (Site N1, MW3)

Continuity of care

Relational care, identified as key to woman-centred care, is supported systemically by continuity of care, meaning relational continuity of care. Participants from all sites valued continuity of care models, so that women see the same midwife at each visit. They argued that such models assist disclosure of DV:

They're not going to disclose it if they aren't feeling safe, which could be—seeing a different midwife every time. They don't feel the rapport with anybody. (Site V4, FG2, MW3)

Midwives working in continuity of care models talked of the opportunities it created to see women on their own, or to build a relationship to support disclosure:

I'm seeing the same women, so I generally get at least one appointment when their partner isn't there. ... They might have said no originally, and then you get to know a little bit more about that situation ... then it prompts you to have that conversation. (Site V5, MW)

Doctors discussed the challenges for them in providing continuity of care at both V4 and V5, given the way in which clinics are structured:

If you're meeting her for the first time, at 36 weeks and she's seen five different care providers throughout her pregnancy, she just may not have had the opportunity to say anything to anybody that she felt a connection with. (Site V5, FG3, D8)

This process could be disrupted if women are referred to medical clinics for ongoing care:

If we identify it way back at maternity booking and she goes to the doctor's clinic for some medical reason, if they don't actually pay attention to what's going on it can be missed [through] the whole pregnancy. (Site N1, MW2)

Electronic systems

Observations about the value and challenges of electronic medical record systems were made by participants at five of the six sites. Practitioners found that electronic medical records provide a communication tool that works well for

identifying whether screening has been completed and providing reminders:

BOS [Birthing Outcome System] is really good, [the questions are] right there on the front; as soon as you open it up. (Site V5, MW)

Sometimes the question's been deferred, and it pops up in e-Maternity. (Site N3, MW2)

Participants at site V5 reported on the value of agreed codes on the electronic system related to screening implementation:

DA—domestic violence questions answered, no, so DAN, or domestic violence questions answered yes, DAY, or unknown, DAU. It's a kind of a code, so you can have it pop up on the screen and they're not at risk if anyone looks at the screen. (Site V5, FG3, MW3)

Electronic records were also used as a communication tool across disciplines:

Making sure that we've recorded what's happening. Making sure that worker safety is noted. (Site V5, SW)

Because of our electronic medical records, sometimes there's been a DV incident presented to Emergency Department and so sometimes we do the screening and the women go, no, no, no. And then we have to have this sort of conversation that sort of says, "Well we've had a look in your medical records it's showing that last week you had some sort of argument with your partner and you were brought in by ambulance." (Site N2, MW4)

Practitioners also related how system changes made without proper planning or consultation made the work more challenging:

A whole new psychosocial screening, which has just got a tick box on there for family violence, but it doesn't actually have any prompts of questions to ask. (Site V6, MW3)

Usually I would like to leave the DV until I've established a bit of a rapport with the patient, but now if you don't answer that section you can't move on with the consult. (Site N1, MW3)

When the new system came in women would get a text message to remind them of their appointment. ... Her partner received a text message because it wasn't her mobile, he had the mobile and so the appointment that we'd made was to follow-up around potential violence and he was present in the waiting room when she turned up. (Site N2, MW1)

Meeting the needs of women from culturally and linguistically diverse backgrounds

Providing models of bilingual responsiveness, including interpreters, supports health practitioners working with women from diverse cultural and linguistic backgrounds. At four sites, work with interpreters in relation to discussions about DV was a concern (Sites V4, V5, N1 and N2). Issues noted commonly across these sites were women's fear and shame if interpreters were known to them or were from their community, not always having the choice to work with a female interpreter, and the variability of skills and comfort of interpreters.

Midwives reported that building a relationship with women is often disrupted by the presence of interpreters, which adds to the complexity of the work and time taken. This was a particular challenge at the site where over 60 percent of women speak a language other than English:

It's not only you building a relationship, you're also relying on an interpreter to build a relationship with the woman as well so they also feel comfortable to disclose to them. (Site N1, MW1)

Site V5, a regional centre with a small CALD community, has two common languages among the refugee community. Practitioners found that using face-to-face interpreters, women would not answer some questions, but switching to a telephone interpreter service seemed to make women more comfortable.

Summary

Structurally, a number of themes were identified that impacted on practitioners' ability to provide a woman-centred response. Participants at two sites identified issues associated with the

physical environment that could impact on safety and privacy. One site had implemented processes to increase safety for outreach clinics, while the other, newly built, site created ongoing issues for privacy and safety, raising the question of whether more input into planning new buildings may have averted these issues arising. Having adequate response capacity was identified as an anxiety both at non-screening and newly screening sites and was confirmed at established screening sites as being a valid concern, if social work services are part-time or positions are vacant. An adequately funded social work response supports practitioners, although limitations in capacity may enable models that provide social work availability beyond the hospital. Gaps in mental health response capacity were identified as being an issue for two of the three well-established screening sites, highlighting the potential overlap between experiences of DV and mental health needs.

Immediate responsiveness onsite is supported by the availability of specialist services external to hospitals, in the short and longer term. Practitioners valued external services, although highlighted that many of these services were constrained, particularly those providing longer-term responses. Services in rural areas are even more constrained than city or regional services, particularly services providing accommodation for women leaving violence. Women in rural areas also faced isolation, lack of access to transport and long distances to travel to access services.

Key to ongoing sustainability is having time available to screen and respond to disclosures. Most commonly across the sites, screening was associated with the booking-in appointment, and, given increasing complexity—particularly if women require interpreters—practitioners raised questions about whether the first contact with women was the appropriate time for screening. Practitioners at these sites also sought guidance on timing of screening. Midwifery models providing continuity of care resonated with providing woman-centred care, but for all NSW sites, booking-in visits were not provided by the midwife who provides ongoing care. This approach may miss the opportunities provided by continuity of care that could allow screening questions to be deferred to a second visit.

Electronic systems were valued at all sites as providing opportunities to screen and communicate, but there could be unanticipated impacts on women's safety. Working with interpreters added complexity and time for practitioners with additional challenges associated with availability of female interpreters, or women's fear and shame if interpreters were known to them or were from their community.

PART F

The REAL Transformation Model for sustainability of identification and response to domestic violence in antenatal care

Introduction

This section of the report provides a synthesis of the study findings in relation to other literature, which has been developed into the REAL Transformation Model. Findings from Parts A, B and C have been integrated to provide a thick, in-depth description using a case study approach (Stake, 2005) of antenatal care within each site. These in-depth descriptions were used in an illustrative manner to develop a model for sustainability of screening and responses to DV in antenatal care. Guided by the WITH Health System Implementation Model, we asked what do the findings tell us about “How does the work get done?” and “Why does it get done that way?” The findings from each site were synthesised and applied to the WITH Health System Implementation Model. The ensuing sections consist of discussions of findings from the study pertinent to the study objectives to:

1. explore how women attending antenatal care perceive the nature and timing of screening questions and risk assessment about DV, including the most effective and acceptable wording of screening questions
2. understand the factors encouraging disclosure and acceptance of referrals from a system perspective
3. understand how practitioners working in antenatal care perceive the process of screening, risk assessment and responses for DV
4. understand the barriers and facilitators to introduction and sustainability of screening and first line responses in antenatal care.

Key findings

In Victoria, the SUSTAIN survey was conducted at a time when mandatory routine antenatal screening had not yet been rolled out, and the results showed that health practitioners are not yet asking about DV consistently. This contrasts with the high rates of screening in NSW (82.4–98.9% between July 2017 and June 2018) after a decade of mandatory screening. Given the high prevalence and associated risks of DV during pregnancy and postpartum periods, these findings further underscore the need for mandatory DV antenatal screening (Australian Bureau of Statistics, 2013). Very low rates of asking about children’s safety in Victoria, despite the negative

impact children exposed to DV often experience (Arai et al., 2019; Katz, 2016) are another area for improvement. Similarly, high rates of under-disclosure by women in both states highlights the need to keep the question of DV alive throughout a women’s encounter with the health service (Evans & Feder, 2016; Garcia-Moreno et al., 2015; Rhodes et al., 2011; Wolff, Cantos, Zun, & Taylor, 2017). Despite the high screening rates in NSW, DV disclosure rates varied considerably, with 0.1 percent and 1.5 percent at sites N1 and N2 respectively, and 5.5 percent at site N3.

The women in this study, whether recruited from established screening sites or sites that are yet to mandate routine antenatal screening, expressed support for screening. This is consistent with the literature on women’s responses to screening, which has found that DV screening is acceptable to women who have experienced abuse (Hegarty et al., 2013; Hinsliff-Smith & McGarry, 2017; Koziol-McLain, Giddings, Rameka, & Fyfe, 2008; Phelan, 2007; Pratt-Eriksson, Bergbom, & Lyckhage, 2014; Spangaro et al., 2011). None of the women in our samples reported any adverse effects from screening and response; this is consistent with the literature, which has reported such events are rare and minimal (MacMillan et al., 2009; Nelson, Bougatsos, & Blazina, 2012; O’Doherty et al., 2015). This has also been found previously in Australian and international literature (Chang et al., 2005; Hinsliff-Smith & McGarry, 2017; Koziol-McLain et al., 2008; Matthey et al., 2005; Phelan, 2007; Pratt-Eriksson et al., 2014; Rhodes et al., 2018; Spangaro, Koziol-McLain, et al., 2016; Spangaro et al., 2010; Webster et al., 1997; Weinsheimer, Schermer, Malcoe, Balduf, & Bloomfield, 2005).

In terms of critical elements of responses to disclosure, the concept of “care” was previously articulated in other research (Spangaro, Koziol-McLain, et al., 2016) conducted by members of this team and defined as “the woman perceives the midwife is caring, i.e. she shows interest and a non-judgemental attitude in the way she asks about abuse”. This support and validation was identified as a key construct in pathways to decisions to disclose abuse by women, but also by SUSTAIN study practitioners’ experiences where it was also key to perceiving the experience as having a positive impact (Spangaro, Herring, et al., 2016; Spangaro, Koziol-McLain, et al., 2016). The value of models providing continuity of care

has also been previously identified in the research literature (Catallo, Jack, Ciliska, & MacMillan, 2013; Eustace et al., 2016; Evans & Feder, 2016). The SUSTAIN survey showed that some participants held negative perceptions that might have influenced their willingness or comfort to disclose DV or social problems. For example, some women thought the midwife or doctor was only there to look after their pregnancy care. By being mindful of the concepts of care, support and validation, health practitioners could make their interactions with women a more positive and rewarding experience.

Key to examining how practitioners perceive the process of screening, risk assessment and responses for DV is consideration of whether health practitioners find screening acceptable. Although some research evidence suggested only half of health professionals in the systematic reviews undertaken found screening acceptable (Feder et al., 2009; Stayton & Duncan, 2005), there is considerable difference across professions, settings and the degree of resourcing and institutional support (Chang et al., 2009; Hammock et al., 2017; Spangaro, Poulos, & Zwi, 2011; Todahl & Walters, 2011). In this study, there was common agreement that screening was part of health practitioners' roles. Understandably, practitioners at sites that were newly screening expressed anxiety with including these new processes in their practice. Practitioners at well-established screening sites valued including screening in their practice, particularly when considering women's responses.

Practitioners in the focus groups described clearly how they saw the roles of different practitioners—doctors, midwives and social workers—and how these roles supported each other. Research literature is relatively silent on practitioners' roles, other than the WHO (2013b) identifying the importance of a first-line response from the screener. Across both SUSTAIN survey sites, the highest number of relationship safety enquiries were made by midwives, followed by general practitioners, and then obstetricians. From the focus group findings emerged the need for clarity about risk assessment and management, both initial and comprehensive, so that there is a clear understanding and focus on safety, particularly if an immediate social work response is not available. A referral pathway subsequent to disclosure is a key element that was identified by practitioners as supporting them—the

concept we identified as “a team behind me”. In this study the usual pathway was to social work. The concept of a clear referral pathway was supported by Kirst et al. (2012), who identified the importance of institutional referral policies. A number of other studies have identified the importance of easily accessible referral services (McCaw et al., 2002; Raissi, Krentz, Siemieniuk, & Gill, 2015). Dienemann, Glass, and Hyman (2005) highlighted how important an immediate positive response was for women: “When you are physically or mentally abused and you tell someone, the feeling you get inside is that you want the help then, because the courage does not last long.” (p. 226) Practitioners value knowing what to do when women disclose DV, an issue reflected in the wider research literature. O'Campo, Kirst, Tsamis, Chambers, and Ahmad (2011) identified that uncertainty about what to do when an individual discloses DV was one element that tended to undermine provider confidence and screening behaviour.

A key facilitator for successful screening was identified by practitioners as screening in the context of building a relationship with women, ensuring there was sufficient time and privacy. This resonated with the literature that emphasised the importance of the health practitioner developing a trusting relationship with the woman (Alhusen, Ray, Sharps, & Bullock, 2015; Feder et al., 2009; Spangaro, Koziol-McLain, et al., 2016), with privacy and confidentiality being essential to building trust (Feder et al., 2009; Gielen et al., 2000). Time was identified by participants as a possible barrier to implementation and sustainability of screening if practitioners did not have sufficient time to listen, reflecting themes found in the literature (Dienemann et al., 2005; Feder et al., 2009).

An identified concern and potential barrier to sustainable screening practices identified at sites that were newly screening was having clear guidelines for screening, using direct questions with guidance on repeat screening. At well-established screening sites, participants did not express anxiety about the process; their focus was on whether the questions could be more sensitive to the full range of experiences of DV and whether the first appointment with a woman was the most appropriate time to screen. Bonomi et al. (2006) identified the limitations of language in diminishing opportunities for women to interpret their situation as abuse; Spangaro, Koziol-McLain, et al. (2016) identified the importance of

direct asking; and O'Campo et al. (2011) identified from a systematic review that practitioners expressed concerns about asking appropriate questions. The literature supported practitioners asking on more than one occasion, as women may not be ready to disclose on the first occasion (Ahmad et al., 2009; Kataoka et al., 2011; O'Reilly et al., 2010; Spangaro et al., 2009; Webster & Holt, 2004).

A further facilitator for engagement with women when implementing screening is that women are seen holistically at the time of screening and in responding, so that screening is not the focus of engagement. Survivors identified the importance of this in a number of studies emphasising that practitioners should take a holistic view of the woman's situation, balancing a range of her needs (Dienemann et al., 2005; Hathaway et al., 2002; Kulkarni, Bell, & Wylie, 2010). This is also supported by our survey findings, which indicated that regardless of the category of abuse they experienced, women greatly valued support for physical and emotional health, parenting issues, personal safety and sexual health issues during pregnancy. Beyond seeing women holistically, there is a need to support a woman's choice and agency when screening and responding to her diverse needs. A number of studies identified the importance of supporting women rather than telling them what to do (Dienemann et al., 2005; Othman, Goddard, & Piterman, 2014), with Campbell (2004) identifying the importance of working with women to do a skilled assessment of the danger in their relationship and to equip them to make more informed plans for their safety.

Clear pathways and roles are supported by adequate resourcing of all elements of screening and responses (Feder et al., 2009; Sprague et al., 2012) that takes into account time and workload priorities (Feder et al., 2009; Minsky-Kelly, Hamberger, Pape, & Wolff, 2005). Given the well-established link between DV and mental health (Luca et al., 2013; O'Doherty et al., 2014; Tiwari et al., 2008), mental health services are an important part of response capacity as identified in the findings from focus groups with practitioners who questioned screening in the instances when a response capacity is not available.

Research literature identified initial and ongoing training, including mentoring and support, as vital to sustainability of screening (Bacchus et al., 2010; Feder et al., 2009) and

“instrumental for building high provider self-efficacy for screening” (O'Campo et al., 2011, p. 862). Along with the benefits of training, mentoring and support are key elements to support practice including the use of simulation training, discussed at one focus group site. Bacchus et al. (2010) provided some insights into training for routine screening based on their work with practitioners: “Although some health professionals were positive about the effect of training on their ability to enquire about DV, others were more reticent” with one health professional saying she “felt unable to ask the husband to leave and couldn't think of what to say as to why she wanted to speak to the woman on her own” (p. 151). This highlights the importance of training, mentoring and support; for example, simulation training is a practice shown to be valued in the findings.

Midwifery continuity of care models (Eustace et al., 2016; Evans & Feder, 2016) support the relational nature of screening, re-screening, and ongoing engagement with women during antenatal care. To maximise the model, there is value in continuity of care commencing from women's first engagement with antenatal services; however, this requires adequate resourcing and staffing. Lack of continuity of care has been identified as a potential barrier to disclosure, thus impacting on sustainability of screening (Spangaro et al., 2019).

As identified earlier in this report, computerised information systems and reminders have been shown to be beneficial in improving the process of care. This was borne out in the focus group findings; however, attention needs to be paid to safety for women when implementing new electronic processes, given women's safety is an important element of woman-centred care (World Health Organization, 2017).

Additional barriers arise for women from CALD backgrounds who experience DV, including structural and institutional inequalities (Messing, Amanor-Boadu, Cavanaugh, Glass, & Campbell, 2013; Raj & Silverman, 2002; Stockman, Hayashi, & Campbell, 2015). Structural barriers impact on the provision of services, as identified in the findings from focus group discussions associated with working with interpreters. This was further reflected in the research literature where women “reported that they faced unfriendly, insensitive and disrespectful interactions with health providers that were

exacerbated by negative attitudes, discrimination and/or racism” (Jones et al., 2017, p. 6). From this same review, a number of elements were identified as contributing to culturally appropriate care, including employing “staff members who shared linguistic and/or cultural backgrounds”, a focus on “culturally-sensitive and respectful interactions”, continuity of care and giving women choices (p. 6). Addressing the provision of culturally appropriate care in the context of screening will address inequities, to ensure sustainable screening and responses for women from CALD backgrounds.

Similar inequities arise for women from rural backgrounds, with practitioners identifying issues already raised by Campo and Tayton (2015). An unexpected finding from the focus groups was the advantages that arise from closely interconnected communities, with a strong sense of care for women, as well as innovative staffing models to provide services that address scarcity of resources and accessibility for women.

In summary, many of the facilitators to successful screening can also be barriers, if there is insufficient resourcing and leadership within the health system. Themes identified by participants were reflected in the extant literature, except for clear role delineation. Practitioners from well-established screening sites identified formal structures that supported screening practices such as mentoring, multidisciplinary meetings, and clear processes and roles. These structures may provide guidance to inform implementation of sustainable screening.

The dilemma of woman-centred care versus family-centred care

Woman-centred care is a well-established concept that encompasses a holistic consideration of the woman’s unique circumstances, needs, expectations and aspirations. It is based on effective communication between a woman and her healthcare providers and supports her right to self-determination in terms of choice, control and continuity of care. Incorporated into care is the woman’s social, emotional, physical, spiritual and cultural needs, and the context of the woman’s life (Brady, Lee, Gibbons, & Bogossian, 2019; Department of Health, 2018; Fahy, 2012; Yanti, Claramita,

Emilia, & Hakimi, 2015). Moving from woman-centred care as the basis of antenatal care, this analysis sought to explore what woman-centred care looks like in the context of screening for DV and family violence, and, in this context, what health providers need to provide a woman-centred response and what enabling conditions are required from the broader health system. The concept of woman-centred care has been identified by the WHO as an underlying principle to guide the healthcare responses to women who experience DV. Similar to the overview of woman-centred care in antenatal settings, the WHO identifies that care and health services for women should be “organized around women’s health needs and perspectives” (World Health Organization, 2017, p. 8), and Garcia-Moreno et al. (2015, p. 1569) note that “health-care providers [should be] trained in woman-centred first-line support, to respect a woman’s right to decide on her own pathway to safety”.

While woman-centred care is a concept used in Australian healthcare, a number of other models inform antenatal practice, family-centred care and people-centred care. Family centred-care emerged in the 1970s, with the aim of fostering “family unity through sensitivity and responsiveness to the beliefs, values, and customs that are specific to each mother’s culture, ethnic group, and/or religion” (Zwelling & Phillips, 2001, p. 5). More recently, the WHO has focused on people-centred care, meaning that health services are tailored to people’s needs and provided in partnership with them, rather than given to them. In people-centred care, people, families and communities are respected, informed, engaged, supported and treated with dignity and compassion (World Health Organization, 2017).

Although there is a commonality of values in these models, it is important to critique what family-centred practice means and subsequently the implications for sustainability of screening. In family-centred practice, there is potential “slippage” in terminology so that the needs of women and family/children become indistinguishable, with implications for safety and autonomy. This seems linked to the challenges identified across all sites with creating a woman-only consultation time for screening for DV, among other psychosocial factors. If the focus is on the family, how can we exclude partners or support people? However, in screening for DV, a minimum

condition is that it must be safe to screen, with no-one else present apart from an interpreter (World Health Organization, 2013b). To screen safely, there needs to be a woman-only consultation space that is positively framed for women and their partner/support persons rather than inadvertently giving the message of exclusion, which may contribute to exacerbating risk to women.

Evidence synthesis

Table F1 summarises the building blocks for a sustainable, woman-centred response that have emerged from the study. As part of the synthesis process, it was valuable to initially categorise the findings based on *a priori* themes from the WITH Health System Implementation Model: relationship building, integrated coordinated care, reflective system, and environment and workplace scan (Hegarty et al., 2017). Following further deliberations by the research team, the subthemes were subsequently regrouped under more precise themes based on the context of the SUSTAIN study and then developed into the REAL Transformation Model, described below.

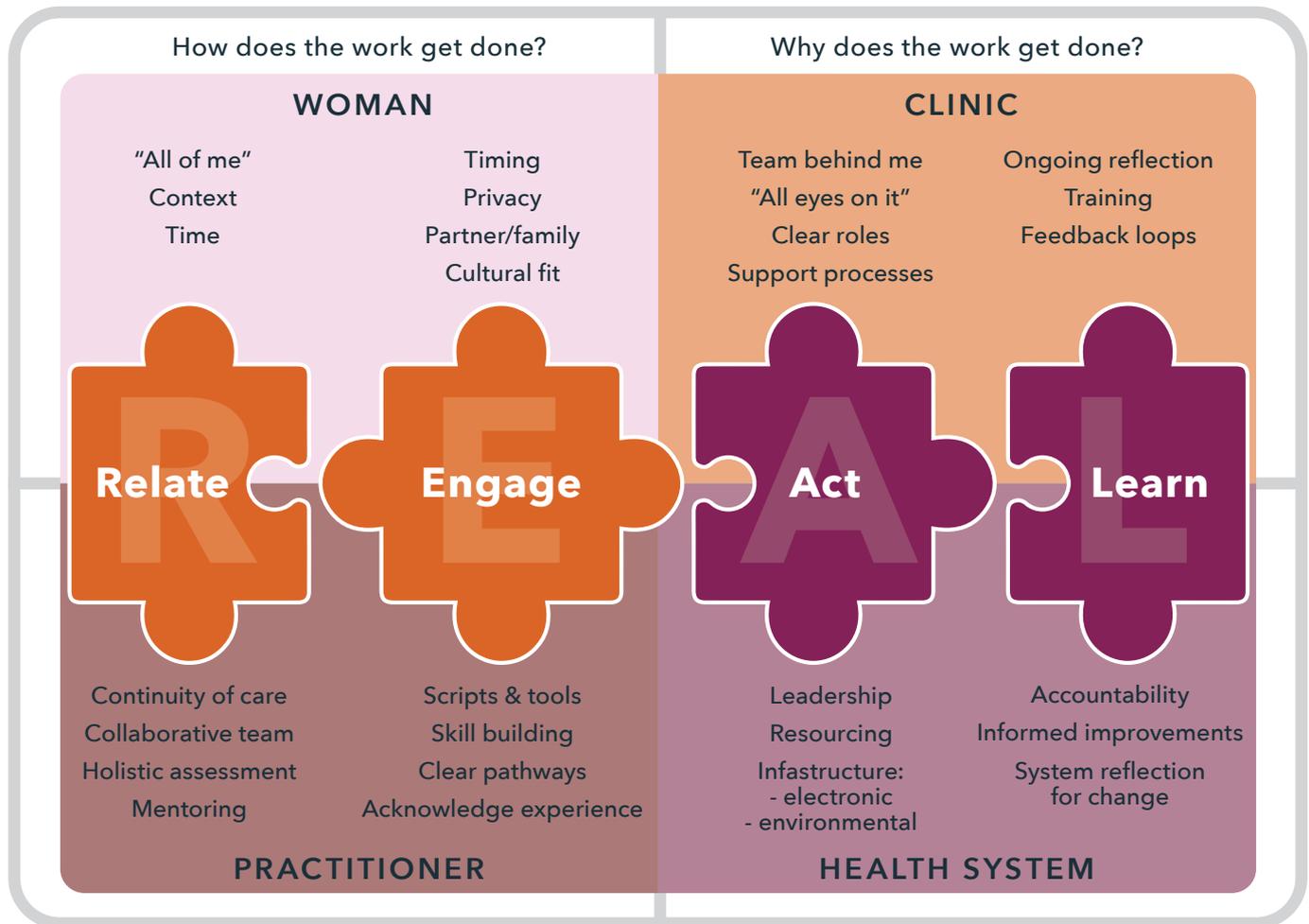
Table F1 Building blocks of key responses across domains from the SUSTAIN study

		BUILDING BLOCKS			
SUSTAIN domains	Sources of data	Relationship building	Integrated co-ordinated care	Reflective system	Environment & workplace scan
Patient domains	Survey (women)	<ul style="list-style-type: none"> • Continuity of care • Asked regularly throughout pregnancy • Ask but do not expect disclosure • Information • Understanding/supportive • More contact • Support of partners • Early intervention in asking woman what they want from partner (partner seek help, support chores, understand pregnancy, spend time together) 	<ul style="list-style-type: none"> • Psychological/legal services • Feel comfortable with midwives/doctors 		<ul style="list-style-type: none"> • Run on time • Better waiting areas • Access • Closer to home
	Interviews with referred women	<ul style="list-style-type: none"> • Space to share concerns • Work with other services where women are seen • Feeling supported and backed up • Shared plan, multidisciplinary clinic • Confidentiality • When to screen, not just once • Managing partner presence 	<ul style="list-style-type: none"> • Clear roles for higher risk cases • Back up from same professional group • Continuity of care (roles: who does risk assessment?) 	<ul style="list-style-type: none"> • No standard pathway for family violence • Training that supports practitioners' needs 	<ul style="list-style-type: none"> • Communication through records for continuity of care

		BUILDING BLOCKS			
SUSTAIN domains	Sources of data	Relationship building	Integrated co-ordinated care	Reflective system	Environment & workplace scan
Staff domains	Interviews with practitioners	<ul style="list-style-type: none"> • Trust each other 	<ul style="list-style-type: none"> • Case meeting team • Availability of multiple overlapping care 	<ul style="list-style-type: none"> • Creative practice • Secondary consultation • Reflective practices • Supervision and consultation • Peer support • Audit of feedback by people they admire • Case reviews 	<ul style="list-style-type: none"> • Continuity of care • Tailored training
	Focus groups with practitioners				
Organisational domains	Service readiness tool		<ul style="list-style-type: none"> • Structures in place but not working consistently 	<ul style="list-style-type: none"> • Provider training (not mandatory and competes with mandatory training) • Present baseline readiness to organisations for feedback 	<ul style="list-style-type: none"> • Need to have better checklist for this area
	Context document	<ul style="list-style-type: none"> • Often easier in relationship building for rural areas 	<ul style="list-style-type: none"> • Lack of continuity of care 		<ul style="list-style-type: none"> • High disadvantage and use of interpreters result in more complexity

Figure F1 The “REAL” Transformation Model: Sustainability of identification and response to domestic violence in antenatal care

Sustainability of Identification and Response to Domestic Violence in Antenatal Care



The REAL Transformation Model: Keeping it real: A model for sustainable identification and response in antenatal care for domestic violence

This case study of rural, regional and metropolitan study sites, encompassing women or health service users and healthcare practitioners, brought to the fore significant factors essential to evidence-based, health system-wide identification of and responses to DV in antenatal settings. This will effectively facilitate the safety and wellbeing of women and their children. We identified important elements pertaining to the woman, practitioners, the process of identification and responses to DV and the health system. How the work gets done and why it happens that way underpin the continuum of care processes necessary to achieve desired results in DV

identification and responses. This is similar to the health system implementation model in the WITH study (Hegarty, Tarzia, Rees, et al., 2016).

As illustrated in Figure F1, the “how” the work gets done pertains to characteristics of the *relationship* developed between women and their health practitioners, and important elements that facilitate effective client-practitioner *engagement*. *Relate* in our model therefore refers to the initial contact with women, including screening and identification of DV. This may involve practitioners establishing a rapport, raising awareness and signalling that they have a safe space to discuss issues and for screening. For women, important aspects of “relate” were a whole-person approach to care (“**seeing all of me**”), and attention to their unique circumstances or **context** and adequate **time** for the process. Health practitioners valued having **continuity of care** for their clients, a **collaborative team**, employing **holistic assessment** for DV and **mentoring**.

Engage refers to the ongoing relationship and factors required to facilitate disclosure or ensure an adequate response to DV (where a disclosure is made). Essential characteristics of this engagement were **timing, privacy, partner/family** and **cultural fit** for the woman; and **scripts and tools, skill building, clear pathways** and **acknowledgement of experience**, for practitioners.

In this study, “why does the work happen that way?” concerns practical *actions* that support DV identification and responses within the health system, as well as activities related to *learning* for the strengthening of existing systems. With regards to *act*, having **support of a team**, with different categories of practitioners playing their part (“**all eyes on it**”), having **clear roles** and **support processes** were important for DV identification and responses. At a health system level, to support the work needs **strong leadership, resourcing** and **infrastructure (electronic and environmental)**. *Learn* involves **ongoing reflection, training** and **feedback loops** for DV identification and responses, supported by **accountability, informed improvements** and **system reflection for change** within the health system.

Conclusion

This section concludes the report and outlines the study limitations and strengths as well as the implications for practice, policymakers and research.

Strengths and limitations

Strengths of the study

Our study sites were located in two Australian states with differing levels of DV screening practices. The diversity of sites in terms of geographical location, as well as different levels and sizes of health facilities in rural and metropolitan settings, was an important strength of the study, as it allowed a broader understanding of the context and current state of DV screening in antenatal settings across Australia. The use of a variety of data sources and methods of data collection provided a better comprehension of study findings by enabling the triangulation of data (Heale & Forbes, 2013).

We achieved a high overall response rate of 71 percent in the SUSTAIN survey, which enhances the representativeness of the study sample and contributes to the credibility of the results. Furthermore, data dependability was strengthened by researchers' engagement in the iterative way that the codes were generated and then recoded for the qualitative interviews.

Limitations of the study

Using the WHO checklist (see Appendix C) for assessing health service readiness to respond to DV, we recognised that the tool could not achieve the level of detail needed to comprehensively appraise the levels of service provision across the six study sites. This resulted in quite similar results/responses across most sites, despite differences in DV screening practices as demonstrated by the other components of this case study. The tool lacks a "partial" response option, as well as more specific measures to reflect differences in responding to DV in Australian healthcare settings. There is a need for sector-wide consultation to determine the best approach for such tools to facilitate feedback for and improvements to DV-related health services.

Women who were accompanied by their partners or other family members were excluded from the survey to avoid potential perpetrator awareness of the DV screening. This could have led to an underestimation of the prevalence of DV in this study, as this cohort of women might otherwise have been eligible for inclusion in the study.

The survey was administered in three languages: English, Arabic and Chinese. Women who were not literate in these languages were excluded from the survey, which could have further affected the DV prevalence obtained in this study.

Additional interviews of women with experiences of DV referred to social work were planned to be undertaken in Victoria. However, this was not completed due to staffing issues at the time of the study. Although similar interviews conducted at the NSW sites involved only a few women, they provided important insight into women's experiences and pathways to disclosure, as well as opinions of screening in antenatal care settings.

The generalisability of these findings to other states, particularly those with remote health services, is limited. Further, there was not a specific focus on Aboriginal and Torres Strait Islander peoples in this project as this group would have required input from Indigenous researchers and careful attention to specific consultation processes, which were beyond the scope of the current project.

Recommendations

Implications for practice

In this study, DV is common among pregnant women, with around 1 in 10 women screening positive for DV and 5 percent expressing fear of their partner. Mental health issues were also common; however, in our study women were more comfortable talking about mental health issues than DV or alcohol and drug issues. The study revealed that more women consider using help for DV than actually reaching out and seeking that help, emphasising the need to consider women's negative perceptions and their expectations about seeking help. There

is a clear need to provide holistic and individualised care, and to create adequate time (where screening questions are to be asked) and conducive environmental conditions for consultations. It is reassuring to note that women want to be asked regularly during pregnancy, even though a disclosure may not be obtained during initial stages of the practitioner-client interactions. Practitioners need to respect women's choice and agency and at the same time keep the safety of woman and baby in sight.

The need for women-only consultations or contact time with practitioners was also an important finding. This would normalise visits in which partners or other family members are not included in the appointment and potentially reduce risk to women with controlling partners. At the same time, it would potentially reduce stress for midwives asked to exclude partners and/or family members from visits. This should, however, be balanced with providing family-centred care.

In general, midwives were making more enquiries than other categories of health practitioners. Also, only a relatively low number of referrals for women who have been abused were made, mostly to social work. Clinics need to establish integrated responses that include both strong internal referrals, for example to social work, drug and alcohol or mental health services, as well as incorporate external referrals, for example to legal services. In addition, practitioners need clarity about their roles and to work as collaborative teams to ensure continuity of care for all women. Responses to DV are the responsibility of all antenatal health practitioners who need to remain alert to possible presence and/or missed screening/follow-up ("all eyes on it"). To further facilitate routine screening, health practitioners require training, support, debriefing and upskilling of interpreters and building of bilingual capacity within their practices.

Audits provide a sense of urgency for accountability and a pathway for improvement. The value of the audit process is important to support a culture of shared responsibility, collaboration and improvement.

Implications for policymakers

Successful health policies in this field need to respond to where women are at any point in time. That is, policies that consider the chronicity and long-term impacts of DV are essential. Implementation plans for any policies made will also need to focus on multiple health professions, as women felt midwives and doctors were supportive, and women may disclose to a subsequent practitioner. Continuity of care models throughout antenatal care are also urgently needed to reflect the nature of disclosure of abuse, as an ongoing process and to ensure ongoing monitoring of risks.

Given that the asking rates in Victoria were around 50 percent in hospitals that did and did not have screening in place, there is a need for support and a clear systems approach, as simply mandating screening will not produce desired outcomes. DV screening needs to be embedded in psychosocial assessment ("see all of me"). Procedures for screening need to attend to the timing of asking questions and allow for the building of rapport with women prior to asking questions; for example, splitting booking-in visits with screening repeated at a later point, such as the 20- or 36-week visit. In this way, screening for DV and other assessment questions, which many women may not have previously discussed with partners or family members, can be more readily asked at subsequent visits.

Initial and ongoing training is required to address broad-based understanding of the nature of IPV, asking about IPV and responding to disclosures. Mechanisms are also required to build practitioner confidence regarding case discussion and debriefing, supervision, and mentoring. Regular systematised, multidisciplinary case discussion meetings will support responses to DV and other related vulnerabilities.

DV screening tools should include a spread of questions beyond physical violence and be applied more than once during antenatal care. Standardised tools are required, incorporating explicit screening questions, guidance on interpretation and use, and information for women. A feasible plan to ask women alone is also vital, as many men accompany their partners to the booking clinic. However, partner-only times should also be offered at antenatal assessment to counter women-only time and address family-inclusive practice. Privacy

and confidentiality issues are particularly heightened in rural areas. Electronic record systems need to be designed to ensure safe implementation of tools at designated times and facilitate team communication.

Processes need to articulate clear roles about primary and back-up designation for screening, responses and risk assessment, and must include a framework for immediate and future risk assessments. Clinics also require onsite social work response capacity to support midwives and other practitioners. Interagency protocols are needed to ensure clarity around requirements and timing for antenatal child protection reports, to reduce uncertainty for women and increase consistency of practice.

Finally, resources to evaluate program accountability and improvement over time to ensure value for money is paramount in any policy implementation plan.

Implications for research

This study underscored the need for validated tools for screening that address the broad range of types of abuse women experience, including controlling behaviours by partners. Standardised tools sensitive to improvements are needed for monitoring infrastructure, accountability and performance.

Further research is needed to test mechanisms to create separate time for women and their partners in antenatal assessment and understand contexts under which women do and do not accept referrals.

All sites indicated using a shared care model, although only five acknowledged a continuity of care model. The high-risk care models that provide an opportunity for integrated case management varied across the sites. Research testing different continuity of care models on disclosure rates and IPV responsiveness may help guide practice.

About 90 percent of respondents found the survey questions acceptable and 80 percent were pleased they were asked. The

survey also increased awareness about DV for 20 percent of participants, but 12 percent reported that they felt problems in their relationship were their own fault. It is important to explore how to undertake surveys safely so that respondents do not feel guilt through their interpretation of questions posed.

Rural issues

Rural sites identified complexity in managing confidentiality and privacy for women where health practitioners' and women's lives are intertwined. Further response is challenging in rural areas with staffing shortages, where social workers may often not be readily available. Some of the specific challenges for implementing a DV health systems change model in a rural setting may include recruiting facilitators, access to health practitioners, absence of DV services in the community and safety from perpetrators, who may also be known to the practitioners. Further, lack of resources was heightened in rural areas, in particular accommodation for women leaving violent relationships, exacerbated by long distances, isolation and women's lack of access to transport. On the positive side, relationship-building across teams in rural areas is often easier because of the existing connections in rural communities.

Conclusion

We have listened to the voices of women and practitioners, examined workplace contexts and appraised the literature addressing DV screening and responses in the antenatal setting. In doing so, we now have a greater understanding of how and why DV screening and responses vary across health locations. Although there will always be uncertainty in practice, we propose the REAL model as a relationship-based, sustainable model to guide ongoing learning and improvement in meeting the health and safety needs of women, children and their families who may be experiencing DV.

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Data extraction from systematic reviews

Author	Objective(s)	Study type	Population/setting & number of studies included	Main findings
Pasha et al. (2018)	To determine if screening using face-to-face interview is as effective in identifying IPV as a screening questionnaire that women complete	Systematic review and meta-analysis	Pregnant women in their first trimester to six weeks postpartum	<ul style="list-style-type: none"> • A more universal standard for screening for IPV during pregnancy is necessary • Practitioners need to provide women with the tools and resources to disclose their experiences and receive treatment • A questionnaire format for screening women for IPV increased rates of identification
Jahanfar et al. (2014)	To examine the effectiveness and safety of interventions in preventing or reducing DV against pregnant women	Meta-analysis	Pregnant women 10 trials with a total of 3417 women	<ul style="list-style-type: none"> • There is insufficient evidence to assess the effectiveness of interventions for DV on pregnancy outcomes • There is a need for high-quality RCTs with adequate statistical power to determine whether intervention programs prevent or reduce DV during pregnancy, or have any effect on maternal and neonatal mortality and morbidity outcomes
Colombini et al. (2017)	To review studies of health-sector responses to IPV in low- and middle-income countries	Systematic review	Health sectors in low- and middle-income countries 11 studies	<ul style="list-style-type: none"> • Important facilitators were: availability of clear guidelines, policies, or protocols; management support; intersectoral coordination with clear, accessible on-site and off-site referral options; adequate and trained staff with accepting and empathetic attitudes toward survivors of IPV; initial and ongoing training for health workers; and a supportive and supervised environment in which to enact new IPV protocols • A key characteristic of the most integrated responses was the connection or “linkages” between different individual factors, with all elements implemented in a coordinated manner
Feltner et al. (2018)	To review the evidence on screening and interventions for IPV, elder abuse, and abuse of vulnerable adults to inform the US Preventive Services Task Force	Systematic review	Women 30 studies (N = 14,959)	<ul style="list-style-type: none"> • Although available screening tools may reasonably identify women experiencing IPV, trials of IPV screening in adult women did not show a reduction in IPV or improvement in quality of life over 3 to 18 months • Limited evidence suggested that home visiting and behavioural counselling interventions that address multiple risk factors may lead to reduced IPV among pregnant or postpartum women

Author	Objective(s)	Study type	Population/setting & number of studies included	Main findings
Arkins et al. (2016)	To identify the best psychometrically tested screening tools available to assess all areas of IPV in men and women in mental health settings	Systematic review	Men and women in mental health settings 36 studies	<ul style="list-style-type: none"> • Ten IPV screening tools were identified; three tools assessed all areas of IPV and were validated against an appropriate reference standard • Mental health nurses need to incorporate a psychometrically tested IPV tool as part of risk assessment and safety planning for clients • Further research is necessary to validate IPV screening tools that are culturally sensitive and have been validated with men and women
Rabin et al. (2009)	To summarise IPV screening tools tested in healthcare settings, providing a discussion of existing psychometric data and an assessment of study quality	Systematic review	Healthcare setting 33 studies	<ul style="list-style-type: none"> • The most studied tools were the Hurt, Insult, Threaten, and Scream (HITS, sensitivity 30%-100%, specificity 86%-99%); the WAST (sensitivity 47%, specificity 96%); the PVS (sensitivity 35%-71%, specificity 80%-94%); and the AAS (sensitivity 93%-94%, specificity 55%-99%) • No single IPV screening tool had well-established psychometric properties
O'Doherty et al. (2015)	To assess the effectiveness of screening for IPV conducted within healthcare settings on identification, referral, re-exposure to violence, and health outcomes for women, and to determine if screening causes any harm	Intervention review	Healthcare settings (antenatal clinics, women's health clinics, emergency departments, primary care) 13 trials that recruited 14,959 women	<ul style="list-style-type: none"> • Screening increases the identification of women experiencing IPV in healthcare settings • Pregnant women in antenatal settings may be more likely to disclose IPV when screened; however, rigorous research is needed to confirm this.
O'Reilly et al. (2010)	To appraise the effectiveness of DV screening and interventions for women identified as experiencing/having experienced DV through screening in pregnancy.	Systematic review	Healthcare settings (screening in pregnancy) Nine studies	<ul style="list-style-type: none"> • Identification of DV was significantly higher compared to studies that used a non-standardised screen or no screen at all • Recurrent screening throughout pregnancy further increased identification rates • Interventions for pregnant women who had experienced DV reduced the amount of violence experienced by these women, but the evidence is very limited by the small number of randomised studies with small participant numbers

Author	Objective(s)	Study type	Population/setting & number of studies included	Main findings
Hussain et al. (2015)	To assess the rate of IPV disclosure in adult women (>18 years of age) with the use of three different screening tool administration methods: computer-assisted self-administered screen, self-administered written screen, and face-to-face interview screen	Systematic review and meta-analysis	Healthcare settings	<ul style="list-style-type: none"> • No significant differences were observed when women were screened in face-to-face interviews or with a self-administered written screen (odds of disclosing: 1.02, 95% CI: [0.77, 1.35]) • A computer-assisted self-administered screen was found to increase the odds of IPV disclosure by 37 percent in comparison to a face-to-face interview screen (odds ratio: 0.63, 95% CI: [0.31, 1.30]) • Disclosure of IPV was also 23 percent higher for computer-assisted self-administered screen in comparison to self-administered written screen (Odds of disclosure: 1.23, 95% CI: [0.0.92, 1.64])
Hegarty et al. (2016)	To identify intervention studies relevant to recovery from domestic and sexual violence in primary care	Systematic review	Healthcare settings	<ul style="list-style-type: none"> • The most promising results have been from nurse home visiting advocacy programs, mother-child psychotherapeutic interventions, and specific psychological treatments (cognitive behaviour therapy, trauma informed cognitive behaviour therapy and, for sexual assault, exposure and eye movement desensitisation and reprocessing interventions) • Holistic healing models have not been formally tested by RCTs, but show some promise • Further research into what supports women and their children on their trajectory of recovery from domestic and sexual violence is urgently needed

APPENDIX B

Data extraction from primary studies

Author & country of study	Study design and aims/objectives	Study population	Findings
Doi et al. (2019) Japan	Design: Cross-sectional study Aims/objectives: to develop an instrument –the Intimate Partner Violence during Pregnancy Instrument –that can detect unmeasured IPV in pregnant women, and which can be incorporated in local governments’ pregnancy notification forms	Setting: Public health centers Population: Women in a 3- or 4-month infant health checkup program Sample: 6590 Mode of screen: Questionnaire	<ul style="list-style-type: none"> • Rate of any IPV 11.1 percent (physical IPV = 1.2%; verbal IPV = 10.8%) • Moderate predictive power (area under receiver operating characteristic curve = 0.719, 95% CI: 0.698 to 0.740) from 0 to 16 with a cut-off point of 2 (sensitivity = 79.5%, specificity = 47.1%)
Escribà-Agüir et al. (2015) Spain	Design: Cross-sectional survey Aims/objectives: to assess the reliability, accuracy, and construct validity of the Spanish Abuse Assessment Screen (AAS) among pregnant women using the Spanish version of Index of Spouse Abuse (ISA) as a reference standard	Setting: Primary care centers Population: Pregnant women Sample: 1329 Mode of screen: Self-administered questionnaire and face-to-face interviews	<ul style="list-style-type: none"> • Retest agreement of AAS was high, from 96.4 percent to 100 percent • Specificity was for all types of abuse above 97 percent, but sensitivity values were lower (33.3%, 22.9%, 6.9%, for severe physical abuse, minor psychological abuse, and minor physical abuse, respectively) • Sensitivity for severe psychological abuse was perfect • Construct validity was good
Kita et al. (2017) Japan	Design: Prospective cohort study Aims/objectives: developed a Japanese version of the WAST-Short (WAST-Short-J) to allow efficient and effective IPV screening for pregnant women in Japanese perinatal health settings	Setting: Antenatal clinic Population: Women in third trimester of pregnancy and one month after childbirth Sample: 453 Mode of screen: Self-administered questionnaires	<ul style="list-style-type: none"> • Good accuracy (sensitivity 66.7–71.4%, specificity 89.7%), and good concurrent, convergent, and predictive validity
Rasch et al. (2018) Tanzania and Vietnam	Design: Cross-sectional study Aims/objectives: to develop and determine the validity of a screening instrument for the detection of IPV in pregnant women in Tanzania and Vietnam and to determine the minimum number of questions needed to identify IPV	Setting: Antenatal clinic Population: Antenatal care women Sample: 1116 Tanzanian and 1309 Vietnamese women Mode of screen: Questionnaires	<ul style="list-style-type: none"> • Performed best in predicting physical IPV (identified 93% and 96% of Tanzanian and Vietnamese women, respectively)

Author & country of study	Study design and aims/objectives	Study population	Findings
Decker et al. (2017) US	Design: Mixed methods (quasi-experimental design and qualitative interviews) Aims/objectives: To describe the uptake and impact of a brief, trauma-informed, universal IPV and reproductive coercion assessment and education intervention	Setting: Family planning clinics Population: Women ages 18 and up and healthcare providers Sample: n = 132; 3-month retention n = 68 Mode of screen: Face-to-face and computer-based	<ul style="list-style-type: none"> • Clinic-based IPV assessment was helpful, irrespective of IPV history • Participants who received the intervention reported greater perceived caring from providers, confidence in provider responses to abusive relationships, and knowledge of IPV-related resources at follow-up • Providers and women alike described the educational card as a valuable tool • Participants described trade-offs of paper versus in-person, electronic medical record-facilitated screening
Jack et al. (2017) US	Design: qualitative case study Aims/objectives: To develop strategies for the identification and assessment of intimate partner violence in a nurse home visitation program	Setting: Nurse-Family Partnership agencies Population: Nurses, pregnant or parenting mothers who had self-disclosed experiences of abuse, and supervisors Sample: Nurses (n = 32), pregnant or parenting mothers who had self-disclosed experiences of abuse (n = 26) and supervisors (n = 5) Mode of screen: Questionnaire	<ul style="list-style-type: none"> • Multiple opportunities to ask about intimate partner violence are valued • The use of structured screening tools at enrolment does not promote disclosure or in-depth exploration of women's experiences of abuse • Women are more likely to discuss experiences of violence when nurses initiate non-structured discussions focused on parenting, safety or healthy relationships • Nurses require knowledge and skills to initiate indicator-based assessments when exposure to abuse is suspected as well as strategies for responding to client-initiated disclosures
Jack et al. (2019) US	Design: RCT Aims/objectives: To determine the effect on maternal quality of life of a nurse home visitation program augmented by an IPV intervention, compared to the nurse home visitation program alone	Setting: Home visitation Population: Socially disadvantaged pregnant women (≥16 years) Sample: 492 Mode of screen: Questionnaires Response rate: 85 percent	<ul style="list-style-type: none"> • Among pregnant women experiencing social and economic disadvantage and preparing to parent for the first time, augmentation of a nurse home visitation program with a comprehensive IPV intervention, compared to the home visitation program alone, did not significantly improve quality of life at 24 months after delivery

Author & country of study	Study design and aims/objectives	Study population	Findings
Long et al. (2019) Canada	Design: Survey Aims/objectives: To understand how obstetrician/ gynaecologists in Edmonton, Alberta screen prenatal women for intimate partner violence (IPV) and to explore attitudes, beliefs, and perceptions regarding IPV and identify barriers to screening for IPV	Setting: Practicing general obstetrics in Edmonton, Canada Population: Obstetrician/ gynaecologists Sample: 49 Mode of screen: N/A	<ul style="list-style-type: none"> • Thirty-three percent of respondents never or rarely screened women for IPV during prenatal visits, 94 percent did not have a screening protocol, and 77 percent did not have written materials to provide to women • A total of 94 percent of OB/GYNs believed that they were inadequately screening for IPV • Multiple barriers were identified
O'Reilly et al.(2018) Australia	Design: Mixed methods Aims/objectives: Identify DV screening practices of community-based health care providers in pregnant and postpartum women	Setting: Western Sydney Local Health District Population: Community-based health care providers Sample: 48 Mode of screen: Varied	<ul style="list-style-type: none"> • Some health care providers did not screen for DV • Barriers were a lack of recognition that this was part of their role; and a lack of DV screening policies and/ or reminder systems, a lack of time, resources and confidence in undertaking the screening and referral of women when DV was detected
Saberi et al. (2017) Australia	Design: Survey Aims/objectives: To explore emergency departments' clinicians' level of support for DV screening; current screening practices; and perceived barriers and readiness to screen prior to a pilot intervention	Setting: One regional public hospital emergency department Population: Nursing and medical staff Sample: 95 Mode of screen: N/A	<ul style="list-style-type: none"> • In the absence of protocols, 72.3 percent of clinicians reported currently conducting case-based screening • The majority did not always feel comfortable screening for DV (79.7%) and reported they had received insufficient training for this role (88.7%) • Lower perceived self-efficacy and fear of offending were statistically associated with discomfort or negative beliefs about DV enquiry
Taghizadeh et al. (2018) Iran	Design: RCT Aims/objectives: To investigate the effectiveness of training problem-solving skills on IPV against pregnant women	Setting: Health centers of Tehran Population: Pregnant women Sample: 257 Mode of screen: Questionnaire	<ul style="list-style-type: none"> • Relative risk of physical and psychological violence was significantly reduced after the intervention in the intervention group

Author & country of study	Study design and aims/objectives	Study population	Findings
Miller et al. (2016) US	Design: RCT Aims/objectives: Assessed the effectiveness of a provider-delivered intervention targeting reproductive coercion	Setting: Family planning clinics Population: Females ages 16 to 29 Sample: 4,009 Mode of screen: Audio Computer-Assisted Self-Interview (ACASI)	<ul style="list-style-type: none"> • Intervention effects were not significant for reproductive coercion or IPV • Intervention participants reported improved knowledge of IPV resources and self-efficacy to enact harm reduction behaviours
Van Parys et al. (2017) Belgium	Design: RCT Aims/objectives: To investigate the impact of a referral-based intervention in a prospective cohort of women disclosing IPV on the prevalence of violence, and associated outcomes for psychosocial health, help-seeking and safety behaviour during and after pregnancy	Setting: Eleven Belgian hospitals Population: Women seeking antenatal care Sample: N/A Mode of screen: N/A	<ul style="list-style-type: none"> • No statistically significant differences between the intervention and control groups; however, adjusted for psychosocial health at baseline, the perceived helpfulness of the referral card seemed to be larger in the intervention group. Both the questionnaire and the interview were perceived to be significantly more helpful than the referral card itself
Spangaro et al. (2016) Australia	Design: Qualitative configurative analysis Aims/objectives: To test, among Aboriginal and Torres Strait Islander women, a model for decisions on whether to disclose intimate partner violence in the context of antenatal routine screening	Setting: Five Aboriginal and Maternal Infant Health Services, and one mainstream hospital Population: Indigenous women 28+ weeks pregnant attending antenatal care Sample: N/A Mode of screen: N/A	<ul style="list-style-type: none"> • Cultural safety, safety from detection by the abuser, safety from shame, and safety from institutional control were important considerations for disclosure • Disclosure was promoted by direct asking by the midwife and a perception of care • Experiences of institutional racism were associated with Indigenous women's perceived risk of control by others, particularly child protection services

Author & country of study	Study design and aims/objectives	Study population	Findings
Zachor et al. (2018) US	Design: RCT Aims/objectives: To explore the effect of provider communication-skills training on frequency of IPV and reproductive coercion (RC) assessment	Setting: Four family planning clinics Population: (Training for) clinicians, nurses, medical assistants and other support staff and (survey of) women Sample: Historical control group: n = 600; communication skills: n = 53; standard training: n = 50 Mode of screen: N/A	<ul style="list-style-type: none"> • Regardless of training type, women at sites that received training reported increased safety card provision, discussion of healthy versus unhealthy relationships, and provision of information about IPV resources • The clinics that underwent standard knowledge-based training discussed RC topics more often following training
Spangaro et al. (2019) Australia	Design: qualitative comparative analysis Aims/objectives: To identify IPV routine screening pathways to impact	Setting: Antenatal clinics Population: English speaking, 28+ weeks pregnant Sample: 32 Mode of screen: Questionnaire	<ul style="list-style-type: none"> • Key conditions for positive impact were care in asking, and support and validation from the midwife • Lack of these and lack of continuity of care were relevant to nil positive impact • Benefits included naming the abuse, connection, unburdening, taking steps to safety, and enabling informed care • Disclosure was not required for positive impact
Bacchus et al. (2016) US	Design: Nested qualitative interpretive Aims/objectives: To explore perinatal home visitors' and women's perceptions and experiences of the DOVE using mHealth technology (i.e. a computer tablet) or a home visitor-administered, paper-based method	Setting: Perinatal community home visitation Population: Women enrolled in a US-based RCT of the DOVE intervention and home visitors Sample: 23 home visiting staff at rural and urban sites, and the 2 DOVE program designers and 26 women Mode of screen: mHealth technology (i.e. a computer tablet) or a home visitor-administered, paper-based method	<ul style="list-style-type: none"> • The computer tablet was viewed as a safe and confidential way for abused women to disclose their experiences without fear of being judged • The DOVE technology was seen as either an impersonal artifact that was an impediment to discussion of IPV or a conduit through which interpersonal connection could be deepened • Other positive influences were factors such as having established trust and rapport, as well as good interpersonal communication • The technology helped reduce the anticipated stigma associated with disclosing abuse • The didactic intervention video was a limiting feature, as the content could not be tailored to accommodate the fluidity of women's circumstances

Author & country of study	Study design and aims/objectives	Study population	Findings
Bright et al. (2018) US	<p>Design: Desk review and a policy scan of local prenatal health care to determine the policy area of DV in pregnancy</p> <p>Aims/objectives: To chronicle the community-based participatory research process used by the Hattiesburg Area Health Coalition (HAHC), identification of infant and maternal health as a policy area, DV in pregnancy as a priority area within infant and maternal health, and a community action plan (CAP)</p>	<p>Setting: Forrest and Lamar counties in Mississippi</p> <p>Population: N/A</p> <p>Sample: N/A</p> <p>Mode of screen: N/A</p> <p>Response rate: N/A</p>	<ul style="list-style-type: none"> • HAHC developed a CAP identifying three goals: increase policies to screen for DV, increase policies for referral to services for women experiencing DV in pregnancy, increase access to information on services available for DV
Sharps et al. (2016) US	<p>Design: RCT</p> <p>Aims/objectives: To evaluate the effectiveness of an IPV intervention in reducing violence among abused women in perinatal home visiting programs</p>	<p>Setting: US urban and rural settings</p> <p>Population: Women experiencing perinatal IPV</p> <p>Sample: 239</p> <p>Mode of screen: Questionnaires</p>	<ul style="list-style-type: none"> • The DOVE intervention was effective in decreasing IPV and is brief, thereby facilitating its incorporation within well-woman and well-child care visits, as well as home visiting programs

APPENDIX C

Service readiness assessment tool

[From WHO (2017) *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence*]

Assessing service readiness	
Questions Checked items (✓) are minimum requirements	Ready (Y/N) Gaps Comments
Service delivery	
Are there written protocols for provision of health care to patients subjected to violence?	
Is a minimum package of care being provided (that is, identification of survivors of intimate partner violence/ family violence, first-line support, clinical care for sexual assault, basic psychosocial support)?	
Health workforce	
Are there health-care providers whose job descriptions assign them specific responsibilities to address violence against women/family violence?	
Have health-care providers received training on responding to violence against women/family violence?	
Are there mechanisms to provide ongoing mentoring, supervision and support to health-care providers?	
Infrastructure and resources	
Is there a space (for example, a room or area) available for private and confidential consultation (that is, that ensures the survivor cannot be seen or heard from outside)?	
Is easy-to-read written information available and provided to women when safe to do so?	

Assessing service readiness	
Leadership, governance and accountability	
Do health-care providers and health managers support addressing violence against women/family violence (for example, willing to provide care, supportive of sending staff to training)?	
Are there confidential mechanisms to receive feedback from patients about services, including any grievances or violations of rights in the health facility (for example, a helpline, ombudsperson, complaint box)?	
Is there a workplace policy addressing discrimination and violence, including sexual harassment faced by health-care providers themselves?	
Budget and financing	
Is there a budget allocated for provision of care/services (for example, for staff training, procuring specific commodities)?	
Multisectoral coordination and community engagement	
Is there a referral system in place across different health services and between health and other sectors (for example, a referral directory, information offered to survivors about available services)?	
Have other services (for example, police) and organizations (for example, local NGOs working on violence against women/family violence) been informed about available health services?	
Information, monitoring and evaluation	
Are indicators and data to monitor the health response to violence against women/family violence being collected, compiled and used to improve services?	
Are there intake forms/registers and confidentiality mechanisms (for example, secure storage and removal of identifying information) for recording information about patient's experience of violence and care received?	

APPENDIX D

The SUSTAIN survey for women

NOTE: The following information will be contained in the survey. This survey will be available online and completed on an iPad, thus the survey will not necessarily be in the following format. The items are numbered and are followed immediately by the available fixed choice answers in parenthesis.

First page/screen

Welcome to the SUSTAIN study. Thank you for taking an interest.

We found that a lot of women have issues at home with relationships and this affects their health, so we ask all women who come into our service a set of questions about home life and relationships.

If this is ok and you would like to find out more about the study, please continue.

Second page/screen

Doing this survey will help us to understand how we can best care for women's emotional health and wellbeing, including relationship issues during pregnancy. This survey asks about your emotional health and how issues such as relationships and domestic violence may affect you.

Even if you have not experienced health issues related to your relationships, your answers are still important to us. Hearing from a wide range of women will help us build a more complete picture about women's experiences and of the ways in which women can be cared for during pregnancy.

All information you provide to the SUSTAIN project team is STRICTLY CONFIDENTIAL and all findings from the project will be presented in anonymous form. Individual responses will not be given to your health care provider. The survey takes around 15 minutes to complete.

The project team comes from the Royal Women's Hospital and the Department of General Practice, The University of Melbourne. If you have any questions about the project, please call [name], a member of the SUSTAIN team, on [number]. This project is funded by Australia's National Research Organisation for Women's Safety.

For the safety of other women in this clinic, it would be helpful not to talk about the contents of this survey with other people while you are in the waiting room.

A participant information form can be found ([hyperlink to Participant information and consent form](#)).

If you agree to participate in the survey, please continue.

Third page/screen

How to fill in the survey

Please read the questions carefully and follow the instructions. There are no right or wrong answers, just answer what is right for you. Your answers will be confidential.

Most of the questions can be answered by placing a tick in the box next to the answer that best applies to you. Please tick only one box per question, unless otherwise specified.

For example:

Is your usual GP male or female?

- Male 1
 Female 2

If you wish to write further comments, please do this in the space provided at the end of the survey.

Structure of the questionnaire

This questionnaire has six sections, numbered A through F.

- A. About you and your care at the hospital
- B. Your health and wellbeing
- C. About your relationships and safety
- D. About support
- E. About you and your household
- F. Your views about the survey

A. About you and your pregnancy care

This section asks you about you and your pregnancy care.

A1	Today's date (dd/mm/yyyy)	
A2	When is your baby due? (dd/mm/yyyy)	
A3a	Is this your first baby? (yes/no)	
A3b	If no, how many babies have you had altogether, including this one? (two, three, four, five babies or more)	
A4	What type of pregnancy care are you receiving at the Women's? (Standard care, shared care, midwifery care e.g. MIST or Cosmos, community clinic)	
A5	Did you feel you could talk to the midwife or doctor about emotional or social issues that might have been concerning you? (Please tick any of the statements that you agree with)	
	I could talk about some, but not all of my problems to the midwife/doctor.	<input type="checkbox"/> 1
	The midwives/doctors were often busy and didn't seem to have time to listen.	<input type="checkbox"/> 1

I could talk to the midwife/doctor and they were very supportive.	<input type="checkbox"/> ₁
I thought the midwife/doctor was only there to look after my pregnancy care.	<input type="checkbox"/> ₁
The midwives/doctors asked me questions that helped me to talk about emotional and social problems.	<input type="checkbox"/> ₁
I was concerned the midwives/doctors might tell someone else.	<input type="checkbox"/> ₁
I found it easier to talk to the midwives because they were female.	<input type="checkbox"/> ₁
There wasn't anything about my emotional wellbeing that I wanted to tell the midwives/doctors.	<input type="checkbox"/> ₁
I thought the midwives/doctors would give me help if it was needed.	<input type="checkbox"/> ₁
The midwives/doctors might have wanted to do something that would make the situation worse.	<input type="checkbox"/> ₁
I don't think any of my problems are serious enough to tell the midwife/doctor.	<input type="checkbox"/> ₁

If yes, please comment...

B. Your health and wellbeing

This section asks you for your views about your health and how you feel.

B1 How often have you experienced any of the following in the last 12 months? (Please tick one box on each line)

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Wanting to cut down on your smoking	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Feeling down, depressed or hopeless	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Being afraid of your partner or ex-partner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Feeling you can't control what or how much you eat	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Wanting to cut down on your alcohol and/or drug use	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Worrying a lot about everyday problems	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

B2 Have you ever talked to your midwife or doctor about any of the following issues?
(Please tick one box on each line)

	Yes	No	I have not experienced this issue
Smoking	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Feeling down, depressed or hopeless	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Being afraid of your partner or ex-partner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Feeling you can't control what or how much you eat	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Alcohol and/or drug use	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Worrying a lot about everyday problems	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

B3 If help was available from a midwife or doctor for the following issues, would you consider using it?
(Please tick one box on each line)

	Yes	No	I have not experienced this issue
Wanting to cut down on your smoking	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Feeling down, depressed or hopeless	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Being afraid of your partner or ex-partner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Feeling you can't control what or how much you eat	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Wanting to cut down on your alcohol and/or drug use	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Worrying a lot about everyday problems	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

B4 How comfortable would you feel talking to your midwife or doctor about any of the following?
(Please answer even if you have not experienced this issue. Please tick one box on each line)

	Very comfortable	Comfortable	Neutral	Uncomfortable	Very uncomfortable
If you wanted to cut down on your smoking?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
If you were feeling down, depressed or hopeless?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
If you were afraid of your partner or ex-partner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

If you wanted to talk about controlling what or how much you eat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
If you wanted to cut down on your alcohol and/or drug use?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
If you were worrying a lot about everyday problems?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

C. Your relationship and safety

This section asks about how safe you feel and about your experiences in adult intimate relationships. By adult intimate relationship we mean husband, partner, or boy/girlfriend for longer than one month.

		Yes	No
C1	Are you currently in an adult intimate relationship?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
C2	In the last year:		
C2a	Has a partner or ex-partner done something that made you feel afraid?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
C2b	Has a partner or ex-partner controlled your daily activities (e.g. who you see, where you go) or isolated or humiliated you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
C2c	Has a partner or ex-partner threatened to hurt you in any way?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
C2d	Has any of the above happened to you by someone else in your family?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀

If yes, please describe your experience if you would like to...

C3 We would like to know if you experienced any of the actions listed below and how often they happened during the past 12 months.
(Please tick the appropriate box, which matches the frequency, over a 12-month period that it happened to you)

Actions	How often it happened					
	Never	Only once	Several times	Once/month	Once/week	Daily
My partner or ex-partner:						
Told me that I wasn't good enough	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Kept me from medical care	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Followed me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Tried to turn my family, friends and children against me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Actions	How often it happened					
	Never	Only once	Several times	Once/month	Once/week	Daily
My partner or ex-partner:						
Locked me in the bedroom	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Slapped me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Raped me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Told me that I was ugly	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Tried to keep me from seeing or talking to my family	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Threw me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Hung around outside my house	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Blamed me for causing their violent behaviour	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Harassed me over the telephone	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Shook me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Tried to rape me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Harassed me at work	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Pushed, grabbed or shoved me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Used a knife or gun or other weapon	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Became upset if dinner/housework wasn't done when they thought it should be	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Told me that I was crazy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Told me that no one else would want me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Took my wallet and left me stranded	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Hit or tried to hit me with something	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Did not let me socialise with my female friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

C3 We would like to know if you experienced any of the actions listed below and how often they happened during the past 12 months.
(Please tick the appropriate box, which matches the frequency, over a 12-month period that it happened to you)

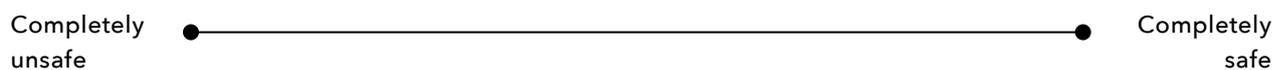
Actions	How often it happened					
	Never	Only once	Several times	Once/ month	Once/ week	Daily
My partner or ex-partner:						
Put foreign objects in my vagina	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Refused to let me work outside the home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Kicked me, bit me or hit me with a fist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Tried to convince my friends, family or children that I was crazy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Told me that I was stupid	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Beat me up	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

C4 Have any of your romantic or sexual partners ever:

- a) Tried to get you pregnant when you did not want to be, or tried to stop you from using birth control?
- b) Refused to use a condom when you wanted to use one, or deliberately broken or damaged a condom?
- c) Removed a condom during sex without your consent?
- d) Forced you, or tried to force you to terminate a pregnancy when you didn't want to?

Answer options for these are: No, Yes in the past 12 months, Yes more than 12 months ago

C5 How safe have you felt at home in the last two weeks?
(Place an X on the point on the line that most closely reflects how you feel)



How safe did you feel at home 6 months ago?
(Place an X on the point on the line that most closely reflects how you felt)



	Yes	No
C6a In the last six months, has any health care provider asked you about your own safety at home?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ <i>If no, got to C7</i>
C6b If yes, who asked you? (Tick all that apply)		
Midwife	<input type="checkbox"/> ₁	
Obstetrician	<input type="checkbox"/> ₂	
Family doctor	<input type="checkbox"/> ₃	
Social worker	<input type="checkbox"/> ₄	
Psychiatrist/psychologist	<input type="checkbox"/> ₅	
Physiotherapist	<input type="checkbox"/> ₆	
Dietitian	<input type="checkbox"/> ₇	
C7a Do you currently have children under the age of 18 years living with you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ <i>If no, got to C8</i>
C7b In the last 6 months, has any health professional asked you about the safety of your children at home?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ <i>If no, got to C8</i>
C7c If yes, who asked you? (Tick all that apply)		
Midwife	<input type="checkbox"/> ₁	
Obstetrician	<input type="checkbox"/> ₂	
Family doctor	<input type="checkbox"/> ₃	
Social worker	<input type="checkbox"/> ₄	
Psychiatrist/psychologist	<input type="checkbox"/> ₅	
Physiotherapist	<input type="checkbox"/> ₆	
Dietitian	<input type="checkbox"/> ₇	

D. About your support

This section asks you to think about your relationship with your partner. Please complete the following sentences with the first words that come to your mind. There are no right or wrong answers, just write what you feel.

- D1 I wish that my partner ...
- D2 I wish that health providers ...
- D3 I wish that I ...
- D4 I wish that my family ...
- D5 I wish that my friends ...
- D6 How have any relationships with family and friends helped you with problems in your relationship with a partner or ex-partner?
- D7 How have any contact with community services helped you with problems in your relationship with a partner or ex-partner?

E. About you and your household

This section asks about some background details and some personal details. These questions are important because they allow your answers to be compared with those of other people who are similar to you, without identifying anybody.

E1	What is your date of birth? (dd/mm/yyyy)	
E2	How many children under the age of 18 years do you have currently living with you? (none/ 1 child/ 2 children/ 3 children/ 4 or more children)	
	None	<input type="checkbox"/> ₁
	1	<input type="checkbox"/> ₂
	2	<input type="checkbox"/> ₃
	3	<input type="checkbox"/> ₄
	4 or more	<input type="checkbox"/> ₅
E3	Are you ...	
	Married	<input type="checkbox"/> ₁
	Living with a partner	<input type="checkbox"/> ₂
	Not living with a partner	<input type="checkbox"/> ₃
	Divorced	<input type="checkbox"/> ₄
	Separated but not divorced	<input type="checkbox"/> ₅
	Widowed	<input type="checkbox"/> ₆
	Single	<input type="checkbox"/> ₇

E4a	Were you born in Australia? (yes/no)	
E4b	If you were born overseas, what is the name of the country where you were born?	
E5	Are you of Aboriginal or Torres Strait Islander origin?	
	Yes, Aboriginal	<input type="checkbox"/> ₁
	Yes, Torres Strait Islander	<input type="checkbox"/> ₂
	Yes, both Aboriginal and Torres Strait Islander	<input type="checkbox"/> ₃
	No	<input type="checkbox"/> ₄
E6	Is English your first language? (yes/no)	
E7	When did you leave school?	
	Completed secondary school to the end of Year 12	<input type="checkbox"/> ₁
	Went to secondary school but did not complete the final year	<input type="checkbox"/> ₂
	Went to primary school only	<input type="checkbox"/> ₃
	Did not go to school	<input type="checkbox"/> ₄
E8	Have you completed further study since leaving school?	
	Yes, finished a degree or higher degree	<input type="checkbox"/> ₁
	Yes, completed a diploma	<input type="checkbox"/> ₂
	Yes, completed a trade apprenticeship or traineeship	<input type="checkbox"/> ₃
	No	<input type="checkbox"/> ₄

Basic information about income is important for understanding health, as it can influence a person's access to health services. Please answer the following three questions about income.

E9	How do you manage on your available income? (Please tick <u>one</u> box only)	
	Easily	<input type="checkbox"/> ₁
	Not too bad	<input type="checkbox"/> ₂
	Difficult some of the time	<input type="checkbox"/> ₃
	Difficult all of the time	<input type="checkbox"/> ₄
	Impossible	<input type="checkbox"/> ₅
E10	Do you hold a current health care card? (yes/no)	

F. Your views about this survey

It is important for us to understand the impact of our surveys on the women who respond to them. Thinking about the survey you are completing right now, please answer the following questions (tick one box on each line).

F1 I am completing this survey in a place where I feel free to answer the questions truthfully

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F2 I am pleased that I have been asked questions about domestic violence

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F3 I felt comfortable answering the questions about domestic violence in this survey

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F4 For me, being asked questions about domestic violence in this survey was...

Very acceptable	Acceptable	Neutral	Unacceptable	Very unacceptable
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F5 As a result of questions about domestic violence being asked, my feelings about my relationship with my partner are...

More positive	Somewhat more positive	Unchanged	Somewhat more negative	More negative
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F6 As a result of questions about domestic violence being asked, I feel my home life is...

Less difficult	Somewhat less difficult	About the same as before	Somewhat more difficult	More difficult
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F7 As a result of being asked questions about domestic violence, I see the quality of my own life as...

Better	Somewhat better	About the same as before	Somewhat worse	Worse
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F8 The questions I was asked in this survey made me feel that the problems in my relationship with my partner are my fault.

Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F9 As a result of being asked questions about domestic violence, my feelings about myself as a person are...

Better	Somewhat better	About the same as before	Somewhat worse	Worse
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F10 Responding to this survey has increased my awareness about possible problems in my relationship

Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F11 Responding to this survey has made me more open to dealing with possible problems in my relationship

Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

F12 When is the best time during pregnancy for health workers to ask about domestic violence?

F13 Please use the space below if there is anything else you would like to tell us about the survey.

If this survey has identified issues about your safety, we encourage you to seek help from a trusted friend, family member, health professional, or the police and finally, you can always ask to see a social worker. Or, if you would like to talk to someone about any other issues raised in this survey, you could contact one of the services listed on the card we provided for you to help you.

Would you like to participate further?

The next step of the study involves interviewing women who have been referred to social work for violence-related issues. If you are interested in hearing more about this, please fill in your details. In giving your details, you do not have to participate further, and you can change your mind at any time.

My name is:

Best phone number to contact me on:

The best time to contact me (please tick all that apply):

Best days:

Mon

Tue

Wed

Thu

Fri

Sat

Sun

In the:
Morning

Lunchtime

After lunch

Late afternoon

Evening

Thank you for your expressing your interest.

Thank you very much for the time and effort you have taken in doing this survey.

If you have any questions or concerns about the project please contact the SUSTAIN project team on [number].

Many thanks,

The SUSTAIN team

This questionnaire includes: Composite Abuse Scale (1999) © Hegarty K. COST Questionnaire (2011) © Locke J.

Social work protocol



SUSTAIN (Sustainability of identification and response to domestic violence in antenatal care) study: Briefing for Social Workers

Overview

Two-year multi-site study funded by ANROWS (Australia's National Research Organisation for Women's Safety).

The study aims to develop sustainable ways to identify and respond to women experiencing domestic violence during antenatal care which can be integrated into antenatal care. It includes identifying how to overcome the challenges for health systems in regional and rural settings with low resources. The research uses a case study approach, learn from experiences in New South Wales to develop a model of implementation for screening and response in antenatal care across urban and rural Victoria, where universal screening has not occurred before.

Study settings

Six antenatal clinics from metro and regional/rural Victoria and New South Wales

NSW	Victoria
NI	V4 (Melbourne)
N2	V5
N3	V6

Components of the study

Part A

Conduct focus groups with midwives/nurse, doctors, and social workers providing care to pregnant women.

Part B

Pregnant women will be invited to be interviewed about their experience of antenatal clinics' response to domestic violence.

Role of social workers in SUSTAIN study

1. Participate in focus groups and interviews for Part A (later in the year)
2. Participate in recruiting women to do brief phone interviews for Part B
3. Organisational audit includes referral information. Still determining what data but likely to be data on number of women referred to social work for domestic violence disclosure, at what point they were referred (at psychosocial screening, subsequent disclosure etc.), number of women seen by social work (and when e.g. at time of referral, at birth, not seen)

Purpose of the interview

The interview is designed to offer women an opportunity to reflect on what worked for them in their experience of being asked about abuse as part of their antenatal care. Interviews **do not** explore women's actual experiences of abuse and as a result, do not tend to be triggering of distress.

The interviews are being conducted for two months only and numbers of eligible women will be low. They are an essential part of the larger project which helps understand what sustains sound screening practice at selected best practice screening sites.

How is recruitment occurring?

- i) Information about the study given to women by social workers
- ii) Small poster in woman-only space with tear-off contact details (back-up strategy)

Role of hospital social worker in recruitment

Your role is not to seek consent for participation in the research. Your role is to give women information about the study and then seek consent to pass on contact details to the research team, who will give further information about the study and gain consent.

Previous experience shows that the best chance of doing an interview is to do it at the time of first contact. Alternatively, we ask you to pass on her contact information with day/time to call (see separate script).

In our experience even when women are seeing a range of services and you might think they are too overwhelmed to talk to researchers, we have found that they are often happy to talk anonymously about their experiences to a researcher, valuing the chance to help other women. For this reason, we ask you to raise the study with **each** eligible woman about participating.

How will the interviews be conducted?

By telephone once we receive contact information. We are also available to come to the hospital if she is reluctant/unwilling to talk by phone.

Who will be conducting interviews with women?

Jeannette Walsh who has extensive counselling experience in supporting women who have experienced domestic violence. She has worked in various roles with direct clinical experience (child and family health, child and family mental health, relationship counselling).

What if she doesn't speak English well?

Interviews can be done with our experienced female bilingual Arabic and Mandarin research officers. Fay, an Iraqi community worker is available for interviews with Arabic speakers and Ronnie, a Chinese-speaking community worker is available for interviews in Mandarin. If you contact Jeannette with the woman's details, we will arrange to link her to the relevant team member.

If women become distressed during our contact with them

If women become upset, we will ascertain if she had current support to deal with the current crisis and suggest we not proceed with the interview at that point, but that she seek appropriate support. If she did not have appropriate support, we would provide information about support options. If it is assessed (in collaboration with her) that she needs assistance in either of these circumstances, the researcher would make contact with the appropriate support service to facilitate the referral. The appropriate resource person may be you—i.e. the social worker who introduced her to the research team.

What happens to the information women share with the research team?

All interviews are anonymous. We are seeking systemic information that will improve and continue the sustainability of routine screening for domestic violence, not information about individual social workers. The data from these interviews with women will be aggregated, themes will be developed and reported on in the overall report.

Contact:

Jeannette Walsh—Research Associate, University of New South Wales

Suggested script for social workers

We are currently working with the University of New South Wales on a research project to improve care for women who come to this clinic.

The researchers want to speak to women who come to this clinic and have also experienced some kind of partner abuse. They only want to talk to a few women, and I think you would be really ideal to help them understand what women need.

Being involved means talking to Jeannette, the researcher, on the telephone just once for about 20 minutes to half an hour. Jeannette is a very experienced counsellor, who has supported lots of women who have experienced this sort of thing. She is really easy to talk to. It's completely anonymous.

Jeannette can explain the study to you herself if you are okay to have a brief chat to her.

OPTION 1--PREFERRED

Can we call her now so that you can set up a time talk to her? Talking to Jeannette does not commit you to doing anything else, it is just a chance for her to explain the research to you so that you can make your own decision as to whether you want to do the full interview. If you were okay to do that, it could be today if you want or it could be at a different time depending on what works best for you.

If NO

OPTION 2--LESS PREFERRED

If now is not a good time for you to talk to her, can I let Jeannette know when she can call you to explain the study and see if you want to take part? (Use Recontact Details on p. 3)

USE RECONTACT FORM ATTACHED AT BACK

If NO to 2

OPTION 3--LEAST PREFERRED (LOW LIKELIHOOD OF UPTAKE)

If woman is unwilling to provide contact details, provide woman with the 1800 number for Jeannette and ask if she might call this telephone number.

Jeannette Walsh 1800 951 211

RECONTACT DETAILS

Yes, I am interested in learning more about the SUSTAIN antenatal study.

Contact details:

Name:

First name only (or name prefers to be known as)

Telephone:

Best date and time to call:

NOTE: If this time turns out not to be convenient, you can let Jeannette know and if possible, a good time for her to call.

Name of social worker: -----

Social worker contact phone number: -----

Social worker to send this form ASAP by email to Jeannette.Walsh@unsw.edu.au

[Or call Jeannette with info](#)

APPENDIX F

Interview guide for individual interviews of women with experiences of domestic violence

Key topics and questions

1 Introduction:

My name is [name]. I am part of the research team from the University of Melbourne/University of New South Wales and am part of the SUSTAIN study which is surveying women's emotional wellbeing. It involves an interview of about 30 minutes. You have been invited because you are receiving pregnancy care at [participating site] and were referred to social work for violence-related issues. Is it a good time to talk?

If not, identify another time when the woman can attend the clinic or telephone.

If so, continue.

2 Explanation of the interview including overview of the study, risks and benefits of participating in the study, explanation of confidentiality and anonymity, and consent to participating and recording the discussion.

If consent not given, thank the woman for her time.

If consent given, continue.

3 Let the woman know there are no right or wrong answers, and that she can stop at any time without giving a reason. Ask about women's gestation, maternal age, languages spoken at home other than English and Aboriginal or Torres Strait Islander status.

4 **Being asked about DV**

During your first visit to the antenatal clinic, do you remember your midwife asking you questions about whether you had been hit, hurt or frightened by your partner in the past year? Do you remember **those** questions?

What do you remember most about being asked those questions?

What comments do you have about the timing of when these questions were asked?

5 **Disclosing DV**

Tell me about when you decided to tell the midwife/doctor about being hit or frightened.

How did you decide to tell the midwife/doctor about being hit or frightened?

Tell me about anything that worried you about telling the midwife/doctor about being hit or frightened.

6 **Accepting the social work referral**

After you told the midwife/doctor about being hit or frightened, can you tell me about what happened after?
(Prompts: type of referral or services referred to)

Tell me about which services you contacted or used.

Tell me about your experience of using these services. (Prompts: how long it took, any difficulties contacting these services)

Tell me about how the services have helped?

7 **Overall experience and recommendations**

Thinking about what has happened, is there anything that would have made your experience better? Anything that stood out in your experience?

How important is it for the midwife/doctor to ask about DV as part of your pregnancy care?

What is the most important thing the midwives/doctors should be aware of when asking about DV?

Is there anything else that you would like to add about asking about DV in pregnancy?

8 **Acceptability of wording of the screening items in the Part B survey**

What did you think about how the screening questions were asked?

What words would be better to use when asking about DV in pregnancy?

9 Closing remarks. Thank the woman for her time and contributions.

APPENDIX G

Interview guide for interviews with practitioners

Key topics/questions	
1	Introduction and explanation of the focus group/interview including overview of the study, risks and benefits of participating in the study, explaining confidentiality and anonymity, and consent to recording the discussion.
2	<p>Discuss ground rules:</p> <ul style="list-style-type: none"> • Length of time for the focus group • Role of facilitator– to progress the conversation and seek everyone’s input as far as people want to contribute • Ask for respect for each other’s opinions, even if you don’t agree • We will keep information confidential as outlined. Ask that you not use names or anything directly identifying of any women you have seen. Help protect other’s privacy by not discussing details outside the group. • Speak as openly as you feel comfortable • Reminder that participation in the focus group is voluntary
3	<p>Allow time for participant’s questions and respond.</p> <p>Ask participants to fill out demographic details and consent.</p> <p>Ask participants to introduce themselves.</p>
4	What role do you think doctors/midwives should play in identifying and responding to domestic violence?
5	What are the barriers for doctors/midwives to screen for DV?
6	What factors would help you to screen for DV?
7	<p>How do you go about identifying DV?</p> <ul style="list-style-type: none"> • What if what she tells you is ambiguous as to whether it is DV? • What do you do when a woman has disclosed DV? • What do you see as your role in responding to disclosures of DV? • What risk assessment do you do?
8	<p>Are there wider systems (or practices) that influence how you might respond to DV?</p> <ul style="list-style-type: none"> • Within Health/hospital? • External to hospital
9	How could the hospital be more effective in screening for DV and responding to women who disclose DV?

10 How do you see the boundaries of your role and the way it overlaps with others?

Are there ways that these processes have changed or been shaped?

11 What changes do you see that have been made or need to be made in the hospital for screening for DV to be sustainable and effective?

12 What additional considerations come up being in a rural area?

13 Is there anything else that I have not asked that you want to talk about?

14 Comments and closing remarks. Thank participants for their time and contributions.

APPENDIX H

Distress protocol

This protocol is used for responding where participants become distressed at any stage during **interviews**.

Before starting any interview, the interviewer will indicate that the interview may be interrupted or concluded at any time should the participant not wish to continue (e.g. to have a break, if the participant is distressed, or for any reason does not want to go on completing the interview).

The interviewer will also explain that sometimes talking about personal experiences in a research project may mean that the person would like to talk further about some of the issues raised, either with the researcher or with someone else afterwards. Resource cards will be provided at the beginning of the interviews for referral options including phone and web site options.

If a participant should become distressed, the interviewer will suspend the research process, support the participant and assist them to contact other support if they wish. This response will include:

- Listening empathically to the participant's account of how she is feeling and what issues she is concerned about.
- Determining what the participant identifies as the reason for the distress, providing an opportunity to express these feelings if they feel comfortable to do so, attending to practical matters, e.g. tissues, comfort items, leaving the interview space etc., assisting her to gain a sense of control over self and environment, and planning for support and contact around follow-up e.g. resource card and/or counselling options.
- The interviewer and the participant would discuss the appropriateness to continue with the research process either then or on another occasion, or to opt out of the project altogether.

Although from the research teams' past experience this is unlikely, there may also be spontaneous disclosure at any point during the research process of the person being in current danger. The researcher will enquire about the safety of participants at the point of such disclosure, and will refer participants to appropriate services as needed. If child sexual abuse is disclosed, mandatory reporting laws oblige the researcher to contact police.

Useful contacts:

Victoria Police, Family Violence Unit	Ph. 03 9865 5100
DHS Child Protection	Ph. 13 12 78
Sexual Assault Crisis Line	Ph. 1800 806 292
National Sexual Assault and Domestic Violence Helpline	Ph. 1800 737 732
Safe Steps Family Violence Response Centre	Ph. 1800 015 188
Lifeline	Ph. 13 11 14

Participant information and consent forms

There are three versions of the participant information and consent forms, each corresponding to the three parts of the study:

- Survey of pregnant women
- Interviews of pregnant women referred to social work
- Interviews/focus group discussions of practitioners



Participant Information Sheet/Consent Form

Health/Social Science Research - Adult providing own consent

Antenatal Care Providers

Title	Sustainability of Identification and Response to Domestic Violence in Antenatal care
Short Title	SUSTAIN study
Protocol Number	<i>[Protocol Number]</i>
Principal Investigator	Professor Kelsey Hegarty
Project Sponsor	Royal Women's Hospital and University of Melbourne
Associate Investigator(s)	Jo Spangaro, Elizabeth McLindon, Jane Koziol-McLain, Jeannette Walsh, Robyn Matthews, Jane Hooker, Jenny Chapman
Locations	Site V4 Site V5 Site V6 Site N1

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this project, which is called the SUSTAIN study. You have been invited because you are a midwife or doctor providing pregnancy care in an antenatal clinic.

This Participant Information Sheet/Consent Form tells you about the project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

The results of this project will be used by the researchers to develop and implement guidelines to asking about and responding to disclosures of domestic and family violence in antenatal care. This research has been initiated by the researcher, Professor Kelsey Hegarty, and funded by Australia's National Research Organisation for Women's Safety (ANROWS). This research is being conducted by the health facilities labelled N1, N2, N3, V4, V5 and V6 in collaboration with the University of Melbourne, the University of New South Wales and Auckland University of Technology.

3 What does participation in this research involve?

If you decide to take part in the project, you will be asked to attend a focus group or interview to talk about your views and attitudes towards workplace processes for screening, risk assessment and responses to domestic and family violence. It is expected that the focus group will take an hour and the interview about 30 minutes. The focus group/interview will be audio-recorded and transcribed. Also, you will be asked to complete a brief survey asking for information about yourself that will help us describe who has participated but not identify individual characteristics.

There are no costs associated with participating in this project, nor will you be paid.

4 Other relevant information about the research project

One or two focus groups per hospital health care setting across Victoria and New South Wales is planned with eight to 12 participants in each setting. If you are unable to attend the focus group, you will be offered an interview either face-to-face or via telephone.

5 Do I have to take part in this research project?

Participation in any project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with your employer.

6 What are the possible benefits of taking part?

There will be no clear benefit to you from your participation in this research, however, it is expected that your participation will be beneficial in increasing the capacity of midwives and doctors to effectively and sustainably identify and respond to domestic and family violence.

7 What are the possible risks and disadvantages of taking part?

You may feel that some of the questions asked are sensitive as they ask about your workplace and are on a sensitive topic. If you do not wish to answer a question, you do not have to or you may stop immediately by letting the facilitator or interviewer know that you would prefer this. If you become distressed as a result of participating in the project, the research team will encourage you to contact the Employee Assistance Program (EAP) or any of the services listed on the resource card that all participants receive. The EAP counselling is provided free of charge.

Whilst all care will be taken to maintain privacy and confidentiality, you may experience embarrassment if one of the group members were to repeat things said in a confidential group meeting.

8 What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time.

If you decide to leave the project, the researchers will not collect additional personal information from you, although personal information already collected will be retained to ensure that the results of the project can be measured properly and to comply with law. You should be aware that data collected up to the time you withdraw will form part of the research project results. As the data collected is de-identified, it will not be possible to remove your information from the focus groups when you withdraw. If, however, you participated in the interviews, the transcripts may be re-identified and responses withdrawn.

9 What happens when the research project ends?

The research is expected to be completed mid-2019. The results of the study will be reported as a group and not individually. You can access results of the project as they become available online at <https://anrows.org.au/node/1427>. Alternatively, a summary of the results can be obtained by providing a forwarding email address to the researchers.

Part 2 How is the research project being conducted?

10 What will happen to information about me?

By signing the consent form you consent to the research team collecting and using personal information about you for the project. Any information obtained for this project that can identify you will remain confidential. Any contact details provided will be stored separately to the survey, focus group or interview responses. You will be given an ID number or pseudonym and the survey asking for information about yourself is anonymous. Only the researchers will have access to the data collected. The data collected will be stored on password protected computers. Your information will only be used for the purposes of this project and it will only be disclosed with your permission, except as required by law.

It is anticipated that the results of this project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided as a group and not individually.

In accordance with relevant Australian, Victorian and/or New South Wales privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. The data collected will be de-identified. If you attended a focus group, it will not be possible to access your information, however, if you participated in the interviews, your responses may be re-identified.

11 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of the Royal Women's Hospital and Bendigo Health. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

12 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on [\[Phone number\]](#) or any of the following people:

Research contact person

Name	Kelsey Hegarty
Position	Professor, Family Violence Prevention
Telephone	8344 4992
Email	k.hegarty@unimelb.com.au

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	Consumer Advocate
Position	Consumer Advocate
Telephone	8345 2290
Email	consumer.advocate@thewomens.org.au

Consent Form - *Adult providing own consent*

Title	Sustainability of Identification and Response to Domestic Violence in Antenatal care
Short Title	SUSTAIN study
Protocol Number	<i>[Protocol Number]</i>
Project Sponsor	Royal Women's Hospital and University of Melbourne
Principal Investigator	Professor Kelsey Hegarty
Associate Investigator(s)	Jo Spangaro, Elizabeth McLindon, Jane Koziol-McLain, Jeannette Walsh, Jane Hooker, Jenny Chapman, and Robyn Matthews
Locations	Site V4 Site V5 Site V6 Site N1

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____
Signature _____ Date _____

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher [†] (please print) _____
Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation - *Adult providing own consent*

Title	Sustainability of Identification and Response to Domestic Violence in Antenatal care
Short Title	SUSTAIN study
Protocol Number	<i>[Protocol Number]</i>
Project Sponsor	Royal Women’s Hospital and University of Melbourne
Principal Investigator	Professor Kelsey Hegarty
Associate Investigator(s)	Jo Spangaro, Elizabeth McLindon, Jane Koziol-McLain, Jeannette Walsh, Jane Hooker, Jenny Chapman, and Robyn Matthews
Locations	Site V4
	Site V5
	Site V6
	Sites N1 and N2

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my routine care, or my relationships with the researchers or the University of Melbourne.

Name of Participant (please print) _____ Signature _____ Date _____
--

In the event that the participant’s decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher[†]

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print) _____ Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.



Participant Information Sheet/Consent Form

Health/Social Science Research - Adult providing own consent

Pregnant Women

Title	Sustainability of Identification and Response to Domestic Violence in Antenatal care (SUSTAIN) study
Short Title	SUSTAIN study
Protocol Number	<i>[Protocol Number]</i>
Project Sponsor	Royal Women's Hospital and University of Melbourne
Principal Investigator	Kelsey Hegarty
Associate Investigator(s)	Jo Spangaro, Elizabeth McLindon, Jane Koziol-McLain, Jeannette Walsh, Robyn Matthews, Jane Hooker, Jenny Chapman
Locations	Site V4 Site V5

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this project, which is called the SUSTAIN study. You have been invited because you are receiving pregnancy care at the Site V4 or V5 health facilities.

This Participant Information Sheet/Consent Form tells you about the project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

Consent will be implied by doing the survey. After reading about the study, and by continuing on to doing the survey, you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

2 What is the purpose of this research?

The results of this research will be used by the researchers to develop guidelines for asking about and responding to domestic and family violence.

This research has been initiated by the researcher, Professor Kelsey Hegarty and funded by Australia's National Research Organisation for Women's Safety.

This research is being conducted by Site V4 and V5 health facilities together with the University of Melbourne, University of New South Wales and Auckland University of Technology.

3 What does participation in this research involve?

If you decide to take part in the project, you will be asked to complete an online survey asking about your emotional health and wellbeing and any relationship issues you may be having. You will be asked about you and your care at the hospital; health and wellbeing; relationships and safety; support; you and your household; and your views about the survey. Completing the questionnaire will take about 10-15 minutes.

If you prefer to complete the survey elsewhere, a paper copy of the survey, with a self-addressed reply-paid envelope, can be given to you or mailed in the post if you provide a forwarding address.

There are no costs associated with participating in this research project, nor will you be paid.

4 Other relevant information about the research project

The project will recruit around 1300 pregnant women having pregnancy care at the Women's, including those who speak and read Arabic or Chinese (e.g. Mandarin and Cantonese), and also at Bendigo Health.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine care, your relationship with professional staff or your relationship with the Royal Women's Hospital.

6 What are the possible benefits of taking part?

We cannot guarantee that you will receive any benefits from this research; however, possible benefits may include improved guidelines for health professionals in the area of asking and responding to domestic and family violence.

7 What are the possible risks and disadvantages of taking part?

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop straight away. If you become upset or distressed as a result of participating in the study the research team can assist you to arrange to seek help for counselling or other appropriate support either at the hospital or in the community. These are listed on the resource card given to all participants. Any counselling or support will be provided by qualified staff who are not members of the research team.

8 What if I withdraw from this research project?

You may withdraw at any time. If you decide to leave the research project, the researchers will not collect additional personal information from you, although personal information already collected will be kept to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected up to the time you withdraw will form part of the research project results. It will not be possible to remove your responses when you withdraw as the survey responses are anonymous.

9 What happens when the research project ends?

The research is expected to be completed mid-2019. The results of the study will be reported as a group and not individually. A summary of the results can be obtained by providing a contact name and email or address to the researchers. The results may also be accessed as they become available online at <https://anrows.org.au/node/1427>

Part 2 How is the research project being conducted?

10 What will happen to information about me?

By completing the survey, your consent is implied. Your participation in the survey will be anonymous. Any information obtained about this research project that can identify you will remain confidential. Any contact details provided will be stored separately to the survey responses. Only the researchers will have access to the data collected. The data collected will be stored on password protected computers. Your information will only be used for the purposes of this research project and it will only be disclosed with your permission, except as required by law. The information that the research team collect and use are your responses to the survey.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. The results will be published as a group and not individually.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. However, the survey will be anonymous, so the researchers will not be able to identify which responses were yours.

11 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of the Royal Women's Hospital. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

15 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on [\[Phone number\]](#) or any of the following people:

Research contact person

Name	Kelsey Hegarty
Position	Professor, Family Violence Prevention
Telephone	8344 4992
Email	k.hegarty@unimelb.com.au

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	Consumer Advocate
Position	Consumer Advocate
Telephone	8345 2290
Email	consumer.advocate@thewomens.org.au

Consent Form - *Adult providing own consent*

Title	Sustainability of Identification and Response to Domestic Violence in Antenatal care (SUSTAIN) study
Short Title	SUSTAIN study
Protocol Number	<i>[Protocol Number]</i>
Project Sponsor	<i>[Project Sponsor in Australia]</i>
Coordinating Principal Investigator/ Principal Investigator	Kelsey Hegarty
Associate Investigator(s)	Jo Spangaro, Elizabeth McLindon, Jane Koziol-McLain, Jeannette Walsh, Jane Hooker, Jenny Chapman, and Robyn Matthews
Location	Site V4 Site V5

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____
Signature _____ Date _____

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher [†] (please print) _____
Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation - *Adult providing own consent*

Title Sustainability of Identification and Response to Domestic Violence in Antenatal care (SUSTAIN) study

Short Title SUSTAIN study

Protocol Number *[Protocol Number]*

Project Sponsor *[Project Sponsor in Australia]*

**Coordinating Principal Investigator/
Principal Investigator** Kelsey Hegarty

Associate Investigator(s) Jo Spangaro, Elizabeth McLindon, Jane Koziol-McLain, Jeannette Walsh, Jane Hooker, Jenny Chapman, and Robyn Matthews

Locations Site V4
Site v5

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my routine care, or my relationships with the researchers or Site V4.

Name of Participant (please print) _____ Signature _____ Date _____
--

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher[†]

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print) _____ Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.



Participant Information Sheet/Consent Form

Health/Social Science Research - *Adult providing own consent*

Pregnant women referred to Social Work

Title	Sustainability of Identification and Response to Domestic Violence in Antenatal care
Short Title	SUSTAIN study
Protocol Number	<i>[Protocol Number]</i>
Principal Investigator	Professor Kelsey Hegarty
Project Sponsor	Royal Women's Hospital and University of Melbourne
Associate Investigator(s)	Jo Spangaro, Elizabeth McLindon, Jane Koziol-McLain, Jeannette Walsh, Robyn Matthews, Jane Hooker, Jenny Chapman
Location	Site N1 Site N2

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this project, which is called the SUSTAIN study. You have been invited because you are having pregnancy care at the Women's and were referred to social work for violence related issues. Your contact details were obtained from the Social Worker.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

The results of this research will be used by the researchers to develop guidelines for asking about and responding to domestic violence.

This research has been initiated by the researcher, Professor Kelsey Hegarty and has been funded by Australia's National Research Organisation for Women's Safety.

This research is being conducted by the health facilities labelled N1, N2, N3 and V4, together with the University of Melbourne, University of New South Wales and Auckland University of Technology.

3 What does participation in this research involve?

If you decide to take part in the project, you will be invited to be interviewed about your experiences of being referred to social work after disclosing domestic or family violence. The interview can take place face-to-face or over the telephone and is expected to take about 30 minutes.

There are no costs associated with participating in this project, nor will you be paid.

4 Other relevant information about the research project

It is expected that up to 20 women be invited to be interviewed.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine care, your relationship with professional staff or your relationship with the hospital where you receive your pregnancy care.

6 What are the possible benefits of taking part?

We cannot guarantee that you will receive any benefits from this research; however, possible benefits may include improved guidelines for health professionals on domestic and family violence.

7 What are the possible risks and disadvantages of taking part?

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. If you become upset or distressed as a result of your participation in the research study, the research team will be able to arrange for counselling or other appropriate support either at the hospital or in the community. These are listed on the resource card given to all participants. Any counselling or support will be provided by qualified staff who are not members of the research team.

8 What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time.

If you decide to leave the research project, the researchers will not collect additional personal information from you, although personal information already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected up to the time you withdraw will form part of the research project results. If you do not want your data to be included, you must tell the researchers when you withdraw from the research project.

9 What happens when the research project ends?

The research is expected to be completed mid-2019. The results of the study will be reported as a group and not individually. You can access results of the project as they become available online at <https://anrows.org.au/node/1427>. Alternatively, a summary of the results can be obtained by providing a forwarding email address to the researchers.

Part 2 How is the research project being conducted?

10 What will happen to information about me?

By signing the consent form you consent to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential. Signed consent forms will be stored in locked filing cabinets in offices only accessible by using security cards. You will be given an ID number or pseudonym. Only the researchers will have access to the data collected. The data collected will be stored on password-protected computers. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided as a group and not individually.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. However, the interview responses will not be identifiable, so the researchers will not be able to identify which responses were yours.

11 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of the study site V4. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

15 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on [\[Phone number\]](#) or any of the following people:

Research contact person

Name	Kelsey Hegarty
Position	Professor, Family Violence Prevention
Telephone	8344 4992
Email	k.hegarty@unimelb.com.au

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	Consumer Advocate
Position	Consumer Advocate
Telephone	8345 2290
Email	consumer.advocate@thewomens.org.au

Consent Form - *Adult providing own consent*

Title	Sustainability of Identification and Response to Domestic Violence in Antenatal care
Short Title	SUSTAIN study
Protocol Number	<i>[Protocol Number]</i>
Principal Investigator	Professor Kelsey Hegarty
Project Sponsor	Royal Women's Hospital and University of Melbourne
Associate Investigator(s)	Jo Spangaro, Elizabeth McLindon, Jane Koziol-McLain, Jeannette Walsh, Jane Hooker, Jenny Chapman, and Robyn Matthews
Location	Site N1 Site N2

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____
Signature _____ Date _____

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher [†] (please print) _____
Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation - *Adult providing own consent*

Title	Sustainability of Identification and Response to Domestic Violence in Antenatal care
Short Title	SUSTAIN study
Protocol Number	[Protocol Number]
Principal Investigator	Professor Kelsey Hegarty
Project Sponsor	Royal Women’s Hospital and University of Melbourne
Associate Investigator(s)	Jo Spangaro, Elizabeth McLindon, Jane Koziol-McLain, Jeannette Walsh, Jane Hooker, Jenny Chapman, and Robyn Matthews
Location	Site N1 Site N2

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my routine care, or my relationships with the researchers or [Institution].

Name of Participant (please print) _____ Signature _____ Date _____
--

In the event that the participant’s decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher[†]

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

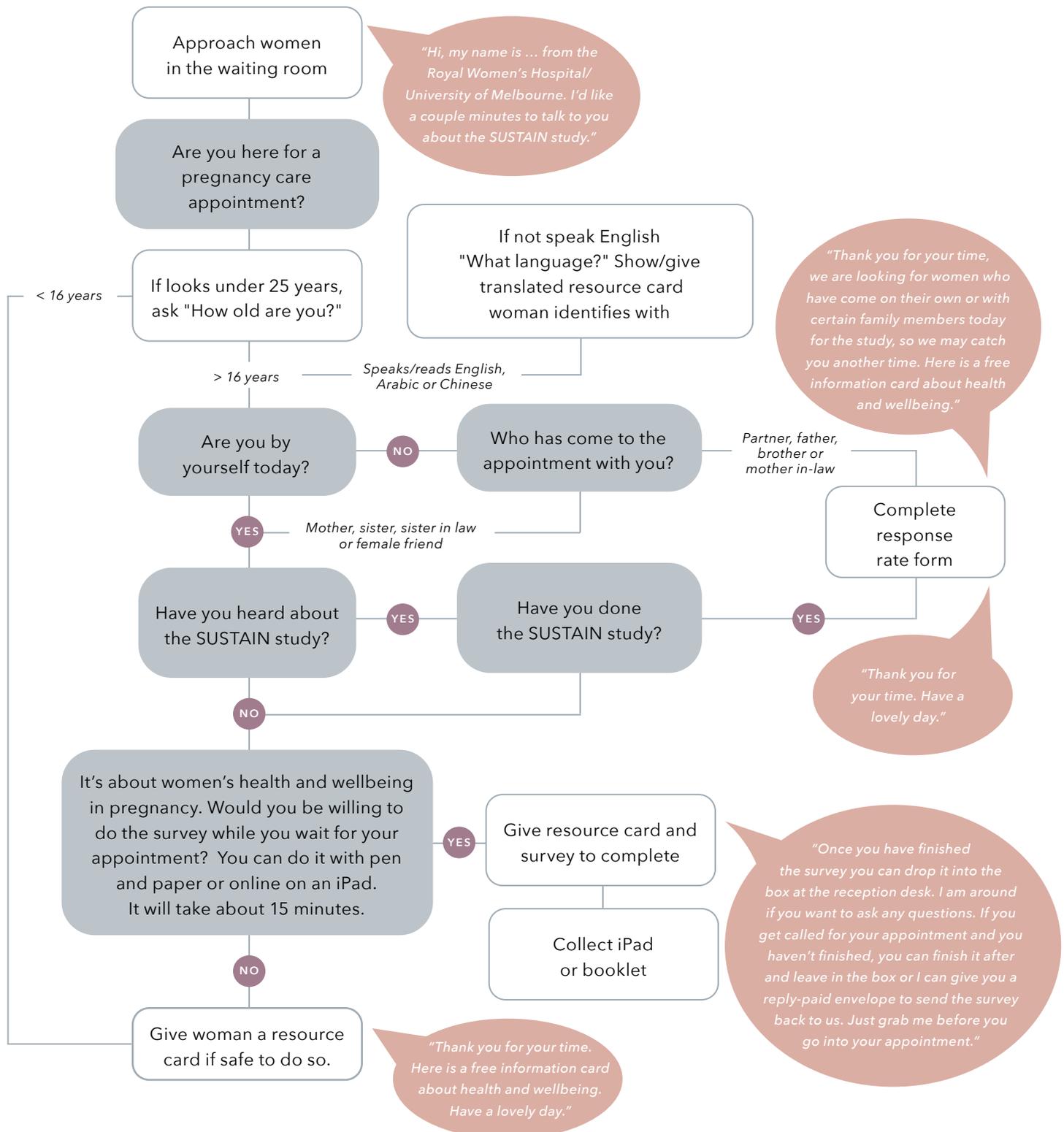
Name of Researcher (please print) _____ Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

APPENDIX J

Flow chart for recruiting women to the SUSTAIN survey



Note: If asked what is the study/survey about or why she can't do survey when accompanied, can inform woman—the survey asks about your relationship with your partner and other family members.

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ANROWS

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AUSTRALIA'S NATIONAL RESEARCH
ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children

