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**Australian Institute of
Health and Welfare**

Screening for domestic violence during pregnancy

**Options for future reporting in the
National Perinatal Data Collection August 2015**



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*Authoritative information and statistics
to promote better health and wellbeing*

Screening for domestic violence during pregnancy

Options for future reporting in the National Perinatal Data Collection

Australian Institute of Health and Welfare
Canberra

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Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ANRQ	Antenatal Risk Questionnaire
COAG	Council of Australian Governments
CRAF	Common Risk Assessment Framework
DSS	data set specification
DV	domestic violence
DVO	domestic violence order
HARK	Humiliation, Afraid, Rape, Kick Screening Tool
HITS	Hurts, Insults, Threatens and Screams Screening Tool
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
NHMD	National Hospital Morbidity Database
NMDDP	National Maternity Data Development Project
NMDS	National Minimum Data Set
NMSP	National Maternity Services Plan
NPDC	National Perinatal Data Collection
NSW	New South Wales
NT	Northern Territory
PDC	Perinatal Data Collection
PSS	Personal Safety Survey
Qld	Queensland
SA	South Australia
Tas	Tasmania
Vic	Victoria
WA	Western Australia
WSS	Women's Safety Survey

Summary

Domestic violence (DV), defined in this paper as ‘acts of violence that occur between people who have, or have had, an intimate relationship,’ is a leading preventable contributor to death, disability and illness for women of reproductive age (15 to 44 years).

Pregnancy is as an important time for screening for DV. It presents an opportunity to identify DV, as many women will have contact with health-care services and professionals on a regular basis during the antenatal period.

Estimates indicate that around 5% of women (aged 18 and over) experience violence during pregnancy from their previous or current partner. The risk of DV has been found to be higher in pregnant women and in the period following birth, posing serious health risks to both pregnant women and their babies. There is known under-reporting of DV due to its complex and sensitive nature (including patients’ reluctance to report) and under-identification by health workers.

Data on DV in pregnancy in Australia are currently poor and inconsistent across jurisdictions, with variations in what is collected and in methods of collection. An opportunity exists to collect higher quality data through the National Perinatal Data Collection (NPDC), which includes data about every woman who gives birth in Australia. These data are important for population level surveillance and for clinical care and outcomes; they can also contribute to researching the association of DV with other maternal and perinatal outcomes. Seeking to improve national data on DV in pregnancy is also timely, in light of the Prime Minister’s Advisory Panel on Violence against Women, established in 2015.

The AIHW’s National Maternity Data Development Project (NMDDP) aims to enhance the collection of nationally consistent data in the NPDC. As part of the NMDDP, this paper was developed as a guide to the issues that need to be considered in deciding whether and how to collect DV data in the NPDC. The data development process included a literature review, investigation of current approaches in Australia, a discussion paper, a national workshop, and consultation with a working party.

It was found that screening for DV – a process to identify victims of violence or abuse in order to offer interventions that can lead to beneficial outcomes – in the antenatal period already occurs in most Australian jurisdictions. This may be structured or unstructured, and the results of screening are not necessarily recorded in data systems.

Potential approaches to obtaining national data in the NPDC include:

- develop and implement a minimum set of standard questions, based on the questions currently in use across jurisdictions
- seek to implement a nationally consistent screening approach by encouraging all midwives to use a recommended validated DV screening tool
- maintain a flexible screening approach consistent with the *National Antenatal Care Guidelines* that enables screening in different ways for different populations.

It is recommended that before national data standards are developed for the NPDC, pilot testing and further consultation be conducted to determine the best way to achieve high-quality data, while gaining acceptability among clinicians and mothers.

1 Introduction

Domestic violence (DV) is a leading preventable contributor to death, disability and illness for women aged 15–44. In this age group, DV has been shown to account for nearly 8% of the total disease burden in Victoria (Vos et al. 2006). Pregnancy, which predominantly occurs within this age range, has been identified as a period of high risk for the onset or worsening of DV (Taft 2002; WHO 2000). Pregnancy outcomes for abused women, in Australia and globally, are worse than those for non-abused women (Taft et al. 2004; WHO 2013).

This report outlines how a more comprehensive and consistent approach to national data collection and reporting on DV in pregnancy might be achieved. After reviewing why better data on DV in pregnancy is important, the paper discusses issues around developing and capturing national data on screening for DV during the antenatal period. It then considers options for collecting, and potentially reporting, some nationally consistent DV data on pregnant women.

1.1 Background

Information on DV in pregnancy was identified as a key information gap as part of the National Maternity Data Development Project (NMDDP). The NMDDP was established to develop the collection of nationally consistent and comprehensive maternity data in Australia and will enable more accurate monitoring and evaluation of maternal and perinatal outcomes. This was identified as a key area under action item 4.1.5 in the *National Maternity Services Plan* [NMSP] (AHMC 2011). As well, action item 2.3.3 of the NMSP specifies that Australian governments investigate, implement, expand and evaluate evidence-based maternity care models for at-risk women, including women who experience DV (AHMC 2011).

In 2011, under the guidance of the NMDDP Advisory Group (see Appendix A for a list of members), the Australian Institute of Health and Welfare (AIHW) scoped national maternity information needs to enhance the Perinatal Data Collection (PDC). ‘Domestic violence’ was one of over 50 data items included in a scoping questionnaire as a topic of potential national importance. Consultation resulted in *Screening for Domestic Violence* becoming one of a number of priority items identified for national standardisation and/or data development. The NMDDP priority information needs were outlined in the report *Foundations for enhanced maternity data collection and reporting in Australia: National Maternity Data Development Project Stage 1* (AIHW 2014).

During NMDDP Stage 1 consultations, jurisdictions expressed in-principle support for a *Screening for Domestic Violence* item; however, there were concerns about the feasibility of implementing it in PDCs (see Appendix B for more detail on jurisdictional feedback). The NMDDP Advisory Group believed the data were sufficiently important to warrant further investigation and recommended that an item be developed. However, a long-term time frame was deemed necessary due to the substantial data development that needed to be undertaken, potential collection difficulties and the highly sensitive nature of the issue. This paper discusses these issues and how they affect options for collecting and reporting DV data in the National Perinatal Data Collection (NPDC).

National Perinatal Data Collection

The NPDC is held at the AIHW and is currently the main source of national reporting on pregnancy and childbirth for mothers, and on the characteristics of, and outcomes for, their babies. The AIHW reports aggregate de-identified data and the NPDC is used to examine patterns and trends in population health. In each state and territory, midwives or other staff collect perinatal data from clinical and administrative records and information systems, including records of antenatal care, the care provided during labour, and the delivery and care provided after birth.

Each jurisdiction maintains its own PDC and supplies data to the AIHW, where it becomes part of the NPDC. The NPDC consists of the Perinatal National Minimum Data Set (NMDS) which currently includes 31 mandatory data items supplied by each jurisdiction, as well as over 80 additional voluntary data items. The NPDC includes data on all live births and stillbirths of at least 400 grams birthweight, or at least 20 weeks gestation (see <http://meteor.aihw.gov.au/content/index.phtml/itemId/597483> for more information).

No jurisdiction currently collects information on DV as part of its PDC; however, some jurisdictions do routinely screen women for DV in pregnancy. Others screen on a case-by-case basis. Options for how *Screening for Domestic Violence* data could become part of the NPDC are the focus of this paper.

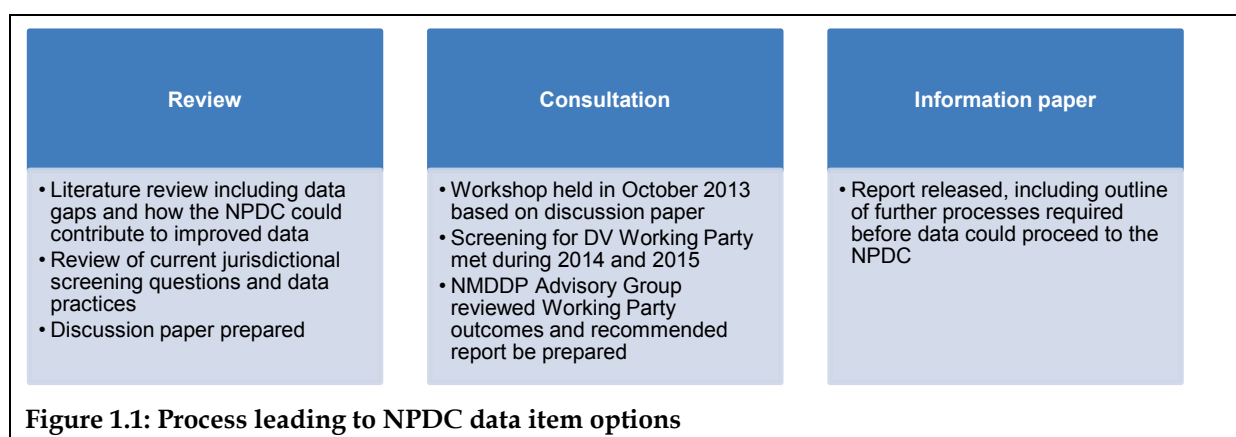
Screening questions have not previously been included in the NPDC; however, it is possible that, over time, the collection could be expanded to include *Screening for Domestic Violence*, as well as screening data for other psychosocial aspects of health such as mental health.

1.2 Process of identifying options for NPDC data

After the NMDDP Advisory Group recommended options for *Screening for Domestic Violence* data be explored, the following processes were undertaken to identify potentially suitable measurement tools and data items that could be considered for inclusion in the NPDC:

- review of the literature to determine:
 - the importance of routine screening and what data would be possible to collect
 - data gaps and the potential of the NPDC to fill these
 - how *Screening for Domestic Violence* could be measured and/or reported in the NPDC
- review of relevant jurisdictional tools and data practices currently in use
- discussion paper written on issues associated with collecting data in the NPDC
- consultation with key experts and stakeholders:
 - a workshop was held (see Appendix C for a list of participants), supported by the discussion paper, to consider whether it would be possible to collect national information on *Screening for Domestic Violence* as part of the NPDC, the kind of information that could be collected and the usefulness of the data
 - a working party was formed (see Appendix D for a list of members) to resolve issues identified in the discussion paper and at the workshop
- development of this report.

Figure 1.1 shows the processes followed that led to this report.



One outcome of the process undertaken was the development of a rationale for collecting data in the NPDC. While not all stakeholders were convinced the NPDC was the best collection for this type of data, the majority thought it appropriate to fully explore why DV screening data should be considered for collection in the NPDC and what uses such data would have. The Screening for DV Working Party helped develop and refine the following rationale.

1.3 Rationale

The purpose of the NPDC is predominantly for population surveillance and monitoring. From this perspective, the collection monitors outcomes for both mother and baby, related to physical health and other factors. However, the collection can also be used to inform maternal health policy, service delivery, planning and practice.

The rationale was developed by drawing on the literature review and stakeholder consultation, and was extensively reviewed by the Screening for DV Working Party and the NMDDP Advisory Group. It was considered critical to have a robust rationale as not everyone is convinced of the legitimacy or appropriateness of collecting data on *Screening for Domestic Violence* in the NPDC, even though in many, if not most, maternity clinics across Australia, midwives are asking pregnant women about DV.

The rationale is divided into four broad areas: why screen for DV, why data are needed, why collect the data in the NPDC, and how the NPDC data would be used. These are discussed below.

Rationale for collecting data in the National Perinatal Data Collection

Introductory statement

DV, defined as ‘acts of violence that occur between people who have, or have had, an intimate relationship,’ is a leading preventable contributor to death, disability and illness for pregnant women and their babies. Australia’s national collection of perinatal data on every woman who gives birth (the NPDC) provides an unparalleled opportunity to collect and monitor vital information on this issue, with the aim of improving outcomes for women and their children.

1. Why screen for domestic violence?

There are multiple purposes for screening during pregnancy including:

- pregnancy being a unique time for women to receive help due to more frequent contact with health services and opportunities for women isolated by DV to discuss this with a health-care provider (Spangaro et al. 2010a)
- increasing opportunities for safety planning, awareness (Chang et al. 2010), support and ongoing care
- decreasing the acceptability of DV among both health professionals and patients (that is, helping to change social norms) (Spangaro et al. 2010b)
- screening not being harmful to women and antenatal screening possibly being more beneficial than screening in other health settings (Taft et al. 2013)
- pregnancy outcomes for abused women (in Australia and globally) being worse than those for non-abused women (Taft et al. 2004; WHO 2013). For example, abused women are at increased risk of miscarriage (Morland et al. 2008), pre-term labour and birth (Shah et al. 2010) and having low birthweight infants (El Kady et al. 2005; Shah et al. 2010; Silverman et al. 2006; Yost et al. 2005). Women assaulted during pregnancy also have higher risks of placental abruption, caesarean delivery, haemorrhage and infection than women without a history of assault (El Kady et al. 2005). In addition, DV before pregnancy is a major independent risk factor for hypertension, oedema, vaginal bleeding, placental problems, severe nausea and vomiting, dehydration, diabetes, kidney infection and/or urinary tract infection, as well as premature rupture of membranes (Silverman et al. 2006).

Not all women will disclose DV, and of those who do, not all will want help or referral. However, referral is not the only reason for conducting screening; if awareness is the only outcome, this can still be beneficial.

2. Why are data needed on domestic violence?

For women aged 15–44, DV is responsible for greater disease burden than many well-known health risk factors such as high blood pressure, smoking and obesity (Vos et al. 2006).

Pregnancy has also been identified as a period of high risk for the onset or worsening of DV incidents (Taft 2002; WHO 2000).

Despite this, there is currently no comprehensive approach to national data collection on DV in pregnancy. The only source of national data is the ABS Personal Safety Survey (PSS) which helps to measure the prevalence of violence during pregnancy; however, the PSS does not collect data annually, nor routinely from the entire population of interest as the NPDC does. Without routine and consistent national collection, Australia is unable to monitor the extent of DV in pregnancy, its associations with pregnancy events and outcomes for mothers and babies, and service provision for responding. This is a serious barrier to informing and developing policy and program responses.

While recognising that the benefits of DV screening for women and their babies are not always clear or simple to evaluate, collecting screening and disclosure data via the NPDC may help to better understand women's pregnancy and health outcomes.

3. Why collect the screening for domestic violence data in the NPDC?

The NPDC is a large data set (a census of mothers with about 300,000 records per year) and is the main source of national reporting on pregnancy and childbirth for mothers, and the characteristics and outcomes of their babies. The NPDC includes a sample of women (that is,

pregnant women only) who predominantly fall within the age range of 15–44 where the highest levels of disease burden attributable to DV have been shown to occur (Vos et al. 2006).

Collecting data in the NPDC could be valuable for the reasons given below:

- No routine national data collection for DV exists for pregnant women and no other data source can provide such comprehensive coverage of the population and the subject matter area.
- Population level data are needed to drive policies, programs, service planning and delivery.
- While aggregated de-identified data would be used for routine reporting, the NPDC also provides opportunities for data linkage to explore individual women's outcomes (using other variables within the NPDC, and with appropriate data security and confidentiality processes in place) as well as children's longer term outcomes if linkage to childhood data sets later becomes possible.
- Identifying violence as an issue for health care is necessary for addressing it, and the NPDC can provide data of relevance to the *National Plan to Reduce Violence against Women and their Children 2010–2022*.
- It could provide data on the sustainability of screening programs.

However, there are a range of data quality issues. Before any reliable national data could be collected, pilot studies need to determine the best type of data to collect and how to collect it.

4. How would the NPDC data on domestic violence be used?

The primary uses for NPDC data on DV include:

- annual reporting to identify DV rates and patterns in pregnancy
- analysis to examine correlations between DV and other clinical characteristics or perinatal risk factors. For example, low birthweight, premature labour and birth, miscarriage, haemorrhage (which are already included in the NPDC) as well as maternal mental health, inadequate weight gain and models of care (which are not currently part of the NPDC but are being considered for inclusion)
- disaggregations to examine different geographic levels and subpopulations to identify high-risk groups (survey data are unlikely to provide adequate sample sizes for generating reliable data for Aboriginal and Torres Strait Islander people or other specific subpopulations).

1.4 Structure of this report

This paper presents information based on prior research and discussions with stakeholders on how to measure or capture *Screening for Domestic Violence* during pregnancy. It reviews the tools and measures currently in use and outlines how a nationally consistent approach to screening might be achieved. It also outlines options for developing appropriate national data item(s). To this end, the paper does the following:

- This chapter (Chapter 1) presents background information on why the NPDC should be considered as a potential source for better national data on DV in pregnancy, the process of identifying options for NPDC data and the rationale for collecting data in the NPDC.
- Chapter 2 considers the policy context in relation to maternity services and other national and jurisdictional strategies for addressing DV.

- Chapter 3 reviews issues associated with definitions and conceptualisation of DV and screening and proposes a definition for the NPDC.
- Chapter 4 reviews literature on why pregnancy is an important time during which to screen for DV, and issues involved in screening for DV.
- Chapter 5 examines the data context, including data gaps, other data sources, some inherent data limitations that affect data quality, and how the NPDC may fill some data gaps.
- Chapter 6 examines the screening tools currently used in jurisdictions and how screening outcomes are recorded (for example, types of data items used in jurisdictions).
- Chapter 7 examines how to move towards more nationally consistent data collection and reporting and outlines some possible NPDC data items. This chapter considers approaches to screening, including potential measurement tools and the advantages and disadvantages of taking a structured approach (for example, by implementing a validated screening tool for use nationally) or a more flexible approach that allow midwives to tailor their screening approach to individual women.
- Chapter 8 reviews other considerations that might affect the inclusion of data in the NPDC, including preconditions for screening to take place, mandatory reporting, Indigenous issues, the relationship of DV data to other psychosocial data items, and other data collection and clinical practice issues.
- Chapter 9 outlines the next steps to be undertaken before formal data development can start.

2 Government initiatives in the area of domestic violence

Better data on DV are recognised as critical in a number of national plans, strategies and other government initiatives at all jurisdictional levels. This chapter reviews those that are relevant to the perinatal context as well as to DV more broadly and highlights where these documents indicate a need for better quality data.

2.1 Maternity services initiatives

National Maternity Service Plan

As noted in Chapter 1, action item 2.3.3 of the NMSP specifies that Australian governments investigate, implement, expand and evaluate evidence-based maternity care models for at-risk women, including women who experience DV. The NMSP highlights a need for better quality data, and the work of the NMDDP contributes indirectly to addressing this through enhancing the collection of nationally consistent data (action item 4.1.5 of the NMSP). The collection of nationally consistent data on DV could enable information about this group of vulnerable women to be analysed, and questions about care and outcomes for these women to be further explored.

The NMSP notes that women who experience DV are a specific group who may have poorer maternity outcomes than the general population and that such women are slower to make contact with health services for antenatal care. However, a range of strategies, which are not explicitly addressed in the NMSP, have been developed in jurisdictions to try to meet the needs of vulnerable women, including those who experience DV (see jurisdictional section later in this chapter). A focus of the NMSP is on identifying and, where appropriate, expanding successful maternity care initiatives for at-risk women. However, national data on screening and disclosure of DV are required to identify the number of pregnant women at risk and where increased services are most required.

The NMSP notes that the AIHW holds the NPDC and that this data informs systematic reviews at a national level and allows trends in maternal and perinatal outcomes to be reported. However, jurisdictional PDCs need to be reported consistently if the NPDC is to report comprehensive national data. Currently no data on DV are contained in the NPDC.

National evidence-based antenatal care guidelines

In 2012, the Australian Health Ministers' Advisory Council released *Clinical practice guidelines: antenatal care – module 1* which recommends that midwives 'at the first antenatal visit, explain to all women that asking about domestic violence is a routine part of antenatal care and enquire about each woman's exposure to domestic violence' (AHMAC 2012). The guidelines state that DV is relatively common during pregnancy and therefore screening for DV is recognised as an important part of providing routine care. It should be undertaken for all women and, if DV is identified, women should be provided with access to additional support and care.

The guidelines do not stipulate the use of any specific assessment tool when screening for DV but instead encourage flexibility so midwives can tailor their approach to a woman's

individual situation. A consensus-based recommendation was that a screening tool that provided a series of structured questions may be used. However, midwives may also call on their own skills and clinical experience to ask their own open questions should the level of trust in the relationship allow. (Chapter 7 of this paper discusses the advantages and disadvantages of a flexible approach compared with using a validated tool in screening.)

The guidelines also note the importance of training programs in improving the confidence and competency of health professionals in identifying and caring for women experiencing DV. For Indigenous women, being aware of family and community structures and support is emphasised. Midwives also need to be aware of DV services in the community that can be called on for urgent assistance. For these reasons, Chapter 8 of this paper further discusses why training and support structures for midwives, and the women they care for, should be considered preconditions for screening and data collection to take place.

The guidelines indicate that asking about DV is part of routine care; they also highlight that additional questions on DV may be asked as part of a broader assessment to identify psychosocial factors that might impact women in the perinatal period. For instance, example questions in the guidelines that help to identify previous or current abuse can be used when assessing psychosocial factors that can impact on a woman's mental health. Due to established associations between abuse and mental health problems, chapters 5 and 8 of this paper also touch on how mental health, another NMDDP priority item, could be considered in conjunction with DV data. Other NMDDP priority items that also have some correlation with DV include alcohol and substance abuse (each of which is also on the NMDDP priority list); these items are discussed in the guidelines and in chapters 5 and 8 of this paper.

National Maternal and Perinatal Mortality and Morbidity Reporting

Actions detailed in the NMSP contribute to other safety and quality initiatives, including the collection of nationally consistent maternal and perinatal mortality data, and mechanisms to improve outcomes for mothers and babies. As part of the NMDDP, two national maternal mortality reports were published in 2014 and 2015, and a national perinatal mortality report will be published later in 2015.

The report titled *Maternal deaths in Australia 2006–2010* (AIHW et al. 2014:77) states the following:

A significant proportion of maternal deaths occur among women with a previous psychiatric history (Austin et al. 2007) and evidence suggests that substance misuse and domestic violence often complicate deaths related to psychiatric illness and in a minority can be the primary cause (Austin et al. 2007; Oates 2003). The antenatal period is a time when many women will have contact with health care services, which presents an important opportunity to evaluate and monitor psychosocial wellbeing and provide access to appropriate mental health services. Although these deaths can be viewed as not strictly due to 'obstetric causes' they are a part of the spectrum of maternal morbidity and a significant cause of mortality in the perinatal period. If the aim of examining and reporting maternal deaths is to make improvements in maternity care that could lead to prevention of maternal deaths and to provide information that can be used to improve maternity services, then it is essential that deaths of women by suicide or assault in the perinatal period are included in systems of review. It is essential that maternity services are able to effectively identify and provide services to women at risk of harm from themselves or others. It is essential that opportunities to prevent the death of vulnerable women are not lost.

The report titled *Maternal deaths in Australia 2008–2012* (AIHW et al. 2015) published data on ‘psychosocial morbidity’ (which describes deaths in which a psychiatric condition contributed to the cause of death) and encompasses the wider issues of DV and substance misuse. There were 16 maternal deaths from causes related to psychosocial morbidity between 2008 and 2012. Psychosocial morbidity was the second leading cause of indirect maternal death in Australia, behind cardiac causes. Of the 16 women who died from causes related to psychosocial morbidity between 2008 and 2012, 12 women committed suicide, 2 were murdered by their partners, 1 was a known substance user who overdosed on illicit drugs with unknown intent, and 1 had an adverse reaction to psychotropic medication.

The maternal deaths reports highlight the importance of examining psychosocial morbidity factors that contribute to a woman’s death, including DV and other correlated factors such as alcohol and substance use.

2.2 Domestic violence initiatives

This section reviews some key jurisdictional plans and guidelines to help address DV.

COAG Advisory Panel on Violence against Women

In January 2015, the Prime Minister announced that a panel would be established to advise the Council of Australian Governments (COAG) on practical ways to address violence against women (COAG 2015). This Advisory Panel on Violence against Women would be chaired by former Victorian Chief Commissioner, Ken Lay, with Rosie Batty, Australian of the Year 2015, as Deputy Chair. Other panel members were nominated by each state and territory, and had specialised knowledge across domestic and family violence, sexual assault, online safety, violence within Indigenous and culturally and linguistically diverse communities, and people with disabilities.

The three COAG priorities for 2015 are:

- a national Domestic Violence Order (DVO) scheme, where DVOs will be automatically recognised and enforceable in any state or territory of Australia
- national standards for perpetrator interventions
- a national approach to dealing with online safety and the misuse of technology.

The Australian Government further committed \$30 million to a national campaign (jointly funded by the state and territory governments) to reduce violence against women and their children, with potential to increase frontline services to support women seeking assistance (COAG 2015).

National Plan to Reduce Violence against Women and their Children 2010–2022

The *National Plan to Reduce Violence against Women and their Children 2010–2022* highlights that violence against women does not occur in isolation from other issues faced by individuals and communities. For example, evidence shows that:

- domestic and family violence are notable risk factors for child abuse and neglect (AIHW 2005)
- a common reason people give for seeking assistance from government-funded homelessness services is domestic or family violence (AIHW et al. 2005; AIHW 2012)

- overcrowding in remote Aboriginal and Torres Strait Islander communities can contribute to high rates of domestic and family violence (AIHW 2006).

Strategy 4.3 of the plan highlights the need for mainstream services to identify and respond to needs and includes a key action item to ‘improve early identification of violence against women through routine home visits and screening tools for antenatal, maternal and child health services’.

The plan outlines strategies for addressing DV and highlights that the evidence base will be improved through jurisdictional commitment to a national data collection and reporting framework. In the long term, the aim is to create nationally consistent data definitions and collection methods. The Australian Bureau of Statistics (ABS) is assisting with this work (see below) and a data framework is proposed to be operational by 2022. In the interim, surveys such as the PSS and the National Community Attitudes Survey will be used to monitor the success of the plan.

Over time, as data collection improves and becomes more consistent, new sources of data will become available. The proposal to collect data in the NPDC could therefore be considered as part of the longer term plan to collect nationally consistent data on DV experienced by pregnant women.

Building the evidence base as part of the *National Plan to Reduce Violence against Women and their Children 2010–2022*

The ABS has released a series of supporting documents to help improve the evidence base and information available on DV. Its work is designed to support research, policy development, operational decision making, service providers, education and community awareness activities into the future. A strong research base is fundamental in understanding how to best address DV and can inform attitudes, legal directions, development of best practice and effective and appropriate responses to DV (ABS 2013a).

The following ABS publications (see Appendix G for publication links) set out a national data agenda for understanding and responding to DV and provide the foundation for building better DV data:

- Defining the data challenge for family, domestic and sexual violence (ABS 2013a)
- Bridging the data gaps for family, domestic and sexual violence (ABS 2013b)
- Foundation for a national data collection and reporting framework (DCRF) for family, domestic and sexual violence Australia (ABS 2014).

The above publications advise that the use of both survey and administrative data would be needed to obtain a comprehensive picture of family, domestic and sexual violence in Australia. The focus of the first two publications is on realising the potential of administrative information – by refining data collection activities and ensuring data items are collected in a consistent and comparable manner – for more robust reporting and a more flexible evidence base (ABS 2014). The final publication builds on information presented in the earlier papers and outlines a data collection and reporting framework that identifies key data items for collection in administrative data sets. Pregnancy status is one such item. That is, the ABS publications specify pregnant women and women with children as a specific population of interest for DV data.

The NPDC is an administrative data set that could be further considered for collecting data on DV in pregnancy because, in contrast to surveys (which are often expensive to run), the NPDC routinely collects data on all pregnant women who use perinatal services.

Administrative data has some limitations (for example, there will always be women who never report DV to official agencies or do not attend perinatal services). But it can also provide considerable benefits as it uses existing infrastructure, can be timely, is available for smaller geographic areas, and has the potential to yield information about specific target populations. Increasing the usefulness of administrative data is crucial in light of current fiscal demands and it also has potential to provide data in between survey periods (ABS 2013a).

Jurisdictional initiatives

Most state and territory jurisdictions have guidelines, strategies or legislation in place to assist in dealing with violence against women and children. Appendix E provides further detail on relevant jurisdictional documents. Some jurisdictional guidelines recommend routine screening for DV in pregnancy and provide midwives with specific questions to ask or strategies for a general approach. Most jurisdictions have a multiple agency response, where services are integrated and information is shared across a number of bodies. For example, the Victorian Family Violence Database requires multiple agencies (including police, hospital, helplines, courts and tribunals) to share their data with the Victorian Department of Justice, which then compiles and releases the information as a comprehensive report. Data on whether the individual was pregnant at the time of the incident are collected in the database (ABS 2013a).

3 Definitions of domestic violence and screening

Screening for DV involves two distinct concepts (that is, screening *and* DV). This chapter discusses some challenges around terminology, and definitions that need to be considered before any potential scope of national measurement for DV in pregnancy could begin. The collection and national standardisation of a data item to screen for DV in pregnancy firstly requires agreement on what constitutes DV and what constitutes screening.

3.1 What is domestic violence?

The term ‘domestic violence’ covers a wide range of abusive and controlling behaviours that can also constitute criminal acts. There is no single nationally or internationally agreed definition as to what constitutes DV; it is complex (and multi-dimensional) in nature and the responses developed to it over time have led to a variety of definitions. However, the *National Plan to Reduce Violence against Women and their Children 2010–2022* (COAG 2011:2) indicates that ‘the central element of domestic violence is an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children’. A key challenge in defining and measuring DV lies in the complexity of the behaviours involved and the relationships or situations in which such acts occur.

There are a number of categories that define the different contexts in which DV can occur and a range of behaviours or actions that constitute DV. To capture these, DV categories can include physical abuse, emotional abuse, verbal abuse, social abuse, economic abuse, sexual abuse or spiritual abuse. Some categories such as emotional, verbal, economic and/or spiritual abuse are sometimes referred to collectively as psychological abuse.

While the *National Plan to Reduce Violence against Women and their Children 2010–2022* provides a comprehensive definition of DV (see Appendix H), including three categories of DV – physical, sexual, and psychological and emotional abuse – O’Reilly (2007) breaks down the different categories in greater detail, and provides examples of behaviours that constitute DV. These examples are outlined in Table 3.1.

Table 3.1: Categories for defining domestic violence

Category	Examples
Physical abuse	Direct assaults on the body, use of weapons, destruction of property, abuse of pets in front of family members, assault of children, locking the victim out of the house, and sleep deprivation
Sexual abuse	Sexual activity without consent, causing pain during sex, assaulting genitals, coercive sex without protection against pregnancy or sexually transmitted disease, making the victim perform sexual acts unwillingly
Emotional abuse	Blaming the victim for all problems in the relationship, constantly comparing the victim with others to undermine self-esteem and self-worth, sporadic sulking, withdrawing all interest and engagement (for example, weeks of silence)
Verbal abuse	Continual ‘put downs’ and humiliation, with attacks following clear themes that focus on intelligence, sexuality, body image and capacity as a parent and spouse

(continued)

Table 3.1 (continued): Categories for defining domestic violence

Category	Examples
Social abuse	Systematic isolation from family and friends by ongoing rudeness to family and friends, moving to locations where the victim knows nobody, and forbidding or physically preventing the victim from going out and meeting people
Economic abuse	Complete control of all monies, no access to bank accounts, providing only an inadequate 'allowance'
Spiritual abuse	Denying access to ceremonies, land or family, preventing religious observance, forcing victims to do things against their beliefs, denigration of cultural background, or using religious teachings or cultural tradition as a reason for violence

Various definitions of DV are used nationwide because DV can be described in many different ways. The term 'domestic violence' may also be referred to as 'intimate partner abuse', 'intimate partner violence' or 'family violence'. Some organisations and researchers differentiate between family and domestic violence on the basis of cohabitation. For example, some family DV legislation defines 'family' in terms of interpersonal relationships that do not necessarily require the victim and offender to cohabit, whereas 'domestic' is defined in terms of living arrangements and includes relationships where two or more people live together (ABS 2009).

While these terms and definitions include different elements, they may be used interchangeably across relevant laws in each state and territory. Laws in each jurisdiction have their own definitions and reporting requirements; however, the types of conduct that constitute DV are generally similar (AGS 2009). Appendix E provides some further detail on jurisdictional legislation.

Given the number of different categories of DV, it is unrealistic to expect that the NPDC could collect data on the different types of DV that women might experience; however, it could collect data on whether any DV had been disclosed as a result of screening. Regardless of what data element is included in the NPDC, a definition of DV needs to be provided. Without this, definitions of DV will vary state by state and possibly even by different health services/clinics within jurisdictions.

Recommended definition of DV in the NPDC

The Screening for DV Working Party considered whether a definition of DV in the NPDC should refer to specific types of violence (for example, physical and/or emotional violence only) or be more general. After reviewing some specific and broad definitions, the working party supported a broad definition. A broad definition provides some flexibility for different screening practices (if flexible practices are deemed appropriate for a national data collection – see Chapter 7 for more information) and it also allows for potential capture of different types of violence. The following definition was adapted from the *National Plan to Reduce Violence against Women and their Children 2010–2022* (COAG 2011:2) and was agreed to by the working party as being suitable for the NPDC:

Domestic violence refers to acts of violence that occur between people who have, or have had, an intimate relationship. The central element is a pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent or by threatening any act that might cause harm or suffering. Domestic violence can include physical, sexual, emotional or psychological abuse.

Elements of the above definition the working party thought important were:

- limiting the definition to violence by a partner or ex-partner because it is:
 - consistent with the *National Plan to Reduce Violence Against Women and their Children*
 - consistent with most screening tools used in pregnancy
 - consistent with research indicating partners and ex-partners are the most common perpetrators of violence in pregnancy
 - more manageable both in terms of asking questions and recording consistent responses
- including threats of violence because threats can:
 - increase cortisol levels, which can have a negative impact on women's and babies' health outcomes.

If a national standard is developed for an item in the NPDC on *Screening for Domestic Violence* (see Chapter 7 for more detail), a definition of DV such the one proposed above would need to be included. Mindful of the proposed definition and the focus on violence between intimate partners, DV is referred to throughout this paper as violence perpetrated by someone against a current or previous intimate partner. This is often referred to as intimate partner violence (or IPV).

3.2 What is screening?

Screening has historically been used in the area of health to detect the underlying presence of disease, so that it can be prevented or at least treated. Screening therefore has its origins in a biomedical model of health care whereas DV is a complex social problem. Managing DV using approaches employed to treat or cure disease may therefore not be appropriate (Feder et al. 2009; Taft et al. 2001). For the purposes of this paper, screening is defined as a process by which an organisation or professional attempts to identify victims of violence or abuse in order to offer interventions that can lead to beneficial outcomes.

Screening for DV typically occurs when a client is asked a series of questions that seek to determine if that person is experiencing, or is at risk of, violence in their intimate relationship. Screening may consist of a few short open-ended questions that a clinician asks the patient. It can also be facilitated by the use of forms or other assessment tools. A screening tool can help to identify the presence of DV and is usually a carefully devised, standardised list of questions that elicit a history of the client's relationship with her partner and any features that may indicate that a woman is at risk of violence from her partner. DV screening is most commonly conducted in health settings and with women only. If a woman screens positively for DV, a screening assessment would normally be undertaken to identify resources and referrals most appropriate to her circumstances (Braaf & Sneddon 2007).

Concepts of screening, identification, assessment and referral

Identification, assessment and referral are separate concepts to screening. The following definitions are useful to consider for each concept:

- Screening refers to a systematic process that involves *asking about DV* to enable the identification of victims of DV in order to take further action or intervention. Routine screening implies that *all* clients attending a service should be asked questions related to the existence of DV, regardless of whether it is suspected or not (Braaf & Sneddon 2007). (Note: 'Being screened' is different from 'being screened positive'.)

- Identification refers to the *presence of DV* in a victim's life; that is, screening positive for DV. 'Disclosure' is an alternative term to 'identification'.
- Assessment (or risk assessment) refers to efforts to *assess the degree of harm* or injury likely to occur as a result of past, present or future DV. That is, risk assessment is more thorough than screening; it is the process of identifying the presence of risk factors and determining the likelihood of an adverse event occurring, its consequence, and its timing (Braaf & Sneddon 2007).
- Referral is a desirable outcome if a woman is screened positive for DV. That is, referral occurs when a woman is *referred to another service* for further help in addressing her situation.

A difficulty sometimes arises in assessing the literature when these concepts are mixed. Robinson and Maloney (2010) highlight that the literature in relation to 'screening for DV' and 'assessment of DV' often conflates screening and assessment processes. That is, the terms 'screening' and 'assessment' are often used interchangeably when they really reflect different processes. Consequently, there is sometimes a lack of distinction between screening and assessment in some tools. It is therefore important to keep the above definitions in mind when considering what items could be collected in the NPDC. (Chapter 7 provides more detail on NPDC data item options.)

If midwives are already conducting routine screening and identifying women at risk, presumably they are also assessing and referring women if needed, in which case it may be relatively easy to collect some information for the NPDC. Chapter 7 discusses how data development might proceed; however, this chapter has highlighted that when considering the proposed data item *Screening for Domestic Violence*, it is necessary to consider what is meant by both 'domestic violence' and 'screening', and to be aware of the separate but interrelated concepts of screening, identification, assessment and referral.

4 Literature review to identify issues in screening for domestic violence

This chapter reviews literature associated with screening for DV and examines some issues that will be necessary to consider in evaluating whether national screening data should be included in the NPDC. This chapter reviews issues such as:

- why pregnancy is an important time to screen for DV
- why routine screening is important
- whether routine screening works
- screening tools and methods
- timing and frequency of screening
- coexistence of mental health disorders and substance misuse.

It is important to note when reading this literature review that the use of the term ‘screening’ in the literature on DV is inconsistent (as discussed in Chapter 3). Clear distinctions are not always made between screening tools and programs, or between screening and its other associated outcomes. For example, the word ‘screening’ is often used to refer to either screening tests, the administration of screening tests or screening programs, as well as for identifying DV or for assessment and referral for DV. For any data item(s) being considered for inclusion in the NPDC it will be necessary to define screening and how it differs from other closely related concepts. However, in terms of the literature reviewed in this chapter, the distinctions between screening and related concepts are not always explicit.

4.1 Why pregnancy is an important time to screen

While both women and men can be perpetrators and/or victims of DV, statistics and research overwhelmingly show that the majority of incidents are perpetrated by men against women and children (AIC 2009). Screening for DV in health-care settings that specifically target women and children therefore provides an opportunity to identify DV. Professionals working in perinatal and maternal and child health services can play a critical role in early intervention by identifying DV and referring women and children appropriately (American College of Obstetricians and Gynecologists 2012; Gazmararian et al. 1996).

Pregnancy has been identified as both a potential protective factor and a risk factor for DV. For some women, DV may begin or intensify during pregnancy, whereas other women may experience a reprieve from abuse during pregnancy (Campbell 2004; Campbell et al. 2004). While women of all ages can experience DV, some research suggests it is most prevalent among reproductive-age women (Devi 2012) and that the risks of DV are higher in pregnant women and in the period following birth (Gazmararian et al. 1996; Taft A 2002; WHO 2000). Violence poses serious health risks to pregnant women (including breast and genital injury, miscarriage, antepartum haemorrhage and infection, blunt or penetrating abdominal trauma, and death) and babies (including fetal fractures, low birthweight, injury, suppressed immune system) (Walsh 2008). Women exposed to violence during pregnancy are more likely to have a miscarriage, stillbirth, premature birth or termination of pregnancy (Taft et al. 2004) and are also more likely to develop depression in the postnatal period (Bacchus et al. 2003; Mezey et al. 2005; Woolhouse et al. 2011). DV can also have other implications for maternal mental health, can be associated with maternal death (both inflicted and

self-inflicted), and can have an impact on a baby's health and survival. Babies born to women who have experienced violence are at greater risk of lower birthweight, illness, premature birth and death in the months following birth (Nelson et al. 2012a; Victorian Department of Human Services 2012). DV can also affect women's reproductive health and lead to gynaecological disorders, unwanted pregnancy, premature labour and birth, as well as sexually transmitted diseases and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) (WHO 2002). There is also some evidence that some perpetrators may specifically target the fetus, using physical violence aimed at their partner's abdominal area, genitals and breasts (Victorian Department of Human Services 2012).

In Victoria, research using the burden of disease methodology shows that the impact of DV on total disease burden is highest among women aged under 45 (Vos et al. 2006). When physical and sexual violence occurred within the context of an intimate relationship, this accounted for 7.9% of the total disease burden for women aged under 45 (compared with 1.5% for women aged over 45, or 2.9% for women of all ages).

Given that the NPDC is a collection predominantly aimed at women in the highest risk age range (15–44 years) and that risks can further increase during pregnancy, the inclusion of data on *Screening for Domestic Violence* is worthy of consideration.

Prevalence

Violence during pregnancy has been noted as a serious public health problem; however, the prevalence of DV (both during and outside of pregnancy) is difficult to determine. Many factors make it difficult to obtain true estimates. Estimates are often based on women's self-report of DV, which requires appropriate disclosure of DV occurrence. Research in developed countries, including Australia, suggests that prevalence rates among pregnant women, based on women's self-report during screening, may be as high as 20% (Gazmararian et al. 1996; Walsh 2008). Rates are possibly even higher when considering that under-reporting and under-recording are highly likely. As well, reliable prevalence rates are difficult to estimate due to inconsistencies in definitions of DV, the measures used, populations sampled, and the ways in which data are collected and by whom.

International research indicates prevalence rate estimates may vary between subpopulations (for example, socioeconomic status, age, geographical location) but the findings are not consistent as some studies show DV occurs within all socioeconomic, age and ethnic groups (Jasinski 2004). However, some differences in the number of women reporting DV during pregnancy would be expected due to the differing measures used and the frequency and timing of screening. For example, the proportion of women who reported experiencing DV during pregnancy has been found to be lower in some private clinics where clients are mostly older married women of high socioeconomic status who are assessed using only one broad question. Conversely, a higher proportion of women who reported experiencing DV during pregnancy has been identified in studies that ask about DV more than once, or ask later in the pregnancy (for example, in the third trimester) (Gazmararian et al. 1996).

In Australia, there are limited national data on the prevalence of DV experienced by women and very limited data for pregnant women. However, three previous ABS surveys have collected some data on DV and pregnancy:

- Women's Safety Survey (WSS) (1996)
- PSS (2005)
- PSS (2012).

Based on the 2012 PSS, the ABS estimates that 17% (1,479,900) of all women (aged 18 and over) had experienced partner violence (that is, either physical or sexual assault or threat from either a current or previous partner) since the age of 15.

The 2012 PSS provides the following statistics for previous partner violence and current partner violence in relation to pregnancy status:

- In terms of previous partner violence, approximately 768,800 (of the 1,267,200 women who experienced violence by a previous partner) were pregnant at some time during the relationship with their most recently violent previous partner. Of these, 54% (414,600) of women were pregnant at the time of the violence. Twenty-five per cent (25%) (195,500) reported that violence occurred for the first time during the pregnancy.
- In terms of current partner violence, approximately 180,600 (of the 237,100 women who experienced violence by a current partner) were pregnant at some time during the relationship. Of these, 22% (39,100) of women were pregnant at the time of the violence. Thirteen per cent (13%) (24,000) reported that violence occurred for the first time during pregnancy (these data have a relative standard error of between 25% and 50% and should be used with caution).

Data from the 2012 PSS can be compared with similar data from the 2005 PSS and the 1996 WSS (Table 4.1).

Table 4.1: Summary of violence in pregnancy data from ABS surveys

	1996 WSS ^(a)		2005 PSS ^(a)		2012 PSS ^(a)	
	Previous partner ^(b)	Current partner ^(c)	Previous partner ^(b)	Current partner	Previous partner ^(b)	Current partner
Experienced violence from a previous or current partner	1,080,800	n.a.*	1,135,500	160,100	1,267,200 ^(d)	237,100 ^(d)
	16%	n.a.	15%	2%	15%	3%
Total no. of women aged 18 and over	6,880,500	n.a.	7,693,100	7,693,100	8,735,400	8,735,400
Women who experienced violence from a previous or current partner who were pregnant at the time of the violence	292,100	n.a.	239,800	18,300	414,600	39,100
	42%	n.a.	36%	15% ^(e)	54%	22%
Women who reported that violence from a previous or current partner occurred for the first time during pregnancy	140,300	n.a.	112,000	8,800	195,500	24,000
	20%	n.a.	17%	7% ^(e)	25%	13% ^(e)
Total no. of women who were pregnant at some time during the relationship with the violent partner	701,200	n.a.	667,900	125,500	768,800	180,600

* not applicable

(a) Women who experienced violence by a female partner are not included in the pregnancy data for WSS 1996 but are included for PSS 2005 and PSS 2012. The impact on the results is negligible.

(b) Most recently violent previous partner.

(c) In the 1996 WSS, questions were asked about current partners but data were not published due to uncertainty around small estimates.

(d) The sum of the components for current and previous partner violence is higher than the total of 1,479,900 reported in text above the table, because women may have experienced violence from both a current and previous partner but are counted only once in the total.

(e) These estimates have a relative standard error of 25–50%.

Sources: ABS 1996, 2006, 2013c.

Based on data derived from the 2012 PSS, a prevalence rate for women (aged 18 and over) experiencing violence during pregnancy from their previous or current partner is estimated to be in the order of 5%, though, as indicated above, it is important to remember that the data are based on self-report and may not represent true prevalence. The ABS surveys are useful in providing some general prevalence data, but provide only limited data specific to pregnancy. A further limitation of the survey data is that DV cannot be examined in relation to other aspects of women's health and care during pregnancy, or for that of their babies. This paper therefore examines why routine screening is important and why collecting data in the NPDC should be considered.

Few data are available on DV during pregnancy in Indigenous populations. However, the NSW Bureau of Crime Statistics and Research reported that Indigenous women are vastly over-represented as victims of DV, with the rate of DV for Indigenous women (3,275 per 100,000) being almost 6 times higher than that for non-Indigenous women (544 per 100,000) between 2001 and 2010 (Grech & Burgess 2011). Further, the Aboriginal Families Study (a population-based survey of mothers of Aboriginal babies giving birth in South Australia between July 2011 and June 2013) identified that of the 344 mothers participating in the study 27% had left their home during pregnancy because of a family argument or fight and 16% reported that they had been pushed, shoved or assaulted during pregnancy (Brown et al. 2015).

4.2 Screening benefits and effectiveness

For a range of complex reasons such as fear, shame, embarrassment or cultural barriers, many victims of DV do not seek early help when they experience violence. However, during pregnancy, abused women usually meet health-care professionals on a regular basis. This affords an opportunity to offer advice, help and protection to these women. Routine screening of all women in health-care settings can identify women at risk and lead to interventions that aim to reduce violence and improve health outcomes. If appropriate referral pathways are available, clinicians can encourage women to seek further help.

Some victims might not recognise or identify themselves as victims of DV, and may come to the attention of service providers only when they or their children are seriously harmed. It is often the case that victims have had contact with a range of mainstream community agencies that, had these agencies known about the violence, could have offered the victim support and safety through their own resources or through referral to a DV service, before the situation escalated and serious harm occurred. Routine screening provides opportunities to engage with and help vulnerable and/or marginalised groups of women.

As DV is under-identified by health workers and under-documented in medical records, the practice of routinely asking questions regarding women's experience of violence by a partner or ex-partner is increasingly being promoted and used in health-care settings (Laing 2003; NSW Health 2004). Screening for DV by health-care professionals is generally acceptable to women under conditions that are perceived as private and safe and when women are asked questions in a comfortable manner, although there is no consensus about the optimal screening setting or method (Feder et al. 2009; Nelson et al. 2012b). Direct questioning has been introduced in clinical settings in the United Kingdom and the United States, as well as in some Australian jurisdictions (NSW Health 2004).

While the benefits of screening may vary, any potential adverse effects have only a minimal effect on most women (Nelson et al. 2012b). Even if women choose not to accept help, the delivery of screening questions by trained workers can break the silence, reduce isolation,

increase the sense of support and send a message that abuse is wrong, that it can adversely affect a woman's health, and that something can be done (Chang et al. 2010; NSW Health 2004). Screening can add to the level of burden for staff, but its benefits are accepted by them; screening increases responsiveness to DV through:

- heightened alertness to DV
- enhanced understanding of the links between DV and specific health problems
- a greater sense of providing comprehensive care when DV is addressed
- increased capacity to make appropriate referrals (Spangaro et al. 2011a).

Whether routine (as opposed to targeted or ad hoc) screening for DV is effective in improving health outcomes – and hence whether it should be done – is debated. Some older research suggested the available evidence was insufficient to support routine screening (Ramsay et al. 2002); however, more recent research concludes that screening instruments can accurately identify women experiencing DV and that screening can provide benefits. A review of 36 studies on intimate partner violence screening in health-care settings by Nelson et al. (2012b) concluded that there are effective screening tools; that screening tools do not cause any serious harm; and that some interventions, primarily for pregnant or post-partum women, have had positive results. However, the outcomes of screening for DV are not easy to evaluate. Even if women do not take action immediately, screening may help initiate thoughts of change by discussing the abuse (Laing 2003).

While evidence to support the use of routine DV screening to improve outcomes for women is limited (Feder et al. 2009; Nelson et al. 2004; Ramsay et al. 2002; Wathen & MacMillan 2003), DV screening and clinical practice guidelines have been widely introduced into health-care settings. There is evidence in some settings that routine screening for DV, carried out in the course of intake or initial needs assessments, results in victims being identified who have not previously been identified as (or recognised themselves to be) victims of DV (Braaf & Sneddon 2007). While routine screening may not always improve women's outcomes, there is evidence that screening by health professionals during pregnancy does lead to higher rates of disclosure and increases the identification of DV (NSW Health 2004; O'Reilly et al. 2010). NSW Health found substantial increases in disclosures after introducing screening, including those made by many patients who agreed to some form of assistance (NSW 2004). However, whether screening and intervention ultimately lead to improved outcomes for women identified as abused is less well established and difficult to determine (Ramsay et al. 2002).

Any benefits of routine screening may not be sufficiently substantial to justify the associated costs and uncertain outcomes. For example, barriers to screening and to the likelihood that women will respond openly include a lack of privacy in clinical settings, staff time constraints, no after-hours social work services for referrals, reluctance of health-care providers to screen, and health-care workers' frustration either when women remain unsafe or if they do not realise that early access to prenatal care has been blocked by the woman's partner (Roush 2012; Spangaro et al. 2011a; Titus 1996).

If appropriate referral pathways are not present, this can also place health-care workers who do screening in a difficult position. Greater focus needs to be placed on ensuring that the health system is able to respond appropriately to women's disclosures of DV. Poor responses can jeopardise women's safety and can lead to re-victimisation, stigmatisation or feelings of hopelessness (Taft 2002). For screening to be successful, there needs to be more emphasis on training for health professionals who conduct the screening; this may involve intensive educational efforts, rather than just the production and distribution of guidelines

(Titus 1996). Such training can be expensive and may be related to why some jurisdictions perform only targeted screening – that is, if there is reason to suspect DV (whereas other jurisdictions recommend that screening be conducted for everyone regardless of whether anything is suspected).

Some additional vulnerabilities that women might experience in pregnancy and early motherhood which may affect their propensity to report include:

- perceived or actual inability to protect themselves and their children from harm (Van Hook 2000)
- fears about changes in financial circumstances (Fugate et al. 2005)
- fears about losing access to their child because of the involvement of Child Protection (a factor that may be particularly problematic for Aboriginal and Torres Strait Islander women who may already be sensitive to the removal of children due to historical factors, the intervention and other social problems) (Laing 2003; Spangaro et al. 2011b)
- lack of safe accommodation options appropriate to an infant or young child (Fugate et al. 2005)
- desire to maintain the child's connection with its father (Fogarty et al. 2002).

While the benefits for routine screening of women across all health-care settings are debated, there is good evidence to suggest that within the perinatal context the benefits may be greater. Based on recent reviews, there are now recommendations in the United States that all pregnant women be screened for intimate partner violence. In 2012, the United States Department of Health and Human Services and the American College of Obstetricians and Gynaecologists recommended that all pregnant women be screened at the first prenatal visit, at least once per trimester, and at the postpartum check-up. In 2013, the United States Preventive Services Task Force also made a recommendation that supports screening of all women of childbearing age for DV. The task force is an independent group of national experts in prevention that make evidence-based recommendations about clinical preventive services such as screenings; its recommendations are widely accepted in the United States medical community (Agency for Healthcare Research and Quality 2007). This recent recommendation was important in that it updated a 2004 task force determination which, at the time, found insufficient evidence to conduct universal intimate partner violence screening. The task force's 2013 recommendation, however, concluded with moderate certainty that intimate partner violence screening for women of childbearing age has a moderate net benefit.

One of the reviews (Nelson et al. 2012b) on which the task force's 2013 recommendation was based looked at evidence related to interventions (that is, responses provided by the clinician or by a different service provider after a women discloses abuse) as a result of screening. The review included six studies that showed evidence that an intervention had a positive effect on reducing exposure to intimate partner violence, physical or mental harms, or mortality (Bair-Merritt et al. 2010; El-Mohandes et al. 2011; Kiely et al. 2010; McFarlane et al. 2006; Miller et al. 2011; Taft et al., 2009). Five of these six studies conducted interventions that targeted pregnant and postpartum women and found modest improvements, including fewer episodes of intimate partner violence, reduction in reproductive coercion, and improved child gestational age and birthweight (Bair-Merritt et al. 2010; El-Mohandes et al. 2011; Kiely et al. 2010; Miller et al. 2011; Taft et al. 2009).

4.3 Screening tools and methods

Screening instruments can accurately identify women experiencing DV (Feder et al. 2009; Nelson et al. 2012b); however, the best method of screening is debated. Some studies find regular face-to-face screening of women by skilled health-care providers greatly increases the detection of DV, whereas others show that self-administered questionnaires (written, audio or computer-based) may be superior (Canterino et al. 1999; Nelson et al. 2012b; O'Reilly et al. 2010). That is, there are differences in the reporting of DV when screening is conducted in person compared with when women complete self-administered questionnaires. Further evaluation of the accuracy, as well as the efficiency and acceptability, of screening methods for DV may be needed to improve screening processes (Nelson et al. 2012b). Variations in collection methods across jurisdictions have the potential to further affect data quality at the national level.

A barrier to early identification and responses to DV may occur if there are no common or coordinated tools and practices within a jurisdiction to assist agencies to conduct simple screening of women who have sought their services for reasons other than DV. While some jurisdictions have common screening tools designed for use across health (and other) settings, others do not. The use of varied data collection methods (for example, when different screening tools are used in different jurisdictions) has implications for data quality in the NPDC.

The length of the screening tools currently in use varies and the evidence is mixed on whether a shorter or a longer screening tool is better. However, using only a single item does not consistently identify victims (Rabin et al. 2009). For routine screening, some clinicians prefer, for practical reasons, an initial screen with only 1–3 questions; however, some screening tools contain 5–10 questions (Fogarty et al. 2002). In addition, health professionals must frame their questions carefully because women who experience DV often are hesitant to acknowledge it. Therefore, the wording of the questions can be important and it may need to be considered whether broad or more specific questions, or a combination of both, are required. The next chapter reviews some screening tools currently in use, and Chapter 7 reviews potential measurement tools and screening approaches including flexible and structured methods.

4.4 Timing and frequency of screening

Differences in the proportion of women reporting that they have experienced DV during pregnancy (see 'Prevalence' in Section 4.1) suggest that it is important to consider the frequency and timing of screening as well as the number of questions used (Gazmararian et al. 1996). Some jurisdictions screen for DV at the first antenatal visit only but this may not be the ideal time as some research suggests that a woman is more likely to report DV after a few visits, rather than on the first visit. While some research suggests a single screening later in pregnancy might be sufficient, other research suggests screening should be conducted at multiple points during pregnancy (Chalfin et al. 2012). Although some patients may not be ready to discuss their situation the first, second or even third time they are asked, consistent screening lets the patient know the provider is concerned and that help is available (Chalfin et al. 2012). Advocates of multiple screening suggest that screening should occur at the first antenatal visit, at least once per trimester, and at the postpartum check-up (American College of Obstetricians and Gynecologists 2012).

The *Clinical practice care guidelines: antenatal care – module 1* (AHMAC 2012) recommend screening at the first antenatal visit. However, they also mention that discussion of DV

requires rapport between the health professional and the woman. Therefore, women who are experiencing abuse may not speak up when the subject is first raised but may choose to open up later when they feel sufficient trust and confidence in the health professional. Spangaro et al. (2011b) identified that continuity of care in antenatal services may contribute to increased trust and disclosure during follow-up care. The likelihood of reporting DV at subsequent visits may therefore be higher and is something that midwives should keep in mind.

For pregnant or parenting adolescents, multiple screenings may be even more important because pregnancy and the postpartum period are times of higher rates of abuse for this group (Chalfin et al. 2012). Adolescent parents are more likely to have a history of DV than older parents and they have a higher risk of experiencing DV in the future. Efforts to prevent DV and to intervene early should be an integral part of all adolescent medical care (Chalfin et al. 2012).

4.5 Coexistence of DV and multiple psychosocial factors

This section touches upon the prevalence of partner violence during pregnancy; however there is little research to shed light on the independent contribution that DV makes to mental health disorders or substance misuse. Historically, explanations for and responses to women's mental ill health have been shaped by explanations that lie within the women themselves rather than with the partners who abuse them. However, more recently, the direction of the association between DV, mental health and substance use has been re-examined, with social and familial factors that contribute to mental health disorders (such as depression) being given greater prominence (Taft 2003).

Discovering the relationship between DV and mental health disorders can be very difficult. As well as the varying definitions of DV, there are also inconsistent definitions of mental health and wellbeing internationally. Comparing rates of DV and mental health disorders in women across the world is problematic as government agencies and researchers in different countries understand, measure and collect DV data differently. Women themselves also understand and disclose partner abuse differently (Fischbach & Herbert 1997; Taft 2003).

Despite the limitations, Golding (1999) conducted a meta-analysis of intimate partner violence studies to examine its contribution to women's risk of mental health disorders. Golding limited the analysis to studies of physical abuse and did not include violence between same-sex couples or pregnant women, as these have additional stressors. Strong evidence was found linking DV to women's mental health, including impacts such as depression, suicidal tendencies, post-traumatic stress disorder and drug and alcohol misuse. For example, just under half (47.6%) of all abused women suffered from clinical depression compared with 10% to 20% of women in the overall community. Abused women were 3 times as likely as non-abused women overall to be diagnosed as depressed (Golding 1999, as cited by Taft 2003). In addition, the longer women were away from abuse, the greater the decline in their depression, demonstrating a close association. Five studies indicated that the more severe the abuse, the more severe the depression, illustrating the dependent relationship between the length of time a woman experiences abuse, its severity, and the subsequent degree of impact on her mental health (Taft 2003). Golding (1999) also found that victimised women were almost 6 times more likely than non-abused women to misuse alcohol: 18.5% per cent of women who had experienced DV misused alcohol compared with between 4.6% to 8.2% in the general community. Almost 9% of abused women misused licit

or illicit drugs and were 5.5 times more likely to do so than other women (Golding 1999, as cited by Taft 2003).

Other more recent research also shows that the severe and prolonged stress caused by intimate partner violence can be detrimental to mental health. Recent studies confirm that it is a major risk factor for depression, deliberate self-harm, and suicide (Jaquier et al. 2013; Pico-Alfonso et al. 2006; Van Dulmen et al. 2012) and is also correlated with alcohol and drug abuse (Lipsky et al. 2005). Chapters 5 and 8 of this paper further discuss whether mental health, alcohol and substance use should be considered for data development together with *Screening for Domestic Violence* in order to provide a clearer national picture on the contribution of each of these psychosocial factors to the outcomes of mothers and their babies.

5 Domestic violence data and data collection

Data on DV in Australia are limited, and the way in which information is collected and reported is generally inconsistent. There are currently no nationally consistent administrative data sets that can be used to report on DV during pregnancy. Yet national data can be important for a range of reasons, including providing evidence on, or for:

- prevalence of conditions
- surveillance and monitoring
- health outcome measures
- service delivery planning and health system responses (such as planning prevention, intervention or operational responses)
- policy development and evaluation
- research
- international comparisons.

Variations in DV data across Australia are affected by differences in what is captured, counted and reported across jurisdictions. This chapter reviews some current data sources and notes the limitations of current data. It also outlines a number of data quality issues because there are some inherent data limitations, such as personal and institutional barriers, that reduce the extent to which DV is disclosed and reported. While this affects the capacity of data to accurately reflect the numbers of women and children who experience DV, some stakeholders view the data as important enough to consider how to collect the best data possible. This chapter therefore examines data gaps and limitations and then turns to how the NPDC could potentially fill some data gaps.

5.1 Data gaps

Australian data

There are extensive gaps in DV data in Australia, including for pregnant women, and the need for robust data collection to support prevention and early intervention services has been recognised. Over the longer term (as part of the *National Plan to Reduce Violence against Women and their Children 2010–2022*), there are plans to create nationally consistent data definitions, collection methods and reporting standards to build an evidence base (see Chapter 2 for more information).

This section reviews a number of current Australian data sources that contain some information on DV. Appendix F provides details of some relevant national surveys and administrative databases. In assessing whether existing data sources might be used to obtain data on *Screening for Domestic Violence* in pregnancy, the following points highlight why existing data are limited as sources of information on pregnant women exposed to DV and its consequences:

- None of the surveys or administrative data sets considered (see Appendix F) provide information on screening for DV – whether it was administered or taken up.

- Pregnant women are not usually identified in national surveys except in the ABS PSS. However, the PSS provides very limited data specific to pregnancy. (Appendix F provides information on two PSS items relevant to pregnancy.) The PSS is also unlikely to provide adequate sample sizes for generating reliable data for Aboriginal and Torres Strait Islander people or other specific subpopulations.
- Even where pregnancy can be identified, samples used in national surveys do not generally allow disaggregation below national geographic levels or particular population groups. Other surveys are limited in scope (for example, the National Drug Strategy Household Survey asks about violence only in the context of alcohol or drug influence).
- Pregnancy is generally not identified in administrative data sets, which are designed to capture information about a particular client base and the services offered and received. For example, the AIHW Specialist Homelessness Services Collection collects data on the reason for seeking assistance, including DV, but does not routinely record pregnancy. Jurisdictional police data and the national ABS Recorded Crime – Victims Collection may identify DV and sexual assault, but, again, a woman’s pregnancy status is not routinely collected or reported. As well, definitions vary across jurisdictions and even if pregnancy data were collected, the data cannot be aggregated into a national picture.
- Very few data sources provide information about outcomes for mother and baby where a mother has experienced DV. The National Hospital Morbidity Database (NHMD) can provide some information. However, admitted patient hospitalisation data capture only those at the severe end of the spectrum and are therefore only for a subset of women who experience DV in pregnancy. Appendix F provides further information on the NHMD data.
- Data linkage might be a means of connecting DV and health outcome information but the underlying quality and purpose of the data sets need to be considered and the purpose for the linkage and its benefits needs to be clearly identified.

International perinatal data collections

A basic search of some international PDCs, including in New Zealand, Sweden, United Kingdom, Scotland and Canada, reveals that data on DV do not appear to be routinely collected during pregnancy at a national level. However, some provincial or regional PDCs do collect data on violence during pregnancy. In 2006, Canada also conducted The Canadian Maternity Experiences Survey, which included 19 questions on physical and sexual violence. In summary, given the complexity of DV and the lack of national and international data on it, particularly for pregnant women, it is important to consider what role the NPDC might have in contributing to improving the evidence base. There appears to be no suitable alternative data source to the NPDC for collecting national data about DV in pregnancy and the outcomes for women and their babies.

5.2 Data quality

Data collection is challenging if it is to ensure that it is representative, accurate and broad enough to capture relevant factors, while also being focused enough to be useful. No single type of data collection method will provide a complete picture of DV. Individual studies and data sets all vary in depth and quality of information, and the strengths and weaknesses of any given data should be kept in mind when drawing conclusions and making recommendations (Braaf & Meyering 2013).

Some data limitations are discussed in Chapter 4; others were raised during NMDDP consultations with jurisdictions (see Appendix B). Data on DV does have considerable inherent limitations. The ABS publication *Defining the data challenge for family, domestic and sexual violence, Australia* (ABS 2013a) broadly outlines many of these limitations in other collections including (but not limited to):

- *under-reporting*: many incidents are not reported (to the police or other authorities) so the total number of victims is unable to be captured in any data set
- *hidden reporting*: this may occur where a victim seeks services, or reports an incident, but does not disclose DV as the reason for the contact
- *under-recording*: this can occur due to process and procedural variations in recording incidents by authorities or services
- *counting/recording rules*: in the health system, treatment for specific injuries may be recorded without recording the cause of the injury, thus not recording that DV may be the cause.

Data quality is also affected by a number of issues at the level of the patient, the health-care provider and health system. Many of these issues are difficult to overcome, and it is important to acknowledge that they will affect data quality. Common challenges faced in collecting DV data are, firstly, the ease with which midwives are able to ask multiple (or in-depth) questions and, secondly, that it may not even be possible to start screening if a partner is present. The factors outlined below should be considered.

Patient issues

Data collection can be affected by a patient's reluctance to report DV due to the following factors:

- partner or other relatives being present
- lack of relationship with health-care provider (for example, being asked too soon, such as on the first visit)
- perceived health system barriers such as disinterested or unsympathetic clinicians (including not being believed, poor communication, not feeling respected by the clinician), lack of clinician's time, lack of privacy in clinical settings and possible legal involvement
- fears around removal of children (which may be exacerbated if mandatory reporting is in place)
- social factors such as obligation to family/partner, lack of finances or future accommodation
- psychological factors such as fear, shame, embarrassment or cultural barriers.

Health-care provider issues

Data collection can be affected by the health-care provider's perception of their ability to respond to identified DV due to factors such as:

- lack of referral pathways or other health system responses
- increased burden on staff including time constraints, lack of appropriate training, lack of tools or resources

- the clinician's psychological factors such as fear of offending the patient, sense of powerlessness, loss of control or over-identification with the victim, discomfort or frustration if the clinician perceives that they cannot make a difference
- the clinician's attitudes such as a belief that the patient lacks initiative or will not admit to abuse, class or race-based prejudices, or prejudices about the patient being non-compliant
- fear of potential ramifications (possibly legal) if DV is detected and recorded in a data collection, and a subsequent serious incident involving the woman occurs.

System issues

Data collection can be affected by systemic factors such as:

- collection methods that can reduce reporting such as those that reduce eye contact between interviewer and client (for example, concentrating on a computer screen during collection may reduce engagement with the patient and inhibit likelihood to report)
- questions over whether electronic systems are the best place for storing DV screening questions and the best way to prompt and ask questions
- considerations over where data are best recorded/stored to protect privacy
- difficulties obtaining data from private hospitals
- constraints on space to add new items to PDC hard copy forms
- availability (or not) of data to the midwife at birth. Data for the PDC are usually collected during or soon after the birth episode; midwives draw upon available information sources (in addition to the mother) which may include a hospital computer system or medical records. If information about whether the woman was screened for DV is not available, the midwife may have no other option than to record 'unknown' to any screening question on a PDC form. Midwives would not be expected to screen the mother at the birth episode.

In summary, there are a number of data collection challenges and reporting issues due to the complex and sensitive nature of DV. Some collection challenges will always be difficult to overcome; nonetheless, collecting national data may be important enough to warrant consideration of how the NPDC might help to improve the evidence base for DV in Australia. The NPDC is an administrative by-product data set and a potential vehicle for obtaining some DV data for pregnant women. While data quality will inevitably be affected due to some inherent data limitations, societal and system changes can provide opportunities to improve DV data collection. For example, state and territory legislative changes, an increased focus on DV training for service providers and community awareness may all contribute to the level of reporting of incidents and the quality of the resulting data.

5.3 Potential role of the NPDC in filling data gaps

While there are challenges associated with obtaining quality data on DV (see above), the NPDC is a large data set (a census of mothers with about 300,000 records per year).

Importantly, these data can be collected by health-care providers who are in a position to routinely screen for and respond to DV during a period of increased risk for some women.

While NPDC data will be subject to many limitations outlined above, the NPDC may represent an opportunity for collecting data that may otherwise go unreported. For example, police (or other) data may predominantly capture cases of a more extreme nature only.

Routine screening during the antenatal period may therefore assist with under-reporting and/or hidden reporting because a pregnant woman experiencing DV may present to an antenatal service hoping to protect her unborn child and may thus be more likely to disclose her situation. An NPDC data item may also assist to address under-recording if there is an expectation of all jurisdictions that they will attempt to record data in a consistent manner for a national collection.

As outlined in the rationale for collecting DV data in the NPDC (see Chapter 1), the NPDC could contribute data about pregnant women who experience DV that may not be recorded in any other collection or survey and that:

- helps to identify high-risk groups
- allows patterns and trends between different geographic levels and subpopulations to be compared
- can be used for annual reporting to identify rates and patterns of DV in pregnancy
- is able to show that appropriate models of care are being provided to vulnerable women, as outlined in the NMSP.

Chapter 7 discusses some data item options that could be considered for *Screening for Domestic Violence* data in the NPDC that would enable the above analyses to be undertaken. As well as the above uses of the data, an additional and important use for NPDC data on DV is the ability to link DV data with other NPDC data. That is, it could be used to examine correlations between DV and other clinical characteristics or perinatal risk factors.

Analysing DV data with other NPDC data

Analysing DV data with other NPDC data, such as health outcomes data and potentially other psychosocial data (for example, mental health or substance abuse if such data were also included in the NPDC), would help to provide a more comprehensive picture of how DV is correlated with other clinical characteristics and perinatal risk factors.

The NPDC already collects data on some clinical characteristics and perinatal risk factors. Including DV data would provide opportunities to analyse and examine correlations between DV and other health inputs and outcomes. For example, low birthweight, premature labour and birth, miscarriage and haemorrhage have been identified as health outcomes that can be associated with DV, and national data on these factors are already included in the NPDC. The inclusion of DV data may help to better understand how such factors interact.

In the future, it is possible that the NPDC may also include items on maternal mental health, alcohol and substance abuse which, together with DV data, form what can be referred to as psychosocial data. Chapter 4 highlights that experiencing DV is correlated with mental health, alcohol and substance use issues. Importantly, mental health, alcohol and substance use are also items being considered by the NMDDP for future inclusion in the NPDC. Given associations between DV, mental health, alcohol and substance use, there are reasons to consider whether data development for these items should proceed independently or whether some of these items (which, when combined, can be referred to as psychosocial items) should be considered collectively during data development. There may be future possibilities for developing a psychosocial risk measure based on a combination of responses to each of these items; however, for this to be effective, how each item is developed before national standards are implemented needs to be considered (for more information on national standards, see Chapter 7).

For example, given the correlation between DV and mental health, it is important to consider what data on each of these items contribute to assessing outcomes. Without separately collecting DV and mental health data, the concepts may be confounded. While this paper looks only at issues relevant to DV data, it is worth considering whether data development for other psychosocial items should proceed independently or be developed in a way that allow data for each item to be used independently as well as in combination. (For example, an index could be developed using items in combination to make a psychosocial risk item.) There should also be some consistency in how national standards are developed for each psychosocial item if associations with women's outcomes are to be examined. For example, given the complex way in which psychosocial factors are identified and measured, if validated tools are required to measure one psychosocial item, they should also be required for other psychosocial items.

Mental health

Mental health has been identified as a priority area for data development as part of the NMDDP. Mental health is recognised as challenging for data development; however, the National Perinatal Epidemiology and Statistics Unit at the University of New South Wales has undertaken some preliminary work on mental health data that could be considered for inclusion in the NPDC. Consultations resulted in proposals for the following three mental health data items being recommended for the NPDC:

1. *Whether antenatal depression/anxiety screening was conducted*
Value domain: Yes/Not Offered/Declined/Unknown or not stated
This would measure the implementation of screening both locally and nationally, which would provide some sense of uptake of the National Perinatal Depression Initiative and enable the comparison of outcomes for women screened and not screened, and their babies.
2. *Whether additional follow up was recommended*
Value domain: Yes/No/Unknown or not stated
This is seen as a proxy for a result but does not require a particular screening tool to be used. Midwives can use a range of ways to identify mental health risk factors but this item has the potential to pick up whether there is a deviation from normal. Referral cannot be included because there is no way of knowing if women take up any recommended follow-up.
3. *Whether there is a presence or history of a mental health condition*
Value domain: Yes/No/Unknown or not stated
While there are some data quality issues for this as it would be a self-report, this is an important risk factor for perinatal mental health.

All of these items were seen as equally important and hence the items were not ranked. The proponents would like all three items to be included as, together, they present a better picture about risk.

The NMDDP Advisory Group agreed that the proposed mental health risk items are indicative of what could be implemented; however, some further work is needed to finalise the appropriate value domains. Definitions would also need to be developed. The items would require pilot testing in different settings to determine how practicable they are and the most appropriate response categories. There would also need to be some consideration and advice provided as to how this item would apply in instances where there is no antenatal care or where antenatal care is undertaken by different providers (for example, shared care and other non-hospital-based care).

Alcohol

There is currently no nationally standardised data item on alcohol use during pregnancy; however, this was identified as a priority area for data development as part of the NMDDP. While three jurisdictions (Tasmania, the Northern Territory and the Australian Capital Territory) currently collect some data in their PDCs, the information is not collected in a standard manner. There does, however, appear to be widespread data collection at the clinical level, with all jurisdictions including at least one question about alcohol consumption in their pregnancy hand-held records or electronic database.

Work remains to be done on developing a national standard set of data items to measure dose and frequency of prenatal alcohol usage. However, some work has been undertaken by the AIHW in recent years for other projects. For example, screening tools for alcohol use in pregnancy have been reviewed and there are strong arguments for their introduction into routine antenatal care. Outlined below is a summary of some of the findings of prior work:

- The AUDIT-C tool has been identified as a preferred data collection tool for gathering information on alcohol use in pregnancy. The AUDIT-C consists of 3 questions relating to consumption, dependence or alcohol-related problems and is recommended for international use in clinical settings. The AIHW is investigating options to explore the acceptability of the AUDIT-C among groups of midwives and pregnant women.
- Monitoring patterns of alcohol consumption in pregnancy using validated screening tools would provide essential information to researchers, clinicians and policy makers to help develop and implement appropriate responses to preventable conditions such as fetal alcohol spectrum disorders.

Further work is required to determine the level of information derived from a collection instrument that should be incorporated into the NPDC.

Substance use

Substance use has been identified as a priority area for data development as part of the NMDDP. However, before any data on substance use could be proposed for inclusion in the NPDC, many issues need to be explored. This work is planned for Stage 3 of the NMDDP.

This chapter has discussed data gaps and limitations as well as how the NPDC might contribute to filling some data gaps. There are clearly issues with collecting DV data for the NPDC in terms of availability of information and quality of data; however, there are also benefits in obtaining the best data possible. While DV data are challenging to accurately collect, many jurisdictions already screen and record some data outside the PDC. This paper next examines what DV data are currently collected and recorded in Australian jurisdictions.

6 Current situation for screening and reporting

Screening for DV is currently undertaken in some jurisdictions but different tools and measures are used across (and possibly sometimes within) jurisdictions. This chapter reviews the tools and measures currently in use for pregnancy. It also examines some collection and reporting issues that might have an impact on progress towards more nationally consistent data collection and reporting.

6.1 Review of screening tools/questions in use

This section examines screening questions currently in use and looks at whether the questions are specific to the maternal and child health setting and/or used in other settings (for example, other health collection areas). It is important to consider whether the screening process and questions need to be the same nationally in order for a screening item to be placed in the NPDC or whether state-based screening tools that can be used across multiple health collection settings might be sufficient.

Some jurisdictions have already invested in developing screening tools that they recommend be widely used in the relevant jurisdiction and may be reluctant to change to a national screening tool. However, other jurisdictions may agree to collect these data only if there is national consistency in the tools used and the data reported. This issue is discussed further in Chapter 8.

New South Wales

New South Wales policy documents indicate that all pregnant women should be routinely screened for DV, with questions being asked at the first antenatal visit. DV screening is also recommended in other health settings such as early childhood health services, mental health, and alcohol and other drugs services. The four target service streams of NSW Health's Domestic Violence Routine Screening use a common 2–4 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?

These questions also form part of the SafeStart psychosocial assessment (NSW Health 2009) and may be supplemented by 4 further questions about children. If the woman answers 'no' to the first 2 questions, no further questions are asked by health services. Responses to these questions are prompted by, and recorded in, an electronic system where available; however, there is no item in the New South Wales PDC.

The New South Wales antenatal care record, often referred to as the yellow card, does not include information on DV.

A 1-month snapshot of screening has been conducted in Local Health Districts each year since 2001 (NSW Health 2014) and is used to monitor the implementation of the NSW Health strategy Policy and Procedures for Identifying and Responding to Domestic Violence. The key findings are shown in Table 6.1.

Table 6.1: Key findings November 2013 1-month snapshot

Category	All services		Antenatal services	
	Number	Per cent	Number	Per cent
Eligible women who attended a participating service (all services)	25,602	100.0	6,352	100.0
Eligible women who were screened	14,940	59.6	5,664	89.2
Eligible women who were screened who were identified as having experienced domestic violence in the previous 12 months	826	5.5	181	3.2
Women who were identified who accepted an offer of assistance	219	26.5	34	18.8
Notifications or referrals (reports to Community Services, notifications to police, other) ^(a)	861	—	212 ^(b)	—

(a) Some women may have multiple referrals.

(b) A total of 102 were for 'support given and options discussed', 18 reports were made to Community Services, 4 notifications were made to police and 88 were for 'other referrals'.

Source: NSW Health 2014.

In the November 2013 data collection, 588 women declined to be screened in antenatal services. The reason most often given for not screening was 'presence of another person' (341; 58.0%). A further 237 women (40.0%) declined for 'other' reasons and 10 (2.0%) did not give a reason (NSW Health 2014).

Annual November data snapshots since 2003 for all participating services show that, while the number of eligible women has increased from 4,036 to 14,940, the proportion screened has remained relatively stable at around 66%; the proportion identified has also been relatively stable, ranging between 5 and 7%. However, the proportion accepting an offer of assistance has declined markedly, from a high of 71% in 2004 to under 27% in 2013. The reasons for this are not clear (NSW Health 2014).

Victoria

Victoria does not have a specific tool to screen for DV in pregnancy; however, jurisdictional feedback collected during the NMDDP visits in 2012 (Appendix B) indicated the majority of hospitals do screen for DV. Routine screening is not currently implemented but screening is undertaken using a risk-based approach.

In Victoria, a Family Violence Risk Assessment and Risk Management Framework, also known as the Common Risk Assessment Framework (CRAF) (Victorian Department of Human Services 2012), provides comprehensive guidance in screening for and assessing DV. Some midwives are guided by the questions in the CRAF manual to hold conversations with pregnant women when screening is undertaken; however, approaches taken by health services do vary.

The screening questions suggested in the CRAF manual are not meant to be asked sequentially; rather, they have been designed as prompts in a conversation about possible DV. So while most of the questions are suitable for yes/no responses, it is not clear whether they are formally recorded as such. Questions include those listed below:

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?

The Victorian hand-held record (a woman's record of her maternity care that she retains and is encouraged to bring to each antenatal visit, and that clinicians update throughout her pregnancy) also has 1 free-text question that asks about social problems and mentions domestic situations among a range of other potential problems.

Queensland

Queensland has not previously had a widely used tool to screen for DV that is specific to pregnancy; however, jurisdictional feedback collected during the NMDDP visits in 2012 (Appendix B) indicated that a number of hospitals do record some DV screening data in the Queensland Perinatal Online system.

In addition, a Domestic Violence Risk Assessment Questionnaire for use in pregnancy has been trialled by Queensland Health at the Royal Brisbane and Women's Hospital; it is intended for routine screening. The tool includes 10 questions with yes/no response categories:

1. Are you ever afraid of your partner or ex-partner?
2. In the last year, has anyone at home hit, kicked, punched or otherwise hurt you?
3. In the last year, has anyone at home often put you down, humiliated you or tried to control what you can do?
4. In the last year, has your partner or ex-partner threatened to hurt you?
5. Has your child/children been hurt or witnessed violence between you and your partner or ex-partner?
6. Does your child/children live with you now? If 'no', specify with whom.
7. Are you safe to go home when you leave here?
8. Are you worried about your child's/children's safety?
9. Would you like help with any of this now?
10. This could be important information for your health-care providers. May we send a copy of this form to your doctor or primary maternity carer?

Questions 7-10 are asked only if patients answer 'yes' to any of the first 6 questions. The questionnaire also allows for recording DV risk status (that is, DV identified; DV identified, help refused; DV identified, help provided), referral information if provided, and reasons for screening not being completed if this applies (that is, presence of partner, presence of family members/friends, absence of interpreter, client refused to answer questions).

The Domestic Violence Risk Assessment Questionnaire is attached to a Psychosocial Questionnaire that covers additional risk factors, including the following 2 questions about relationship problems: 1. *How would you describe your relationship with your partner?*, 2. *What do*

you think the relationship will be like after the birth? and 1 question about economic circumstances: *Do you have control of your own money?*

Both these questionnaires are specifically for maternity outpatients and accompany the woman's hand-held record as a separate document.

Western Australia

Western Australia does not have a dedicated screening tool for DV that is specific to pregnancy; however, it does have a Common Screening Tool (Western Australian Department for Child Protection 2011) that is recommended for use in a variety of health and other settings. The tool is intended to support agencies (whatever their primary focus) to incorporate common practices for DV screening, risk assessment and risk management. It is possible that midwives use it because the hand-held record includes two references to whether family DV screening checks have been conducted – one at 10–20 weeks and another at 34–40 weeks. The following open-ended questions are asked in the Common Screening Tool:

1. Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do?
2. Has someone in your family or household ever hurt or threatened to hurt you?
3. Are you worried about the safety of your children or someone else in your family or your household?
4. Would you like help with any of this now?

South Australia

South Australia does not have a dedicated screening tool for DV that is specific to pregnancy; however, for women who have a fully completed hand-held pregnancy record, there should be a score for the AnteNatal Risk Questionnaire (ANRQ). Although the ANRQ is not specifically targeted at screening for DV, its use indicates that some screening may have occurred. The ANRQ is designed to consider specific risk factors thought to increase the risk that women may develop perinatal mental health morbidity (for example, postnatal depression or anxiety disorder) and sub-optimal mother-infant attachment. It includes some questions that are relevant to screening for DV, with one component relating to a patient's past history of physical (including DV), sexual or emotional abuse. Questions of relevance include those listed below:

1. Is your relationship with your partner an emotionally supportive one?
2. Have you had any stresses, changes or losses in the last 12 months (for example, separation, domestic violence, unemployment, bereavement)?
3. Have you ever been sexually or physically abused?

Response categories vary between these questions. The response category for the first question is a 6-point scale from 'very much' to 'not at all'. Response categories for the next two questions are yes/no. Patients who answer 'yes' to the third question are considered high risk *irrespective* of their total ANRQ score.

Tasmania

Tasmania does not have a dedicated screening tool for DV that is specific to pregnancy; however, jurisdictional feedback collected during the NMDDP visits in 2012 (Appendix B)

indicated there are some questions on ObstetrixTas (the computerised recording system used by public hospitals) for DV that may be used in some hospitals. How widely used the ObstetrixTas questions are is not clear. The questions include those listed below:

1. Have you been hit, slapped or hurt by partner or ex in last 12 months?
2. Are you ever frightened by your partner or ex-partner?
3. Does your partner have an AVO [apprehended violence order] against them? If 'yes' can you provide a copy?

Response categories vary for these questions: for Question 1, they are yes, no, not known, and unable to ask; for Question 2, they are no, yes frightened by partner, yes frightened by ex-partner, not known and unable to ask; for Question 3, they are yes/no.

A series of 11 response categories are also available for the health-care provider to record what action/referral was taken in relation to family violence (FV). These 11 categories are as follows: no FV identified – info. given, no FV identified – info. refused, FV identified – info. given, FV identified – info. refused, support and options given, reported to Child Protection Services, police notified, referral made, other action taken, other abuse disclosed, deferred. If deferred is selected, the health-care provider can then indicate in the relevant field the reason for this by selecting one of the following categories: presence of partner, other family present, declined, other.

If a patient responds 'yes' to Question 2 above, the following questions are also asked:

1. Are you safe to go home when you leave here?
2. Would you like some assistance with this?

Response categories to these last two questions include yes/no and not known.

Australian Capital Territory

The Australian Capital Territory does not have a dedicated screening tool for DV that is specific to pregnancy. No screening tool was identified as being used in other health-care settings.

Northern Territory

The Northern Territory has implemented routine antenatal screening for DV, with data being collected at the first visit and/or second trimester visit. A tick box on the hand-held pregnancy record indicates whether the DV survey has been appended.

The guidelines of the Northern Territory Department of Health's screening tool recommend that the Domestic and Family Violence Survey be conducted with pregnant women who are aged at least 18 in the antenatal clinics at each of the five hospitals in the territory, as well as at the Home Birth service. The screening is also conducted with all adults admitted to Northern Territory hospitals, both men and women.

On completion of the screening tool, a copy of the form is kept in the client's medical record. A de-identified copy is forwarded to the Women's Health Strategy Unit for data collection purposes.

The Northern Territory tool includes the following 6 questions that directly pertain to DV:

1. Are you ever afraid of your partner or someone in your family?
2. In the last year, has your partner or anyone in your family hit, kicked, punched or hurt you?

3. In the last year, has your partner or your family often put you down, made you feel ashamed or tried to control what you do?
4. In the last year, has your partner or anyone in your family threatened to hurt you in any way?
5. In the last year, has your partner or anyone in your family made you have sex when you didn't want to?
6. Would you like help with any of this now?

The first 5 questions include response categories for yes, no and sometimes. The final question includes only a yes/no response category.

Screening questions commonly used across jurisdictions

Table 6.2 shows questions that are currently used or are proposed as suitable for use in each jurisdiction. While the screening tools vary considerably between jurisdictions, there are some common questions in use across the tools. Common questions used in at least four jurisdictions include:

1. Within the last year, have you (ever) been hit, slapped or hurt in other ways by your partner or ex-partner? OR
(In the last year,) has (your partner or) someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you?
2. Are you (ever) afraid of your partner or ex-partner (or someone in your family)?
3. (In the last year) has (your partner or) someone in your family or household ever (often) put you down, humiliated you or tried to control what you can or cannot do?
4. (In the last year), has your partner or ex-partner (ever hurt or) threatened to hurt you (in any way)?
5. Would you like help with any of this now?

Response categories for the commonly used screening questions (as well as for the less commonly used questions) vary across jurisdictions. Some jurisdictions include only yes/no response categories (Queensland, New South Wales); others have additional response categories such as sometimes (Northern Territory), not known (Tasmania) or unable to ask (Tasmania). One jurisdiction (Western Australia) has free-text fields and it is not clear how this is coded in different collections that use these data.

Table 6.2: Summary of screening questions asked in each jurisdiction when screening for DV

Question	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus (n)
Within the last year, have you (ever) been hit, slapped or hurt in other ways by your partner or ex-partner? ^(a) OR (In the last year,) has (your partner or) someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you? ^(a)	Yes	Yes	Yes	X	X	Yes	X	Yes	5
Are you (ever) afraid of your partner or ex-partner (or someone in your family or household)? ^(a) (If so, who?)	Yes	Yes	Yes	X	X	Yes	X	Yes	5
Are you safe to go home when you leave here?	Yes	X	Yes	X	X	Yes	X	X	3
Would you like help with any of this now?	Yes	Yes	Yes	Yes	X	Yes	X	Yes	6
(In the last year) has (your partner or) someone in your family or household ever (often) put you down, humiliated you or tried to control what you can or cannot do? ^(a)	X	Yes	Yes	Yes	X	X	X	Yes	4
In the last year, has your partner or ex-partner (ever hurt or) threatened to hurt you (in any way)? ^(a)	X	Yes	Yes	Yes	X	X	X	Yes	4
Are you worried about your children or someone else in your family or your household?	X	Yes	X	X	X	X	X	X	1
Has your child/children been hurt or witnessed violence between you and your partner or ex-partner?	X	X	Yes	X	X	X	X	X	1
Does your child/children live with you now? If 'no', specify with whom.	X	X	Yes	X	X	X	X	X	1
Are you worried about your child's/children's safety (or someone else in your family or your household)?	X	X	Yes	Yes	X	X	X	X	2
This could be important information for your health-care providers. May we send a copy of this form to your doctor or primary maternity carer?	X	X	Yes	X	X	X	X	X	1
Is your relationship with your partner an emotionally supportive one?	X	X	X	X	Yes	X	X	X	1
Have you had any stresses, changes or losses in the last 12 months (e.g. separation, domestic violence, unemployment, bereavement)?	X	X	X	X	Yes	X	X	X	1
Have you ever been sexually or physically abused?	X	X	X	X	Yes	X	X	X	1
In the last year, has your partner or anyone in your family made you have sex when you didn't want to?	X	X	X	X	X	X	X	Yes	1
Does your partner have an AVO [apprehended violence order] against them? If 'yes', can you provide a copy?	X	X	X	X	X	Yes	X	X	1

X Question not used in this jurisdiction

(a) There are slight variations in the wording of the question between jurisdictions but the question is broadly asking about the same aspect of DV. For example, some jurisdictions use 'in the last year', rather than 'ever'; some refer to 'someone in your family or household', rather than 'your partner or ex-partner'; some replace words such as 'frightened' and 'afraid', or 'humiliated' and 'ashamed'. See earlier in the chapter for the exact wording used in each jurisdiction.

6.2 Recording of screening outcome

Although some jurisdictions routinely screen for DV, there are currently no data items for DV screening (or for the identification, assessment or referral of DV) in any of the national, jurisdictional or specialist perinatal collections. Some jurisdictions do record data on what has been found, although it is not clear where the data are recorded (for example, whether it is only a note on a woman's file or whether it is recorded electronically).

Table 6.3 shows the type of data collected by some jurisdictions that corresponds to each of the four domains for screening, identification, risk assessment and referral. However, the terminology used across jurisdictions can differ and differences in terminology can mean that it is easy to conflate the screening and identification domains, or the identification and risk assessment domains. This issue has been discussed in Chapter 3. Table 6.3 therefore categorises data collected in some jurisdictions according to slightly different category labels than those used by the jurisdictions.

While it is possible (and even likely) that some jurisdictions collect a screening-specific data item with yes/no response categories to record whether screening has occurred, this information was not easily sourced. For jurisdictions that conduct routine screening and collect information such as 'screening not completed' or 'screening deferred', it could be assumed that women have been screened if either the screening or identification fields have been completed. This might mean screening levels could be derived from the identification and screening items but this is not ideal for a national data collection.

Table 6.3: Examples of some jurisdictional data collected after screening for DV is undertaken

Screening conducted	Identification of DV
New South Wales Tick boxes for 'Screening not completed due to': Presence of partner, Presence of other family members, Woman declines to answer the questions, Other reason (specify)	New South Wales Tick boxes for 'action taken': DV identified, information given; DV identified, information declined; DV not identified, information given; DV not identified, information declined; Support given and options discussed; Reported to NSW Department of Community Services; Police notified; Referral made to (specify); Other action taken (specify); Other violence/abuse disclosed
Queensland Tick boxes for 'Screening not completed due to': Presence of partner, Presence of family members/friends, Absence of interpreter, Client refused to answer questions	Queensland Tick boxes for 'DV risk status' ^(a) : DV not identified; DV identified, help refused; DV identified, help provided Permission to provide information to a doctor or primary maternity care provider is also separately sought
Tasmania Indicators for 'Reason for deferral': Presence of partner, Other family present, Declined, Other	Tasmania No FV identified—info. given, No FV identified—info. refused, FV identified—info. given, FV identified—info. refused, Other abuse disclosed. Support and options given
Northern Territory Tick boxes for 'Screening not completed due to': Presence of partner, Presence of family members/friends, Absence of interpreter, Client's injury/illness/level of intoxication, Client refused to answer the questions, Other (specify)	Northern Territory Tick boxes for 'DV/FV risk status' ^(a) : DV/FV not identified; DV/FV identified, help refused; DV/FV identified, help provided; Perpetrator—partner or other family member
Risk assessment ^(a)	Referral
Victoria and Western Australia Response categories of 'yes', 'no' or 'unknown' for the presence of the following vulnerability factors: <i>Victim</i> —Pregnancy/new birth ^(b) , Depression/mental health issue, Drug and/or alcohol misuse/abuse, Has ever verbalised or had suicidal ideas or tried to commit suicide, Isolation <i>Perpetrator</i> —Use of weapon in most recent event, Access to weapons, Has ever harmed or threatened to harm victim, Has ever raped or sexually assaulted the victim, Has ever tried to strangle the victim, Has ever tried to kill the victim; Has ever harmed or threatened to harm or kill children, Has ever harmed or threatened to harm or kill other family members, Has ever harmed or threatened to harm or kill pets or other animals, Has ever threatened or tried to commit suicide, Stalking the victim, Controlling behaviour, Unemployed, Depression/mental health issue, Drug and/or alcohol misuse/abuse, History of violent behaviour (not FV) <i>Relationship</i> —Recent separation, Escalation—increase in severity and/or frequency of violence, Financial difficulties	New South Wales Tick box for 'Referral made to (specify)'; however, sits alongside a series of items for 'action taken' (see 'Identification of DV' data above) Queensland Tick boxes for 'Provided with': Written information on DV, Referral to hospital-based service—Social Work Department, Other Tasmania Reported to Tasmanian Child Protection Services Police notified Referral made Other action taken Northern Territory Tick boxes for 'Provided with': Contact phone numbers, Written information on DV/FV, Referral to hospital-based service; Referral to community DV/FV service; Referral or notification to general practitioner/community doctor, Referral to police, Other

(a) These are examples of differences in terminology across jurisdictions. Queensland calls its screening questionnaire a 'DV risk assessment'. Both Queensland and the Northern Territory use the term 'risk status' to refer to identification and whether help was accepted or refused, whereas Victoria and Western Australia use the term 'risk assessment' to refer to a process that enables the level of risk to be determined (that is, via a separate questionnaire) after DV has been identified. In Victoria and Western Australia, risk assessment helps guide the type of referral made. Differences in terminology make it easy to confuse distinctions between screening, identification, risk assessment and referral.

(b) Note that risk assessments in Victoria and Western Australia include pregnancy/new birth as one of a number of items that may indicate an increased risk of the victim being killed or almost killed.

This section shows that many jurisdictions already conduct some form of screening for DV in health settings, including pregnancy care. For many midwives, there should be little additional burden in collecting and recording data for the PDC. While jurisdictions vary in relation to the types of data they collect and record, there are some commonalities among the approaches taken and screening questions used. There are also variations and commonalities in a number of other factors, such as:

- whether screening is specific to the antenatal context or more broadly implemented across multiple health settings
- the timing and frequency of screening
- where data are recorded
- where screening is positive, whether referral is available and/or is used.

Some jurisdictions also collect and record information on DV risk status, referral and reasons for screening not being completed. However, for data on *Screening for Domestic Violence* to be included in the NPDC, a more consistent national approach to data collection would need to be implemented. The next chapter examines options for moving towards more nationally consistent data.

7 Moving towards nationally consistent data collection and reporting

This chapter outlines options for how national consistency in screening for DV collection might be achieved. This could arguably occur in different ways. While national consistency for most data typically occurs at multiple levels by having the same questions asked, the same screening processes and data collection methods followed and the same recording of data, national consistency may not be necessary at all these levels for DV screening. For example, could flexibility in the screening approach enhance data quality because some women may be more likely to disclose DV in these circumstances?

This chapter examines different screening approaches and their impact on data collection and data quality. The aim is to help readers form a view on the proposed data items that could be included in the NPDC, and whether there is a need for national consistency in both the screening approach taken and data collection options.

7.1 Potential NPDC data

When considering the proposed data item *Screening for Domestic Violence* and what data item(s) might be included in the NPDC, it is important to note that responses to individual screening questions (such as whether a woman has been physically attacked or sexually assaulted, for example) are not being proposed for recording in the NPDC. It is the recording of the *outcomes* of screening that is being considered for national collection such as a yes/no response to whether screening was conducted and/or to whether DV was identified.

Chapter 3 highlights the importance of separating the interrelated concepts of screening, identification, assessment and referral. Keeping the concepts separate and considering associated data items for each concept can have benefits for establishing different factors related to prevalence and health system responses.

In terms of potential NPDC data, screening data alone would not be useful in helping to determine rates, trends or potential associations with conditions. For this reason, identification (or disclosure) data would also be necessary to collect. However, it is not proposed that assessment data be collected in the NPDC as this is most relevant for service providers in terms of helping manage women's risk of harm and for determining the best referral pathway. It is also unlikely to be feasible to collect referral data in the NPDC. While it is hoped that women who are screened positive for DV will be referred to a relevant service for further assistance, referral may not always be possible, either due to a lack of services or because the woman does not wish to obtain further help.

Should any DV data item(s) proceed to the NPDC, national standards will need to be developed (for more information on national standards see Chapter 9). Keeping the data standards for screening and identification separate will require data elements for each concept.

Possible NPDC data items

Depending on the level of information determined appropriate for collecting in the NPDC, a number of data elements could be considered. At a minimum, data on screening and identification would be required for the data to be useful (note that identification is referred to as disclosure in this section). The following indicators could therefore be considered:

- a screening indicator to indicate whether screening was conducted
- a disclosure indicator to indicate whether DV was disclosed
- possibly an item to capture whether additional follow-up was indicated if DV is disclosed. While this could not indicate whether any action had been taken, it could indicate whether there was any action required as a result of the screening process.

Should it be decided that DV data be included in the NPDC, it will be necessary, as part of the data development process, to develop national standards in METeOR (the AIHW's metadata online registry). Each national standard will require a data element, value domain (set of response categories), definition, guide for use and collection methods information. Table 7.1 provides options for potential DV data elements and an associated value domain.

Table 7.1: Possible NPDC data items

Data item	Values
Whether screening for DV was conducted	Yes, Not offered, Declined, Unknown or not stated
Whether DV was disclosed	Yes, No, Not applicable, Unknown or not stated
Whether additional follow-up was indicated due to disclosure of DV	Yes, No, Not applicable, Unknown or not stated

A potential definition of what constitutes DV in the NPDC (discussed in Chapter 3) was developed by the Screening for DV Working Party:

Domestic violence refers to acts of violence that occur between people who have, or have had, an intimate relationship. The central element is a pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent or by threatening any act that might cause harm or suffering. Domestic violence can include physical, sexual, emotional or psychological abuse.

This definition of DV could be used as a glossary item attached to each data element included in the NPDC. However, in addition to the above DV definition, each data element may require its own definition. For example, for the data element relating to whether screening was conducted, a definition for what constitutes screening may also need to be included. Chapter 3 provides some information that might help with developing a definition.

There are also some additional issues that will affect the development of data elements. For example, the Screening for DV Working Party thought it important to limit the period for asking about a woman's experience of DV to 12 months. This will impact on the wording of any proposed screening tool questions and the wording of relevant data items. Further information on issues around screening tool questions is presented in Section 7.2; however, when developing national standards, the points in Table 7.2 need to be considered in relation to each potential indicator.

Table 7.2: Issues to consider in developing indicator definitions and supporting guidelines

Possible NPDC indicator	Issues that need to be considered/included
Screening indicator	1. Including a time frame to indicate that it is the experience of DV only in the last 12 months that is being asked about. The Screening for DV Working Party recommended that 12 months be included in the definition (and not to use 'ever') or as part of the screening questions. 2. Needs to be differentiated from the standard way screening is used in public health settings. For example, diabetes screening in a clinical context is different from screening for DV, which is more about routine enquiry or asking.
Disclosure indicator	Needs to be tight around what disclosure is and is not. For example, there is a need to consider wording such as 'based on screening undertaken' because this could refer to women's disclosing when screening is initially undertaken or to women who disclose at a later time. This would not be clear in the data. The Screening for DV Working Party recommended that 'in response to screening questions' be considered for inclusion in a definition or guide for use.
Additional follow-up indicator	Could include whether follow-up was indicated (such as a referral to services) but it would not be possible to know whether a referral or additional care was taken up. Referral is not the same as uptake but is an important output of screening.

Therefore, before national standards could be finalised, there are a number of issues to resolve. Further consultation with jurisdictions and pilot testing of any proposed standards would also be necessary. Chapter 9 discusses further steps that need to be taken. However, regardless of what item(s) might proceed to the NPDC, there will be some limitations on what NPDC data could provide.

As discussed in Chapter 5, there are some inherent limitations in collecting DV data that will affect data quality. Any future data reported from the NPDC would need such limitations acknowledged, including qualifications around a high likelihood of under-reporting. As well, there will be data comparability issues if the approaches taken to screening are inconsistent across jurisdictions. To increase the reliability of national data, a consistent screening approach may be required. The next section discusses the advantages and disadvantages of different potential screening approaches.

7.2 Potential screening approaches

This section outlines potential approaches to screening, each of which would enable data to be collected in the NPDC. Potential approaches include:

- develop and implement a minimum set of standard questions, based on the questions currently in use across jurisdictions
- seek to implement a nationally consistent screening approach by encouraging all midwives to use a recommended validated DV screening tool
- maintain a flexible screening approach consistent with the *National Antenatal Care Guidelines* that enables jurisdictions to screen in different ways for different populations.

The Screening for DV Working Party advised that the preferred approach was to encourage all midwives to use a validated DV screening tool (preferred tools are discussed below).

Many stakeholders argue that this is most appropriate for ensuring the best possible data quality. However, for a topic as sensitive and complex as DV, there are reasons to consider other approaches, including whether a flexible approach to screening could be maintained.

Whichever approach is ultimately agreed, the options for national data items presented above allow for either flexible or consistent screening processes.

Flexible approach

Flexibility in DV screening is recommended in the *National Antenatal Care Guidelines*, which means midwives can take different approaches to screening with different women. The guidelines provide the following consensus-based recommendation (AHMAC 2012:xii):

Ask about domestic violence when alone with the woman, tailoring the approach to her individual situation and your own skills and experience (e.g. use open-ended questions about her perception of safety at home or use an assessment tool).

The guidelines also indicate the following when discussing and responding to DV (AHMAC 2012:84):

Discussion of domestic violence requires rapport between the health professional and the woman. Women experiencing abuse may not speak up when the subject is first raised but may choose to open up later when they feel sufficient trust and confidence in the health professional, possibly at a subsequent visit. It is important for health professionals to enquire about domestic violence in a sensitive manner and provide a response that takes into account the complexity of women's needs (Bacchus et al 2003).

Recognising that different women and different populations of women respond to screening approaches differently, the *National Antenatal Care Guidelines* provide the following practice point in relation to Aboriginal and Torres Strait Islander women (AHMAC 2012:86):

Responses to assisting Aboriginal and Torres Strait Islander women who are experiencing domestic violence need to be appropriate to the woman and her community. Health professionals should be aware of family and community structures and support.

One consideration mentioned in the guidelines is that midwives should (AHMAC 2012:85):

Use direct or indirect questions or an assessment tool, depending on clinical experience and the perceived level of trust in the relationship.

One reason the guidelines recommended a flexible approach was that, at the time of writing, evidence that using a screening tool was fundamentally better than having a discussion with a woman was not strong enough. Hence, the authors produced a consensus-based recommendation for a flexible approach. Should this change in the future, it may be necessary to update the *National Antenatal Care Guidelines*.

Advantages of a flexible approach

There are benefits in taking a flexible approach to screening, particular with some (groups of) women. For example, informal conversations can reveal DV and for some groups this may be more effective than using a tool.

Many state and territories already have guidelines recommending that health-care professionals routinely ask all pregnant women about their experiences of abuse and provide guidance for the various approaches that can be taken. Some jurisdictions specify a consistent set of questions for midwives to ask women; others allow a more tailored approach so midwives may ask open-ended questions or use different conversational styles.

Disadvantages of a flexible approach

The *National Antenatal Care Guidelines'* review of the evidence indicated that whereas some women may benefit from a flexible questioning approach, others may disclose DV more readily if a DV screening tool providing a structured series of questions asked of all women is used (AHMAC 2012).

The use of different screening tools across jurisdictions may impact on data comparability at the national level. Matters to consider include:

- whether direct questions (with specific response categories) or open-ended questions are used. Open-ended questions tend not to be validated, but some experts prefer this type of screening method
- the length of the screening tool. Some jurisdictions ask only 2 questions and others ask up to 10 questions
- consistency of response categories. Some jurisdictions use questions with only yes/no response categories, others include categories such as 'unsure' or 'sometimes', yet others use a scale approach (for example, 6-point scale from 'very much' to 'not at all').

Given a number of issues around data quality, including indirect questioning sometimes being ambiguous and leading to vague or unclear responses, the Screening for DV Working Party did not favour a flexible approach.

Structured screening approaches

The Screening for DV Working Party recommended that structured approaches be considered. Alternatives discussed by the working party and the NMDDP Advisory Group included:

- developing a minimum standard set of questions, based on those currently in use across jurisdictions, which could be recommended for use in the NPDC. If this approach were to proceed, further investigations would be necessary to determine the best set of questions
- recommending that a short validated tool be implemented nationally for clinicians to use before any data are recorded in the NPDC.

There are currently no validated screening tools in use by any jurisdiction in Australia. It is not clear what process each jurisdiction followed in developing its current screening tools; however, given similarities in some of the questions asked across jurisdictions (see Table 6.1) and in some questions that appear in some validated tools, it seems likely a review of validated screening tools would have been undertaken. However, no jurisdiction uses a complete validated tool.

In considering the structured approaches above, the Screening for DV Working Party determined that the use of a short validated DV screening tool was the preferred method. It was deemed very important that jurisdictions collect the same validated information so it could be collated nationally.

It may ultimately be decided not to implement a validated tool nationally but, instead, to consider the alternative structured approach above – that is, development of a minimum standard set of questions. In that event, the mapping shown at Appendix I would be useful for helping to determine whether some of the current questions could form a standard set of minimum questions for the NPDC.

If either of the above approaches were implemented, the questions asked would not necessarily need to dictate the full approach to screening, so elements of a flexible approach could be maintained in line with the *National Antenatal Care Guidelines*. For example, if a woman disclosed DV on the basis of a conversation – or DV was suspected and midwives initially approached the screening in a way they considered appropriate for a particular woman – this would not be ruled out. However, before data were recorded in the NPDC, there would be a recommendation for clinicians to ask a minimum set of standard questions

or to follow the questions of a validated tool. NPDC data would need to be recorded on the basis of answers to the recommended screening questions. Jurisdictions could collect additional information but a consistent set of national questions for NPDC data would enhance clarity and data comparability across jurisdictions. That is, the use of a particular tool should be recommended but jurisdictions would still retain flexibility in following their own risk assessment and referral processes if someone screens positive and in collecting whatever additional data they deemed important.

Validated DV screening tool implemented nationally

The Screening for DV Working Party advised that the best way to gather consistent, nationally comparable data would be to implement a validated DV screening tool nationally. From a data perspective, standardised questions are most appropriate. It was noted that health-care providers can sometimes struggle to interpret a client's answers and, without clear questions and answers, incorrect recording of responses can occur. A validated tool therefore provides clear direction about how to assess and interpret answers to clear questions as well as a scoring system for determining positive responses for DV. However, it was recognised that this approach may take some time to implement, as consultation with jurisdictions would be required as well as pilot testing of any recommended instrument and any recommended NPDC data item(s).

Advantages of implementing a validated DV screening tool nationally

- A consistent national approach increases comparability of data across jurisdictions.
- Use of a validated DV screening tool formalises the process of determining whether violence has occurred and, depending on the tool(s) used, may determine the type of violence experienced.
- Scripted questions, as part of a validated DV screening tool, may also facilitate clinicians' asking the right questions, without having to find the appropriate words (Spangaro et al. 2011a).
- Violence is predicted relative to a norm-based reference group. Validated tools have been shown to correlate with various measures of violent behaviours (Robinson & Moloney 2010).
- Use of a validated DV screening tool can increase accuracy due to empirical approaches finding better predictors and reliability (Robinson & Moloney 2010). For most constructs, the use of a validated tool increases data quality; however, there may be special considerations for DV data that mean data quality may not increase with the use of a validated tool (see disadvantages).
- If a screening tool is used in conjunction with a risk assessment tool, health-care workers may be able to assess the risk of further harm. This may increase the chances that referral services are offered.

Disadvantages of using a validated screening tool for DV

- Informal conversations can reveal DV, so it may not be desirable to exclude data using this approach. For some groups and individuals, it may be more effective than using a tool.
- There is no clear evidence about the most effective tool or the most appropriate length of time to devote to screening (Robinson & Moloney 2010).

- A single tool alone may not deliver the desired outcome or guarantee victim safety. Existing instruments are not precise enough to discriminate types of risk (Robinson & Moloney 2010).
- Practitioners may resist their use due to their lack of flexibility (Robinson & Moloney 2010). Tools can place less emphasis on unique, unusual or context-specific factors which may affect whether clinicians take the time to complete and score a validated tool.
- Tools have historically been focused on identifying immediate and visible harm, but may be less successful in identifying concerns associated with neglect or emotional harm, or with supporting vulnerable families (Robinson & Moloney 2010).
- Even the most common screening tools have been evaluated only in a small number of studies in health-care settings (Rabin et al. 2009). Further validity and reliability testing is needed.
- No single screening tool has well-established psychometric properties. No 'gold standard' currently exists by which to test sensitivity, specificity and overall effectiveness of tools (Rabin et al. 2009).

Some of the questions currently in use in the jurisdictions are the same, or very similar, to those in some validated tools. Appendix I maps the current jurisdictional questions to existing validated instruments. This mapping is useful for highlighting which validated tools map most closely to questions currently in use.

7.3 Validated tool review

International research shows that some validated tools can differentiate between abused and non-abused women. A review of some existing validated tools was undertaken. While there are many tools that can screen for DV, the review undertaken for this project was limited to tools most relevant to the perinatal context that had undergone some validation. For a tool to be considered, it needed to have been tested within a health-care setting and used in a perinatal context (either in part or full). Ten tools were reviewed, as listed below. Appendix I provides details of each tool, including questions asked, scoring procedures, collection methods and populations studied:

- Abuse Assessment Screen
- Humiliation, Afraid, Rape, Kick (HARK) Screen
- Hurt, Insult, Threaten, Scream (HITS) Screen
- Ongoing Abuse Screen
- Ongoing Violence Assessment Tool
- Partner Violence Screen
- Slapped, Thrown and Threatened Screen
- Woman Abuse Screen Tool (WAST)
- WAST – Short
- Women's Experience with Battering Scale.

When comparing the advantages and disadvantages of each tool, the Screening for DV Working Party encountered a number of issues. It therefore needed to determine some criteria that would be applicable to assessing each tool. Table 7.3 provides an overview of some of the issues the working party considered important in tool selection.

Table 7.3: Screening for DV Working Party considerations in tool selection and recommendations

Issue	Screening for DV Working Party recommendation
Wording of questions in relation to potential perpetrators. There is inconsistency between tools in regard to whom the potential perpetrator refers to (that is, partner/ex-partner/someone in family/someone important to you etc.).	Many tools use 'partner' because that is the most common perpetrator in terms of violence in pregnancy. Needs to be consistent with the definition the working party agreed to, which refers to partner or ex-partner only. Wording in selected tool should therefore refer to partner and/or ex-partner. Interpreting the data is more manageable if the questions are limited to partner or ex-partner.
Wording of questions in relation to time period of abuse. Some tools ask whether abuse has ever been experienced whereas others focus on currently or in the last 12 months.	It is important to distinguish between experiencing DV 'ever', 'in the last 12 months' and 'currently'. Members agreed that 'ever' should not be included in any recommended tool and that either a current focus or within the last 12 months was preferable.
Wording of questions in relation to specificity. Some tools ask more specific questions whereas others word questions more broadly or ask multiple things in a single question.	More specific wording of questions preferred. A question should ask about only one domain of violence.
Tool length	The best length for any recommended tool would be a maximum of 4–5 questions.
Diagnostic accuracy	Tools with the highest sensitivity and specificity ratings preferred.
Scoring	Simplicity of scoring preferred.

The working party agreed that, of the 10 validated DV screening tools it reviewed, two best fitted the criteria and were worth considering further: the HITS and HARK tools.

7.4 Preferred tools: HITS and HARK

The HITS and HARK tools were both considered potentially useful to recommend for national use in the perinatal context. Both have been recommended for routine screening of women of childbearing age by the United States Preventative Services Task Force (2013) and cover a number of domains of DV. Both can give clinicians a clear picture of whether a woman is experiencing DV or not. However, each tool was considered to have advantages and disadvantages, outlined in Table 7.4.

Table 7.4: HARK and HITS DV screening tools: tool properties, advantages and disadvantages

HARK	HITS
Tool properties Four (4) items assess physical, sexual and emotional abuse by a partner or ex-partner within the last year: (1) Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? (2) Within the last year, have you been afraid of your partner or ex-partner? (3) Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? (4) Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner? <i>Response categories:</i> Yes/no for all questions <i>Scoring procedure:</i> If any questions are answered affirmatively, the HARK can be considered positive for abuse Self-report Advantages Covers most aspects of recommended NPDC definition Most closely aligns with what jurisdictions already collect Simplicity and directness Disadvantages Does not include anything about controlling behaviour More recently developed and not included in as many reviews (however, is based on the Abuse Assessment Screen which is better tested and recommended) Only a self-report tool available Questions on sexual violence mean a higher level of intrusiveness and some health professionals may have reservations about asking such questions. Women may be reluctant to provide simple yes/ no answers to questions and commonly provide partial or vague answers (disclosure can be a process that involves shame associated with admitting abuse). Midwives can struggle to know how to treat vague or partial answers and whether they should be classified as DV or not. A lack of guidance on interpreting answers can lead to diverse practice among midwives in recording responses.	Tool properties Four (4) items assess the frequency of physical or emotional abuse by a partner: (1) How often does your partner physically hurt you? (2) How often does your partner insult you or talk down to you? (3) How often does your partner threaten you with harm? (4) How often does your partner scream or curse at you? <i>Response categories:</i> Each question is answered on a 5-point scale: 1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = frequently <i>Scoring procedure:</i> Responses are summed for a total score which can range from 4 to 20. A cut-off score of 10 or greater can be used to classify participants as victimised Self-report or clinician administered Advantages Recommended by many reviews that show it has good sensitivity and specificity Can be either clinician administered or self-report Responses ranging from 'never' to 'frequently' allow space for women to not feel locked into admitting abuse. Disadvantages Does not include anything about controlling behaviour More time required to score Wording around frequency may be less well understood Asks about current violence, not violence in the last 12 months

Sources: Sherin et al. 1998; Sohal et al. 2007.

While both tools have relatively easy scoring systems, it should be noted that the NPDC is not proposing to collect any score obtained from the tool, nor any answers to individual questions from the tool. Chapter 6 provides more detail on the data item(s) that could be considered for collection by the NPDC.

Some working party members expressed a preference for a modified HARK – that is, the HARK tool with a control/coercion question added. The HARK tool most closely aligns with what the jurisdictions already collect and it was thought this may assist with future take-up by some jurisdictions. Other working party members preferred the HITS tool, which has the advantage of being available as either a self-report or clinician administered tool.

The NMDDP Advisory Group also reviewed the HITS and HARK tools, preferring the HARK due to its simplicity and directness and the similarity of HARK questions to those currently being used in jurisdictions. The advisory group thought wording around frequency in the HITS (for example, ‘how often does your partner...’) could potentially be less well understood or received by women.

It is possible both tools may require some minor modification if recommended for use in the NPDC. However, if a tool is modified, this may mean further validation would be required. It may therefore be necessary to recommend the use of a validated tool as is. Before any tool were recommended for national use, any licensing issues to be aware of would need to be investigated.

7.5 Preferred collection method

Variations in collection methods across jurisdictions have the potential to affect data quality at the national level. If use of a validated tool is the preferred screening approach, it would need to be determined whether it should be self-administered or administered by a clinician via face-to-face interview.

Some studies find regular face-to-face screening of women by skilled health-care providers greatly increases the detection of DV (McFarlane et al. 1991), whereas others show that self-administered questionnaires (written, audio or computer-based) may be superior (Canterino et al. 1999; Nelson et al. 2012b; O’Reilly et al. 2010). For women with lower levels of literacy, self-completion may be more difficult; however, some Screening for DV Working Party members indicated women should at least have the option of self-completion.

Further evaluation of the accuracy, as well as the efficiency and acceptability, of screening methods for DV may be needed to improve screening processes (Nelson et al. 2012b). Should a pilot on *Screening for Domestic Violence* data be undertaken in any jurisdiction, it would be ideal if collection methods could also be incorporated to determine whether a mandated collection method would be necessary. Some jurisdictions and/or clinicians may prefer to adopt whichever collection method works best for them so this is another area where flexibility could be considered, but needs to be weighed against the impact it may have on data. Should a data item proceed to the NPDC, there will need to be clear instructions and guidance for clinicians on how to ask the questions and record responses. That is, it is not just the tool that needs to be determined but also the protocol that goes with how to best use it and collect data. Training and support for midwives would need to be included.

8 Other data development issues

As well as the issues discussed in earlier chapters, there are a number of other matters that need to be considered before any data item could be placed in the NPDC. This chapter reviews these considerations.

8.1 Enablers for screening

The Screening for DV Working Party indicated that there are factors to enable screening that would desirably be in place before any data collection in the NPDC proceeds. These enablers include:

- funding for sustained training and staff support
- referral pathways for women who disclose
- maintenance of confidentiality and privacy.

Funding for sustained training and staff support

The *National Antenatal Care Guidelines'* review of evidence found that, while health professionals accept the need for routine enquiry about DV, they may not feel comfortable about putting this into action, particularly as they may have concerns around being able to respond effectively in cases where DV is identified, and may feel that they lack relevant training and experience. Language and cultural barriers and clinicians' own experiences of DV can also affect their ability to ask women about DV. Therefore, training and support are essential to provide clinicians with the skills they need to identify DV and respond effectively to it (AHMAC 2012).

The *National Antenatal Care Guidelines* advise that, depending on a midwife's skill and experience in discussing DV with women and assisting them if they are experiencing it, advice and support should be sought through training programs, clinical supervision, mentoring and/or helplines. The following consensus-based recommendation is provided (AHMAC 2012:84):

Be aware that training programs improve the confidence and competency of health professionals in identifying and caring for women experiencing domestic violence.

Baird et al. (2013) also provide evidence for the importance of sustained training and staff support. In a study to evaluate the degree to which practice changes identified in the Bristol Pregnancy Domestic Violence Programme for routine enquiry for DV have been maintained over time, Baird et al. found that midwives' self-reported confidence in asking women about domestic abuse and knowledge of how to deal with a disclosure of DV increased when comparing 2010 data with 2005 data. This increase in confidence was attributable to sustained training and staff support, which had led to substantial changes in the attitudes of midwives, such that all believed enquiry was a fundamental part of their role (Baird et al. 2013).

Need for referral pathways

The *National Antenatal Care Guidelines* emphasise that an immediate response is needed if a woman discloses that she is experiencing DV, as the woman's safety is a primary consideration. This point underlines the need for referral pathways to be available for any

women who discloses. However, the guidelines also note that assisting women experiencing DV in rural and remote areas may be complex due to:

- limited resources to call on for advice or an immediate response
- limited specialised services to assist in the woman's ongoing care
- difficulties ensuring confidentiality in smaller towns and communities
- difficulties when the health professional has a relationship with the woman (for example, through family, kinship or friendship), particularly if mandatory reporting is required.

Maintenance of confidentiality and privacy

The NPDC maintains the confidentiality of individual women because only national aggregated, de-identified data are reported. Data at the individual level are kept under tight security processes and do not contain personal identifiers.

The NPDC is held by the AIHW, which operates under a strict privacy regime informed by the *Australian Institute of Health and Welfare Act 1987* (Cwlth). The AIHW Board closely monitors the AIHW's performance regarding maintenance of the privacy of its data (AIHW 2015).

At the jurisdictional level, PDC data are identifiable and each jurisdiction is responsible for ensuring that it complies with privacy legislation. Jurisdictions have responsibilities at the point of collection for ensuring that the security of the data cannot be breached. If consent from patients is required to collect and share the data, this would also be a jurisdictional responsibility and some jurisdictions may provide – in a maternity information pack – information on how client data are maintained.

De-identification of data is the main compliance issue. It would be a jurisdiction's responsibility to ensure data are properly de-identified before they are passed onto the NPDC. Each jurisdiction would determine for itself whether the data it is providing are in accordance with its own jurisdictional privacy legislation. Once de-identified data are contained in the NPDC, the Commonwealth privacy legislation should not have an impact on reporting of the data. However, any changes to Commonwealth and/or state privacy legislation would need to be considered as they arose.

The legislation around mandatory reporting to police and child protection in relation to disclosure of DV varies across Australia and can affect how disclosure of DV is handled. The impact of privacy legislation may also be different in jurisdictions with different mandatory reporting requirements. Health professionals (for example, midwives) need to be aware of the relevant laws and requirements in their jurisdiction. This is a further reason why funding for sustained training and staff support is highlighted as a pre-condition for screening to take place.

The next section discusses issues associated with mandatory reporting.

8.2 Mandatory reporting

Over the past several decades, governments at the national, state and territory levels have taken steps to respond to DV through legislative and non-legislative measures. All states have laws specific to DV but mandatory reporting is not a common feature of such legislation where it occurs between adults only, without children present (see Appendix E for relevant legislation, policies, strategies and mandatory reporting status). Mandatory reporting is common if DV directly involves children; however, some jurisdictions stipulate mandatory reporting where children witness (but do not physically experience) family

violence (for example, Tasmania and the Northern Territory). Mandatory reporting for violence in relationships generally (that is, without children present) is not implemented in any jurisdiction other than the Northern Territory. However, some researchers have noted that how the NT legislation operates at face value may be different from how well it operates in practice when agencies respond to DV (West 2011).

Some issues may affect the likelihood of patients reporting DV where mandatory reporting is incorporated in state law. Even if guidelines exist for dealing with mandatory reporting, there can be unintended consequences. There is a large body of literature relating to practical obstacles faced by victims of DV in attempting to engage with the legal system, as well as the limitations of a legal response. For example, patients could be forced into legal processes in states with laws requiring mandatory reporting of DV. Some unintended consequences might relate to difficulties in bringing about successful prosecutions of violent abusers, victims of violence having difficulties in legal battles for custody of children, or a victim-blaming culture that could mean victims end up being victimised again by the legal system (Devi 2012). If mandatory reporting were proposed for wider implementation, these may also be issues of concern to health-care providers. The presence of mandatory reporting may therefore mean women are less likely to disclose abuse.

Further issues that may need consideration in relation to mandatory reporting laws and effects on data quality before an item to screen for DV in the NPDC could proceed include:

- how to determine whether data quality is differently affected in jurisdictions with different mandatory reporting requirements (for example, in one jurisdiction, witnessing violence between parents is considered child abuse but in other jurisdictions this is not the case)
- whether differential impacts of mandatory reporting may occur between women who experience violence in pregnancy in front of existing children, compared with women who are pregnant with their first child.

8.3 Indigenous issues

The *National Antenatal Care Guidelines* provide a good summary of considerations in Aboriginal and Torres Strait Islander communities.. The guidelines state (AHMAC 2012:86):

Domestic violence has a significant impact in some Aboriginal and Torres Strait Islander communities. Historical circumstances, the loss of land and traditional culture, the disempowerment of traditional elders, breakdown of Aboriginal law and community kinship systems, entrenched poverty and racism are factors underlying the use of violence in Aboriginal and Torres Strait Islander communities (Mulroney 2003). Intergenerational effects of institutionalisation, oppression and child removal policies, have also resulted in ongoing trauma, loss and unresolved grief and contributed to a range of health and wellbeing problems and issues, including violence (NACCHO 2006).

Aboriginal and Torres Strait Islander women may choose not to disclose domestic violence. Factors that may influence a woman's decision to disclose include:

- mistrust of police, the law and other state institutions (Heenan 2004)
- the implications of reporting (e.g. fear of the woman's partner being imprisoned in the context of the disproportionate rates of Aboriginal men in prison and high rates of Aboriginal deaths in custody) (Heenan 2004)
- the cultural competence of the health professional involved

- kinship systems (e.g. in intrafamilial violence there may be a need to cut ties with the family following disclosure) (Cox 2008).

These factors also influence responses to disclosure of domestic violence by Aboriginal and Torres Strait Islander women. Confidentiality and privacy are important considerations. Women should be asked about who they would like involved in their care and offered a clear choice about referral options, including both Aboriginal-specific services and mainstream services’.

It is possible that mandatory reporting further reduces the likelihood that Indigenous women may report DV.

8.4 Relationship to other psychosocial data items

As mentioned in Chapter 5, the NMDDP currently has four items on the priority data development list that could be considered in assessing psychosocial risk. As well as *Screening for Domestic Violence*, other items that relate to psychosocial risk factors include mental health, alcohol and substance use in pregnancy. While this paper addresses data issues in relation to *Screening for Domestic Violence*, it should be considered whether each psychosocial item should be developed either in isolation or collectively, to provide a broader measure of psychosocial risk. For example, it may be possible to develop data standards so these items could be used in isolation from each other as well as in combination to provide a better understanding of psychosocial risk. Without considering how the items might be analysed individually and potentially collectively, it may be more difficult in the future to combine them during data analysis to better inform how multiple psychosocial risk factors can have an additive effect on women’s and babies’ outcomes.

A number of data quality issues apply for each of the psychosocial items, some similar in nature to those that affect *Screening for Domestic Violence* data. Even if it is determined that the items should not be used in any composite index to reflect psychosocial risk, it is important that the basis of the decisions to implement national standards for psychosocial items be similar.

Given the complexity of psychosocial factors, and the ways in which they are identified and measured, issues to consider for NPDC data include the following:

- How much consistency is required between collection methods or standards for each psychosocial item, and should similar criteria be applied to all psychosocial items? For example, in relation to the use of validated tools, if there is a requirement to use a validated tool to measure risk for one psychosocial item (such as screening for DV) should the same criteria apply to other psychosocial items (such as mental health, alcohol and substance use)?
- How might the items be used to represent levels of risk? Are there certain criteria that should apply to each item in determining risk? This may impact how the items could be used collectively in data analysis and would need to be determined before national standards for each item are finalised.
- Do any planned analyses require particular guide-for-use information to be provided as part of any national standard developed?

Without some consistent data collection principles applied to each psychosocial item, there may be differing levels of validity between any psychosocial data items contained in the NPDC.

8.5 Data collection and clinical practice

One issue that arose during consultation for the *Screening for Domestic Violence* item (which was also of concern to the NMDDP Advisory Group) was that data collection may be seen to be driving clinical practice. This appears to be an area of contention that is hard to resolve, particularly in relation to psychosocial items. Some clinicians can be opposed to collecting data they view as not core to a particular setting. As well, there may be some who are concerned that the data could be used for monitoring clinical practice or for auditing purposes. While the purpose of collecting DV data is not to monitor whether midwives are undertaking screening, there is the possibility the data could be used in this way if requested. These points could apply to any psychosocial screening item that proceeds to the NPDC, or indeed any data item that already exists in the collection.

It is important to recognise that data collection and clinical practice should not be in conflict. There are strong clinical reasons for asking pregnant women about their experience with DV, and clinical considerations should take precedence over data collection. Recognising these priorities will ensure that attention is paid to staff training, choice of questions and the need for clear explanations to be built into screening protocols.

In order to help overcome some of the concerns about the balance between data collection and clinical practice, the following points might be useful to consider:

- the involvement of clinicians and experts in deciding upon and agreeing to potential data collection tools (*Note:* there are obstetric and midwifery clinicians and experts on the NMDDP Advisory Group and clinical and academic experts on DV on the Screening for DV Working Party)
- if validated instruments are recommended for use (on the basis that they aid in obtaining the most valid and consistent data possible), would clinicians be more amenable to collecting psychosocial data?

A further area in which data collection and clinical practice should align relates to the coexistence of national standards and clinical practice guidelines. That is, if both national standards and clinical guidelines coexist, it is ideal if they align. If a national standard for *Screening for Domestic Violence* data is developed, some future action may also be required to review and update the *National Antenatal Care Guidelines* so that they reflect the national standards. This point would apply to any new national standards that are developed for item(s) already contained within the guidelines (for example, mental health, alcohol and substance use). Equally, existing clinical practice guidelines should be reviewed and used to inform development of new national standards as has been done for the development of *Screening for Domestic Violence*.

9 Next steps

Not all stakeholders are convinced about the validity of incorporating *Screening for Domestic Violence* data item(s) in the NPDC; however, all agreed the exploratory work needed to continue. This report has been developed as a guide for the issues that need to be considered in deciding whether the NPDC is appropriate for collecting any DV data. Should it be decided that the NPDC is an appropriate collection point, it will be necessary for stakeholders and jurisdictions to agree on screening approaches and the best data item(s) to include. There will also be a number of issues to resolve around how the item(s) would be captured, recorded and validated. Further consultation and pilot testing would be required before any national data standards could be developed.

9.1 Further consultation

The options and/or recommendations made in this report need to be explored in more detail with stakeholders and jurisdictions. Further consultation would be required to:

- discuss whether jurisdictions would be amenable to any change in DV screening questions or approaches
- determine acceptable screening approaches and/or screening questions
- ensure any proposed NPDC data item(s) are widely agreed as valuable, reliable and feasible to collect
- pilot test any recommended screening tool (if applicable)
- pilot test any proposed NPDC data item(s)
- seek agreement on national standards if the pilot suggests DV data are reasonable.

Undertaking this work may also involve integration or collaboration with other related work or projects. For example, as discussed in chapters 5 and 8, there are other priority psychosocial items being developed as part of the NMDDP for perinatal mental health risk, alcohol and substance use in pregnancy. Each of these items can be associated with DV, and mental health in particular may be confounded with DV. Whether data development for DV should proceed independently of mental health risk and alcohol or substance use is a decision that needs to be made based on further consultation, including pilot testing.

Addressing DV is a slow process and piloting of questions and definitions will be an important step for anything being proposed. Pilot tests are valuable for exploring ways to improve data quality.

Whether pilot testing of DV data for the NPDC could be combined with pilot testing for other psychosocial items such as mental health should also be considered.

Pilot testing in a clinical setting may involve:

- planning and ethics approval
- methodology and sampling, in addition to the design and analysis of the study
- consultation with jurisdictions and antenatal clinics/maternity services selected for inclusion in the study
- design and deployment of data collection and collation forms
- design of information package for patients
- coordination and development of training workshops for interviewers, including information for interviewers and related training tools

- development of guidelines for data collectors
- provision of support to pilot study participants during the collection phase of the study
- analysis of the collected data and publishing the results.

A simpler form of pilot testing or a potential pre-clinical testing pilot could involve testing the questions or tools among groups of clinicians, data collectors and non-pregnant women of reproductive age or women contemplating pregnancy. This focus testing could assist to evaluate acceptance of the questions in the community and among relevant health and health information professionals.

9.2 Development of national data standards

National data standards enable nationally comparable and consistent information to be produced. These will need to be developed, if agreement to a collection approach is reached. A national data standard specifies the nationally agreed name, definition, response categories and other characteristics of the data as well as guidelines for their collection. When collected according to the national data standard, data can be consistently compared across different jurisdictions, settings and sectors. Data collection activities are also more efficient because duplication is minimised (AIHW 2007).

The AIHW's Metadata Online Registry (METeOR) is an electronic repository and registry for metadata and operates according to international standards. It is used across the health, community services and housing assistance sectors in Australia. Metadata refers to the underlying definition or structured description of the content, quality or other characteristics of data. Metadata that have been endorsed for use across Australia are referred to as data standards and can be stored in a data dictionary or a metadata registry (AIHW 2007).

In Australia, national health data standards are contained in the National Health Data Dictionary. Should any national standards be developed for DV data to be collected via the NPDC, the national standard would be added to this dictionary.

9.3 Staged implementation

Should it be decided that any *Screening for Domestic Violence* data items should proceed to the NPDC, it is expected that this would involve a staged implementation. Initially, data item(s) would be included in a Perinatal Data Set Specification (DSS). A DSS is a set of data items to be collected according to standardised definitions (national data standards); however, there is no obligation on jurisdictions to collect or report the items. This is different from an NMDS, which is for mandatory collection and national reporting. An NMDS depends on agreement from every state and territory to collect and supply data according to the national definitions; that is, to implement the data items in their PDCs.

A DSS therefore allows national data standards to develop but takes pressure off jurisdictions in terms of implementation timelines and resources. The process of data development for items being added to a DSS or NMDS is the same. National data standards must be created and agreed to, and endorsed by relevant national data and standards committees.

Including any DV data in the NPDC is a long-term project and it is unlikely that any DV item(s) would go into the NPDC in the foreseeable future. However, this paper highlights the importance of such information and provides a basis for considering how data development could proceed if it were agreed that the NPDC was an appropriate collection.

Appendix A: NMDDP Advisory Group

The main role of the NMDDP Advisory Group is to provide expert advice and guidance on current and emerging perinatal and maternal mortality and morbidity issues of relevance to the project. The NMDDP Advisory Group (see Table A1 for a list of members) provides input and advice on clinical, technical and policy considerations at various stages of the NMDDP.

Table A1: NMDDP Advisory Group members

Name	Organisation/Expertise
Dr Fadwa Al-Yaman (Chair)	AIHW
Ms Belinda Barnett	Maternity Choices Australia
Dr Georgina Chambers	National Perinatal Epidemiology and Statistics Unit
Ms Sue Cornes	Chair, National Perinatal Data Development Committee
Prof. Ross Haslam	Australian and New Zealand Neonatal Network
Prof. Caroline Homer	Clinical expert—midwifery
Prof. Michael Humphrey	Consultant—National Perinatal Epidemiology and Statistics Unit
Ms Ann Kinnear	Australian College of Midwives
Mr Conan Liu	AIHW
Mr Peter Mansfield	National Perinatal Data Development Committee Representative—Tasmania
Ms Marisa Monaco	Department of Health
A/Prof. Michael Nicholl	Clinical expert—obstetrics
Prof. Jeremy Oats	Maternity Services Inter-Jurisdictional Committee
Prof. Michael Permezel	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Mr Adrian Riches	Department of Health

Appendix B: Feedback from jurisdictional consultations

As part of the NMDDP scoping and prioritisation of national maternity information needs, stakeholders were canvassed for their views (via a questionnaire) on data items they thought were of the highest priority for national collection. The majority of respondents agreed that domestic violence screening was important for national collection (69%), and just over half of respondents (55%) agreed that its collection was an essential or high priority. However, some respondents noted that:

- there may be difficulties in obtaining information, and due to potential data quality issues the usefulness of the data may be questionable
- due to a relatively small sample, this may be better addressed via dedicated research
- no interventions have yet proven to reduce the impact of adverse events on mother and baby through the detection of DV and therefore this item does not meet the criteria for a screening test
- hospitals can be surveyed regarding policies on DV screening for antenatal clients in a Health Service questionnaire. Official reported incidents may be useful as a data source.

So, while there was a broad consensus on the importance of the item and its relevance to women and their children, some respondents expressed concerns about the validity of the NPDC for this type of item. Table B1 provides more detail on jurisdictional feedback.

Table B1: Screening for domestic violence – jurisdiction feedback

New South Wales	
PDC unit (Centre for Epidemiology and Research)	• All women presenting to NSW Health services in Antenatal and Child and Family Health services, and women aged 16 and over in Mental Health and Drug and Alcohol services, are screened for DV. • The issue is important but PDC manager is not sure of purpose of collecting data at the population level.
Midwife	• Needs to be collected nationally. New South Wales already screens with a 4-question tool and is collected at first visit. However, sometimes women are not asked due to challenges associated with collection such as partner being present. If collection is not possible, a small pamphlet is provided to the woman. New South Wales also does a 1-month audit in November on the number of women asked, screened positive and referred on.
Policy group	• There needs to be more education and practice for how questions relating to psychosocial items should be asked in order to get reasonable data/information. • Getting this and other psychosocial items collected at a national level is very important. Early intervention/prevention is very important. Self-report is better than not asking at all. • In New South Wales, when clinicians first started using electronic systems (rather than paper forms) when interviewing patients for their history, there seemed to be a reduction in DV responses. It has been anecdotally reported that some staff were concerned that the use of the computer reduced eye-to-eye contact and direct engagement with the patient, which was thought to affect a woman's likelihood to respond to screening questions. Research has also shown that a woman is more likely to report DV after a few visits, rather than on the first visit. • In the NMDDP item list, DV is under 'Maternal risk factors', but there are considerable risks for the unborn child. Suggest change this heading to include the baby.

(continued)

Table B1 (continued): Screening for domestic violence – jurisdictional feedback

Victoria
Representatives from the Clinical Councils Unit; data systems; epidemiology; research; clinical/midwife • A majority of hospitals screen for DV. • This can be collected in some systems. • However, it would not be available for all women.
Queensland
PDC unit (Data collection unit) • Not collected in the PDC but is in Perinatal Online (for hospital use). Maybe for the future; currently, the data are stored outside of the state database. The PDC could collect a Yes/No response as to whether screening for DV was conducted. Queensland Maternal and Perinatal Quality Council • Screening is already conducted at the Royal Brisbane Women's Hospital and a number of other Queensland hospitals. At the Royal Brisbane Women's Hospital, the Edinburgh Postnatal Depression Scale and DV screening are done for all women but DV screening is done on a separate piece of paper (not the hand-held record) so that partners do not have access to seeing that a woman has reported it. • Unpublished data show a relationship between obesity and DV, and it is known that obesity and socioeconomic status are correlated. This is where education is so important because well-educated people more often leave DV situations. Network • There have been no reports by the midwives of problems asking these questions. However, not being able to get the partner out of the room is an indicator that DV may be present.
Western Australia
PDC unit (Maternal and child health unit) in consultation with members of the WA Women and Newborn Clinical Network, Stork Business User Group, midwives, nurse and systems managers from various hospitals, Australian College of Midwives, members of Women and Newborn Health Service, Country Health Service, and community health • Not currently collected by Western Australia's Midwives Notification System. • There is a push for all health ministers to sign up for a risk assessment framework for a national minimal standard response to DV. • Screening is done well at some hospitals, but not so well at others. • Do we need to collect whether women are screened at a national level? It is not important to collect whether the woman is screened; it is whether she screened positive for DV. • Outside scope of the PDC, which is not the solution to everything that stakeholders may want to collect. Alternate ways of collecting data are necessary. • Also need to consider if we are putting women at risk if the information is not confidential, and whether the hospital/midwife is resourced to respond to a positive screening. Clear and effective referral pathways are needed. • There is national funding at the COAG level for data collection of DV. • One Western Australian private hospital is currently receiving complaints for asking women about illicit drug use—may also get this with DV screening. • Consensus was that it is yet to be determined if this is appropriate for collection, but it needs to stay on the agenda.
South Australia
PDC unit (Pregnancy outcomes unit) • Not currently screened but gets occasional reporting through other medical records. • Validity of the item may be questionable since it tends to be under-reported. • If a consistent screening tool were used state-wide, South Australia could consider including this item, but currently not in use in the state. Clinical • If there is a standard score, South Australia would support but is definitely a long-term item. • A definition of vulnerable women would also be good.

(continued)

Table B1 (continued): Screening for domestic violence—jurisdictional feedback

Tasmania
PDC unit (Health statistics unit) • There are questions on DV in ObstetrixTas. • Tasmania is currently discussing what prompts flash up on the ObstetrixTas screen when it opens for items that are sensitive. Alerts that cannot be seen by patients are an option. • These data have not been analysed, so the quality is unknown.
Australian Capital Territory
PDC unit (Epidemiology section, Population Health Division) • The hospital maternity information system (Birthing Outcome System or BOS) has risk assessment screens and prompting questions to ask mothers in the antenatal period, and/or on discharge; however, these fields are not used. If used, the questions are only for screening and the system does not record the results of this screening.
Northern Territory
Program leader for Women's Health Strategy Unit, Northern Territory Department of Health • DV should be seen as important as collecting blood pressure as it has just as large an impact on the health of the mother and baby as do other things. • A pilot to evaluate the introduction of DV screening was done in the Northern Territory in two hospital emergency departments—results showed 30% of those screened had a positive result for DV. Antenatal screening was implemented after this. • The screening has been done for years, but not consistently. The form used in Northern Territory hospitals is based on the New South Wales questions. • It is of concern that DV data are not consistent; however, not collecting them would be detrimental, because ultimately it is about referral and service, not the data. • There is new legislation (2 years old) for mandatory reporting; however, it has not yet translated down to services. All people aged over 18 have a mandatory obligation to report serious violence. The form has not been updated since this mandate came in. • There is a <i>National Plan to Reduce Violence against Women and their Children 2010–2022</i> initiated by the national Office of Women's Policy in the Department of Families, Housing, Community Services and Indigenous Affairs. There is a COAG select committee on women's policy and gender equity overseeing the plan. Jurisdictions will have to respond to the strategy which will have implications for showing what work is being done to prevent and respond to DV in the Northern Territory. • It is difficult to support and do quality control on the collection of DV antenatal screening data because there are limited resources for training of staff, analysis and reporting of data and development of strategic approaches to preventing and responding to DV and FV. PDC unit (Acute care information services) and Perinatal Information Management Group members • The main concern with recording DV is confidentiality. People might also be more reluctant to report DV if they thought data would be available to others. Staff impost is also an issue, as there has to be training and guidelines. A safety issue can be created for women if questions are asked in the wrong way. • The Northern Territory DV form states that 'whatever you reply will remain strictly confidential and remain in your hospital records'. This gives the impression it is not recorded in a data system. Data would be de-identified if collected nationally. • Have to think about what action would be taken from perinatal data results. It is important to have these data to analyse the outcomes of pregnancy against DV responses. • There is a difference between what would be desirable to collect and what can be collected. We need to think about whether the PDC is the right collection or whether a research project would be better. • The Northern Territory supports the item if there is a nationally consistent form and data are non-identifiable.

Appendix C: Screening for Domestic Violence Workshop attendees

A workshop was held in October 2013 to consider whether it would be possible to collect national information on *Screening for Domestic Violence* as part of the NPDC, the kind of information that could be collected and the usefulness of the data. A discussion paper formed the basis of the workshop.

Table C1: Summary of DV workshop attendees

Organisation or group represented	Number of representatives
AIHW	5
NMDDP Advisory Group	5
Department of Health	3
NMDDP Clinical and Data Reference Group	3
ABS	2
SA Health	2
Department of Social Services	1
LaTrobe University—subject matter expert	1
National Perinatal Epidemiology and Statistics Unit, University of New South Wales	1
NSW Ministry of Health	1
NT Health Department	1
Private hospital representative	1
University of NSW—subject matter expert	1

Appendix D: Screening for Domestic Violence Working Party

The Screening for DV Working Party (see Table D1 for a list of members) was established after the October 2013 workshop to advise on the feasibility of data development, to comment on this report, and to help determine any data item(s) that might proceed to the NPDC.

Table D1: Screening for Domestic Violence Working Party members

Name	Organisation/Expertise
Ms Tamsin Anderson	NSW Health
Ms Mary Beneforti (Chair)	AIHW
Dr Donna Hartz	University of Western Sydney
Ms Megan Howitt	Northern Territory Department of Health
Ms Jessica Gourlay	ABS
Mr Conan Liu	AIHW
Mr Peter Mansfield	Tasmanian Department of Health and Human Services
Mr William Milne	ABS
Mr George Neale	Private hospital representative
Dr Michelle Quee	AIHW
Dr Jo Spangaro	University of New South Wales—expert in DV
Dr Angela Taft	La Trobe University—expert in DV

Note: Ms Fiona Blackshaw and Ms Stephanie Kelly were former members of the working party, representing the ABS.

Appendix E: Jurisdictional legislation/policies/strategies

Table E1: Jurisdictional legislation/policies/strategies

Jurisdiction	Legislation	Other initiatives, policies or strategies	Mandatory reporting
Commonwealth	<i>Family Law Act 1975</i>	<i>National Plan to Reduce Violence against Women and their Children 2010–2022</i>	No
New South Wales	<i>Crimes (Domestic and Personal Violence) Act 2007</i>	<i>It Stops Here—the Domestic and Family Violence Framework</i> ; NSW Health policy; <i>Domestic violence—identifying and responding</i>	No
Victoria	<i>Family Violence Protection Act 2008</i> <i>Family Violence Protection Amendment Act 2014</i>	<i>Action Plan to Address Violence against Women and Children</i> ; Sexual Assault Reform Strategy; <i>Victorian Aboriginal Affairs Framework 2013–2018</i> ; <i>Victorian Family Violence Database</i> ; <i>Family Violence Risk Assessment and Risk Management Framework</i>	No
Queensland	<i>Domestic and Family Violence Protection Act 2012</i>	<i>For our Sons and Daughters—a Queensland Government strategy to reduce domestic and family violence 2009–2014</i> ; Queensland Health's domestic violence initiative; Special Taskforce on Domestic and Family Violence in Queensland (final report <i>Not Now, Not Ever</i>)	No
Western Australia	<i>Restraining Orders Act 1997</i> <i>Acts Amendment (Family and Domestic Violence) Act 2004</i>	<i>Western Australia's Family and Domestic Violence Prevention Strategy to 2022</i> ; <i>Family and Domestic Violence Common Risk Assessment and Risk Management Framework</i> ; <i>Guidelines for responding to family and domestic violence</i>	No
South Australia	<i>Domestic Violence Act 1994</i> <i>Intervention Orders (Prevention of Abuse) Act 2009</i>	<i>A Right to Safety—South Australia's Women's Safety Strategy 2011–2022</i> ; Family Safety Framework	No
Tasmania	<i>Family Violence Act 2004</i> <i>Children, Young Persons and their Families Act 1997*</i>	<i>Safe at Home: a criminal justice framework for responding to family violence in Tasmania</i>	No*
Australian Capital Territory	<i>Domestic Violence and Protection Orders Act 2008</i>	<i>ACT Women's Plan 2010–2015</i> ; <i>Prevention of Violence Against Women and Children Strategy 2011–2017</i> ; Family Violence Intervention Program	No
Northern Territory	<i>Domestic and Family Violence Act 2007</i> <i>Domestic and Family Violence Amendment Bill 2009</i>	<i>Domestic and Family Violence Reduction Strategy 2014–2017: Safety Is Everyone's Right</i>	Yes

* *The Children, Young Persons and their Families Act 1997* recognises children as victims of family violence in their own right and amendments were made to recognise exposure to FV as a form of child abuse requiring mandatory reporting. Therefore, in Tasmania, if a woman was pregnant with her first child and was experiencing abuse during pregnancy, mandatory reporting would not apply because the child would not be 'witnessing' FV as such. However, if there were already other children in the family, mandatory reporting would apply. A review of DV laws in Australia (2009) highlights that, while there are differences in legislation across jurisdictions, the types of conduct that constitute DV are generally similar. In all jurisdictions, DV includes assault/personal injury (including sexual assault) and threats of such behaviour. DV also encompasses intimidation in all jurisdictions except the Australian Capital Territory. In some jurisdictions, there is specific provision to make orders to protect a child from exposure to DV. Some jurisdictions go further, so that exposing a child to DV against another person is itself DV perpetrated against the child. Legislation in several jurisdictions expressly includes 'economic abuse' as a form of DV but each jurisdiction deals with this differently. Some jurisdictions expressly include 'emotional abuse' or 'psychological abuse' as a form of DV.

Appendix F: Existing data sources

When deciding if it is appropriate to include an item on screening for DV in the NPDC, it is important to consider whether the required data—or a reasonable compromise for the required data—could be obtained from any other existing data sources. A number of data sources contain some information on violence, including DV, but for reasons discussed in Chapter 5 are not entirely suitable to monitor the long-term outcomes for women. Existing data sources include:

- national surveys such as the ABS PSS, the National Crime Victimization Survey, the ABS General Social Survey and the AIHW National Drug Strategy Household Survey. Of these, only the PSS has information specific to pregnancy. The PSS (2005) has two pregnancy-specific questions which are asked in relation to both current and previous partners:
 1. whether violence during the relationship ever occurred during pregnancy. Response categories include: Not applicable, Violence occurred during pregnancy, Violence did not occur during pregnancy, Not pregnant during relationship
 2. whether violence during the relationship occurred for the first time during pregnancy. Response categories include: Not applicable, Violence occurred for the first time during pregnancy, Violence did not occur for the first time during pregnancy, Don't know
- administrative databases that collect client information and from which by-product data can be obtained include the AIHW NHMD; the AIHW Non-admitted Patients Emergency Care Database; the AIHW National Mortality Database; the AIHW Specialist Homelessness Services Collection; the ABS Recorded Crime – Victims collection; and police data on reported incidents, offences, apprehensions and court proceedings.

An example of the kind of information the AIHW NHMD (Table F1) might provide includes information on assaults and injury sustained for admitted patients as well as the type of perpetrator. While there is no ICD-10-AM code clearly identifying a pregnant woman in these data, it is possible to use a number of codes to identify the population of interest.

Table F1: Separations for women aged 15–49 admitted to hospital for injury due to assault, by perpetrator, 2010–11

	Separations with an obstetric code	Separations with a Z33 code (Pregnancy, incidental)
Spouse or domestic partner	48	93
Other person	31	50
Total	79	143

Source: NHMD unpublished data 2010–11.

Information could also be collected about the woman's birth episode and mother and baby outcomes from the NHMD through diagnosis and procedure coding, and/or could be linked with information in the PDC. Retrospective studies could examine DV incidents in pregnancy through data linkage of a woman's episodes of hospitalisation preceding and during pregnancy.

However, limitations of admitted patient's hospital data include those points outlined below:

- The data capture only those at the severe end of the spectrum – that is, those who have been hospitalised as a result of injury due to assault. The information is therefore only for a subset of women who experience DV in pregnancy. As can be seen in Table F.1, the numbers for 2010–11 are small and do not lend themselves to much further analysis (although numbers could be combined over years).
- Identification of pregnant women in the collection relies on derivation based on a number of codes and will not capture all pregnant women who are hospitalised. The additional diagnosis of pregnancy may not be known to the doctor, the woman may not mention it or may not know herself if the pregnancy is in its early stages, or the additional diagnosis may not be coded if not thought to be relevant to the principal reason for admission, or may be missed in the coding.
- Many women may present to the emergency department and not be admitted to hospital. However, the AIHW Non-admitted Patients Emergency Department Care Database does not hold diagnosis data.

Appendix G: Resources

Links to National Maternity Data Development Project papers:

AIHW 2014. Foundations for enhanced maternity data collection and reporting in Australia: National Maternity Data Development Project Stage 1. Cat. no. PER 60. Canberra: AIHW.
<<http://www.aihw.gov.au/publication-detail/?id=60129547184>>

Links to other maternity services papers:

Australian Health Ministers' Advisory Council 2012. Clinical practice guidelines: antenatal care – module 1. Canberra: Department of Health and Ageing.
<<http://www.health.gov.au/antenatal>>

Australian Health Ministers' Conference 2011. National Maternity Services Plan 2010. Canberra: Department of Health.
<<http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesplan>>

Links to DV background papers:

ABS 2013a. Defining the data challenge for family, domestic and sexual violence, Australia: a conceptual data framework. ABS cat. no. 4529.0. Canberra: ABS.
<<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4529.02013?OpenDocument>>

ABS 2013b. Bridging the data gaps for family, domestic and sexual violence. ABS cat no. 4529.0.00.002. Canberra: ABS.
<<http://www.abs.gov.au/ausstats/abs@.nsf/mf/4529.0.00.002>>

ABS 2014. Foundation for a national data collection and reporting framework (DCRF) for family, domestic and sexual violence. ABS cat. no. 4529.0.00.003. Canberra: ABS.
<<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4529.0.00.0032014?OpenDocument>>

Council of Australian Governments 2012. National Plan to Reduce Violence against Women and their Children 2010–2022. Canberra: COAG.
<http://www.fahcsia.gov.au/sites/default/files/documents/05_2012/national_plan.pdf>

Links to national policies:

Council of Australian Governments 2009. Protecting children is everyone's business: national framework for protecting Australia's children 2009–2020. Canberra: COAG.
<https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf>

Department of Human Services 2012. Family and Domestic Violence Strategy. Canberra: Department of Human Services.
<<http://www.humanservices.gov.au/corporate/publications-and-resources/family-and-domestic-violence-strategy>>

Links to jurisdictional policies and/or screening tools:

New South Wales:
<http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_017.pdf>

Victoria:
<http://www.dhs.vic.gov.au/__data/assets/pdf_file/0010/718858/1_family_violence_risk-assessment_risk_management_framework_manual_010612.PDF>

Western Australia:
<<http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/CRARMF.pdf>>

Appendix H: Definition of domestic violence from the *National Plan to Reduce Violence against Women and their Children 2010–2022*

Violence against women can be described in many different ways, and laws in each state and territory have their own definitions.

The term violence against women means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. (United Nations Declaration on the Elimination of Violence against Women)

DV refers to acts of violence that occur between people who have, or have had, an intimate relationship. While there is no single definition, the central element of DV is an ongoing pattern of behaviour aimed at controlling a partner through fear (for example, by using behaviour that is violent and threatening). In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal.

DV includes physical, sexual, emotional and psychological abuse.

Physical violence can include slaps, shoves, hits, punches, pushes, being thrown down stairs or across the room, kicking, twisting of arms, choking, and being burnt or stabbed.

Sexual assault or sexual violence can include rape, sexual assault with implements, being forced to watch or engage in pornography, enforced prostitution, and being made to have sex with friends of the perpetrator.

Psychological and emotional abuse can include a range of controlling behaviours such as control of finances, isolation from family and friends, continual humiliation, threats against children or being threatened with injury or death.

FV is a broader term that refers to violence between family members, as well as violence between intimate partners. It involves the same sorts of behaviours as described for DV. As with DV, the National Plan recognises that although only some aspects of FV are criminal offences, any behaviour that causes the victim to live in fear is unacceptable. The term, 'family violence' is the most widely used term to identify the experiences of Indigenous people, because it includes the broad range of marital and kinship relationships in which violence may occur.

Appendix I: Validated screening tool summary

International research shows some validated tools can differentiate abused from non-abused women. Table I1 summarises validated instruments that have been used in pregnancy contexts (either in part or full) and is largely based on a review conducted by the Centre for Disease Control and Prevention (Basile et al. 2007). Bolded questions are either used by one or more Australian jurisdictions, or a jurisdiction asks a very similar question. Note however that a systematic review of intimate partner violence screening tools (Rabin et al. 2009) found that no single screening tool for intimate partner violence had well-established psychometric properties and that further testing and validation are critically needed.

Table I1: Validated screening tool summary*

Screening tool	Collection method	No. of questions and domain assessed	Populations studied*	Questions, response categories, scoring procedures and notes
Abuse Assessment Screen	Clinician administered	Five (5) items assess frequency and perpetrator of physical, sexual, and emotional abuse by anyone. Body map to document area of injury.	Abused pregnant and non-pregnant African-American, Hispanic, and white women in health and prenatal clinics and emergency departments.	(1) Have you ever been emotionally or physically abused by your partner or someone important to you? (2) Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? (3) Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? (4) Within the last year, has anyone forced you to have sexual activities? (5) Are you afraid of your partner or anyone you listed above? Question 3 may be omitted when interviewing non-pregnant women. Response categories: Yes/no for all questions. Scoring procedure: If any questions on the screen are answered affirmatively, the Abuse Assessment Screen is considered positive for abuse (Weiss et al. 2003 as cited by Basile et al. 2007). Notes: The Abuse Assessment Screen is the only validated screening tool that asks specifically about abuse during pregnancy and therefore potentially represents an important screening tool for obstetric populations (Rabin et al. 2009).

(continued)

Table I1 (continued): Validated screening tool summary*

Screening tool	Collection method	No. of questions and domain assessed	Populations studied*	Questions, response categories, scoring procedures and notes
Humiliation, Afraid, Rape, Kick (HARK) Screen	Self-report	Four (4) items assess physical, sexual and emotional abuse by a partner or ex-partner within the last year.	Woman in general practice waiting rooms in the United Kingdom	(1) Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? (2) Within the last year, have you been afraid of your partner or ex-partner? (3) Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? (4) Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner? Response categories: Yes/no for all questions Scoring procedure: If any questions on the screen are answered affirmatively, the HARK is considered positive for abuse.
Hurt, Insult, Threaten, Scream (HITS) Screen	Self-report or clinician administered	Four (4) items assess the frequency of physical or emotional abuse by a partner.	Female patients in family practice settings; male patients in health-care settings	(1) How often does your partner physically hurt you? (2) How often does your partner insult you or talk down to you? (3) How often does your partner threaten you with harm? (4) How often does your partner scream or curse at you? Response categories: Each question is answered on a 5-point scale: 1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = frequently Scoring procedure: Responses are summed to form a total HITS score which can range from 4 to 20. For female patients, a HITS cut-off score of 10 or greater can be used to classify participants as victimised (Shakil et al. 2005; Sherin et al. 1998 as cited by Basile et al. 2007).
Partner Violence Screen	Clinician administered	Three (3) items assess physical partner violence in the last year and current safety	Women and men in emergency room settings in the United States and Canada	(1) Have you been hit, kicked, punched or otherwise hurt by someone in the past year? If so, by whom? (2) Do you feel safe in your current relationship? (3) Is there a partner from a previous relationship who is making you feel unsafe now? Response categories: Response categories not provided; however, yes/no would be appropriate. Scoring procedure: The Partner Violence Screen is positive for current physical abuse if there is a yes response to any question. <i>Note:</i> The Partner Violence Screen has not been found to be as sensitive as other screening tools (Chuang & Liebschutz 2002); however, the advantage of the screen is that it is short and easy to use.

(continued)

Table I1 (continued): Validated screening tool summary*

Screening tool	Collection method	No. of questions and domain assessed	Populations studied*	Questions, response categories, scoring procedures and notes
Slapped, Thrown and Threatened screen	Clinician administered	Three (3) items assess lifetime partner violence for physical and emotional abuse.	Female patients in non-acute section of hospital emergency department	(1) Have you ever been in a relationship where your partner has pushed or slapped you? (2) Have you ever been in a relationship where your partner has thrown, broken or punched things? (3) Have you ever been in a relationship where your partner has threatened you with violence? Response categories: Response categories not provided; however, yes/no would be appropriate. Scoring procedure: A positive response to each item scores 1 point. A positive response to any one of the 3 questions makes a history of violence likely whereas a negative response to all 3 questions essentially rules it out (Chuang & Liebschutz 2002).
Women Abuse Screening Tool (WAST)	Self-report	Seven to eight (7–8) items assess physical and emotional partner abuse.	Abused and non-abused English-speaking women in clinical health-care settings and women's shelters	(1) In general, how would you describe your relationship? (2) Do you and your partner work out arguments? (3) Do arguments ever result in you feeling down or bad about yourself? (4) Do arguments ever result in hitting, kicking or pushing? (5) Do you ever feel frightened by what your partner says or does? (6) Has your partner ever abused you physically? (7) Has your partner ever abused you emotionally? (8) Has your partner ever abused you sexually? The eighth question is not always used. Response categories: Question 1 uses a 3-point scale: a lot of tension, some tension, no tension. Question 2 uses a 3-point scale: with great difficulty, some difficulty, no difficulty. Questions 3–8 use a 3-point scale: often, sometimes, never. Scoring procedures: Recode responses to reflect a higher score for higher reported frequency of experiences and sum the Women Abuse Screening Tool scores for individuals who answered all 8 items (Basile et al. 2007).
WAST – Short	Self-report	Two (2) items assess tension in relationship and how respondent and partner work out arguments	Abused and non-abused English-speaking women in clinical health-care settings and women's shelters	The first 2 questions of the Women Abuse Screening Tool constitute the WAST – Short, which has been found to be effective for initial screening for the presence of abuse; however, the WAST—Short would benefit from validation in a larger sample. The remaining questions on the WAST are used to gain a more complete assessment of the abuse. Scoring procedures: Assign a score of 1 to the most extreme positive response ('a lot of tension') and a score of 0 to other response options. Scores range from 0 to 2 and criterion cut-off score is 1.

(continued)

Table I1 (continued): Validated screening tool summary*

Screening tool	Collection method	No. of questions and domain assessed	Populations studied*	Questions, response categories, scoring procedures and notes
Women's Experience with Battering Scale	Self-report	Ten (10) items assess emotional partner violence or battering	African-American and white women in family practice settings	(1) He makes me feel unsafe even in my own home. (2) I feel ashamed of the things he does to me. (3) I try not to rock the boat because I am afraid of what he might do. (4) I feel like I am programmed to react a certain way to him. (5) I feel like he keeps me prisoner. (6) He makes me feel like I have no control over my life, no power, no protection. (7) I hide the truth from others because I am afraid not to. (8) I feel owned and controlled by him. (9) He can scare me without laying a hand on me. (10) He has a look that goes straight through me and terrifies me. Response categories: 6-point scale ranging from agree strongly (6), agree somewhat (5), agree a little (4), disagree a little (3), disagree somewhat (2), disagree strongly (1). Scoring procedures: Reverse score and then add the responses for all items. Range of scores is 10 to 60. A score of 20 or higher is a positive screening test for battering (Coker et al. 2002; Punukollu 2003 as cited by Basile et al. 2007).
Ongoing Abuse Screen	Self-report	Five (5) items assess ongoing physical, sexual, emotional partner violence, and fear. The Ongoing Abuse Screen is adapted from the Abuse Assessment Screen; however, it assesses ongoing violence rather than 'present' (within a year) violence which the Abuse Assessment Screen assesses (Ernst et al. 2002).	Women and men in emergency departments. Tested on African-Americans, Hispanics, and whites.	(1) Are you presently emotionally or physically abused by your partner or someone important to you? (2) Are you presently being hit, slapped, kicked, or otherwise physically hurt by your partner or someone important to you? (3) Are you presently forced to have sexual activities? (4) Are you afraid of your partner or anyone of the following (circle if appropriate): husband/wife, ex-husband/ex-wife, boyfriend/girlfriend, stranger? (5) (If pregnant) Have you ever been hit, slapped, kicked, or otherwise physically hurt by your partner or someone important to you during pregnancy? Response categories: Questions 1–3 and 5 are yes/no. Question 4 shows response categories above. Scoring procedure: If any questions are answered affirmatively, the Ongoing Abuse Screen is considered positive for ongoing abuse.

(continued)

Table I1 (continued): Validated screening tool summary*

Screening tool	Collection method	No. of questions and domain assessed	Populations studied*	Questions, response categories, scoring procedures and notes
Ongoing Violence Assessment Tool	Self-report	Four (4) items assess for ongoing (present) physical and non-physical violence (Ernst et al. 2004).	Unknown	(1) Within the last month my partner has threatened me with a weapon. (2) Within the last month my partner has beaten me so badly that I had to seek medical care. (3) Within the last month my partner has no respect for my feelings. (4) Within the last month my partner has acted like he or she would like to kill me. Response categories: Questions 1, 2 and 4 are true/false. Question 3 is a 5-point scale: Never, Rarely, Occasionally, Frequently, Very Frequently. Scoring procedure: A true response to questions 1, 2, or 4, or a response of 3 or higher for question 3 is considered positive for ongoing intimate partner violence.

* List is not exhaustive.

Table I2 presents screening tools used in Australian states and territories. Bolded questions are similar to questions contained in a validated tool such as some of those in Table I1. Table I3 presents similar information but in a different format for easy reference.

Table I2: Jurisdictional screening tool summary

Screening jurisdiction	Usual collection method	No. of questions and domain assessed	Questions and response categories
New South Wales	Clinician administered	Four (4) items which assess physical abuse, fear and safety concerns; 2 items only if abuse not identified	Within the last year, have you been hit, slapped or hurt in other ways by your partner or ex-partner? Are you frightened of your partner or ex-partner? Are you safe to go home when you leave here? Would you like some assistance with this? Yes/no response categories for each question. The questions form part of the SafeStart psychosocial assessment (NSW Health 2009) and may be supplemented by 4 further questions about children. If the woman answers 'no' to both of the first 2 questions, no further questions are asked.
Victoria	Varies depending on the tool used	Six (6) items which assess fear, emotional abuse, threats, and physical abuse	The CRAF provides some standardised assessment but other tools or approaches may also be used. Some questions from the CRAF include: Are you ever afraid of someone in your family or household? If so, who? Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do? Has someone in your family or household ever threatened to hurt you? Has someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you? Are you worried about your children or someone else in your family or your household? Would you like help with any of this now? While most questions are suitable for yes/no response categories it is not clear whether they are formally recorded as such.

(continued)

Table I2 (continued): Jurisdictional screening tool summary

Screening jurisdiction	Usual collection method	No. of questions and domain assessed	Questions and response categories
Queensland	Clinician administered	Ten (10) items which assess fear, physical abuse, emotional abuse and threats	Are you ever afraid of your partner or ex-partner? In the last year, has anyone at home hit, kicked, punched or otherwise hurt you? In the last year, has anyone at home often put you down, humiliated you or tried to control what you can do? In the last year, has your partner or ex-partner threatened to hurt you? Has your child/children been hurt or witnessed violence between you and your partner or ex-partner? Does your child/children live with you now? If 'no', specify with whom. Are you safe to go home when you leave here? Are you worried about your child's/children's safety? Would you like help with any of this now? This could be important information for your health-care providers. May we send a copy of this form to your doctor or primary maternity carer? Yes/no response categories for each question. Questions 7–10 are asked only if patients answer 'yes' to any of the first 6 questions.
Western Australia	Clinician administered	Four (4) items which assess emotional or physical abuse, threats and fear	Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do? Has someone in your family or household ever hurt or threatened to hurt you? Are you worried about the safety of your children or someone else in your family or your household? Would you like help with any of this now? Open-ended questions.
South Australia	Self-report	Three (3) items which are part of the ANRQ, assess emotions, stress and physical abuse	Is your relationship with your partner an emotionally supportive one? Have you had any stresses, changes or losses in the last 12 months (e.g. separation, domestic violence, unemployment, bereavement)? Have you ever been sexually or physically abused? Response categories vary between questions. The response category for the first question is a 6-point scale from 'very much' to 'not at all'. Response categories for the next 2 questions are yes/no. Patients who answer 'yes' to the third question are considered high risk irrespective of their total ANRQ score.

(continued)

Table I2 (continued): Jurisdictional screening tool summary

Screening jurisdiction	Usual collection method	No. of questions and domain assessed	Questions and response categories
Tasmania	Clinician administered likely—awaiting confirmation from Tasmania	Three (3) items which assess physical abuse, fear and presence of apprehended violence order (AVO)	Have you been hit, slapped or hurt by partner or ex in last 12 months? Are you ever frightened by your partner or ex-partner? Does your partner have an AVO against them? If 'yes', can you provide a copy? If a patient has responded 'yes' to the second question above, the following questions are also asked: Are you safe to go home when you leave here? Would you like some assistance with this? Response categories vary between these questions. Those for the first question are Yes, No, Not known, and Unable to ask. Those for the second question are No, Yes frightened by partner, Yes frightened by ex-partner, Not known and Unable to ask. Those for the third question are yes/no only. If the last two questions are asked, the response categories to these are yes/no and not known.
ACT	n/a	No questions identified	n/a
Northern Territory	Clinician administered	Six (6) items which assess fear, physical abuse, emotional abuse, threats and sexual abuse	Are you ever afraid of your partner or someone in your family? In the last year, has your partner or anyone in your family hit, kicked, punched or hurt you? In the last year, has your partner or your family often put you down, make you feel ashamed or tried to control what you do? In the last year, has your partner or anyone in your family threatened to hurt you in any way? In the last year, has your partner or anyone in your family made you have sex when you didn't want to? Would you like help with any of this now? The first 5 questions include response categories for yes, no and sometimes. The final question includes only a yes/no response category.

Table I3: Questions similar to both validated and jurisdictional tools

Jurisdictional questions	Jurisdictions that use the question	Maps to which validated instrument
Within the last year, have you (ever) been hit, slapped or hurt in other ways by your partner or ex-partner? OR (In the last year,) has (your partner or) someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you?	NSW, Vic, Qld, Tas, NT	Abuse Assessment Screen Question 2: Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? Partner Violence Screen Question 1: Have you been hit, kicked, punched or otherwise hurt by someone in the past year? If so, by whom?
Are you (ever) afraid of your partner or ex-partner (or someone in your family)?	NSW, Vic, Qld, Tas, NT	Abuse Assessment Screen Question 5: Are you afraid of your partner or anyone you listed above?
(In the last year) has (your partner or) someone in your family or household ever (often) put you down, humiliated you or tried to control what you can or cannot do?	Vic, Qld, WA, NT	The HITS Screening Tool Question 2: How often does your partner insult you or talk down to you?
(In the last year), has your partner or ex-partner (ever hurt or) threatened to hurt you (in any way)?	Vic, Qld, WA, NT	The HITS Screening Tool Question 3: How often does your partner threaten you with harm?

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This report discusses barriers to, and opportunities for the collection of data on screening for domestic violence during pregnancy. It proposes options for data collection through the National Perinatal Data Collection, which includes data about every woman who gives birth in Australia. The work is part of the Australian Institute of Health and Welfare's National Maternity Data Development Project.