Centre for Child Development and Education
Research Brief

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Asking about domestic and family violence: insights from an evaluation of a maternal and early childhood home visiting program in remote NT communities

This research brief draws on mixed-methods research with Aboriginal families and remote health practitioners involved in the Maternal Early Childhood Sustained Home-visiting (MECSH) program. The aim is to inform better alignment between policy, practice, and health information systems as Aboriginal Community Controlled Health Services implement the NT Government's Domestic and Family Violence (DFV) Risk Assessment and Management Framework (RAMF) framework.

Key findings

- Practitioners described using relational, flexible approaches to identify and respond to DFV, in addition to formal screening.
- DFV disclosures often occurred after crises or referrals, rather than through screening questions.
- Some MECSH practitioners were providing holistic, trauma-informed responses, including engagement with families and perpetrators, going beyond the expectations of standard guidelines.
- Women's narratives emphasised coercive control, including jealousy, surveillance, financial abuse, and manipulation, often not captured by existing screening tools.
- Documentation in Communicare does not adequately reflect practices in how DFV is identified, discussed, or documented in primary health care
- Critical actions such as risk assessment, safety planning, and follow-up are often documented in free text or not at all, limiting service-wide reporting and continuity of care.

Recommendations

1. Further develop, test and refine suggested opening and screening questions to better reflect women's experiences of violence and coercive control.
2. Allow time to build rapport, avoid screening on first meeting with client.
3. Broaden Communicare documentation beyond screening to include:
   - Disclosures from crisis, referral or follow-up
   - Types of violence experienced
   - Support actions taken
4. Include DFV screening and response items in Communicare for use by all primary health providers to allow for NT-wide DFV reporting and comparison across services and regions.
5. Incorporate a short risk assessment tool tailored to remote NT contexts
6. Ensure practitioners are appropriately trained and have record keeping tools for comprehensive documentation of DFV.

Background

Health services in the Northern Territory (NT) are being tasked with implementing the NT Government's Domestic and Family Violence (DFV) Risk Assessment and Management Framework (RAMF). The RAMF provides Territory-wide, cross-sector guidance to help services identify and safely support people experiencing DFV (NTG 2020). It consists of a series of practice guides and tools to assist a range of generalist and specialist practitioners with screening, risk assessment (the CRAT), safety planning, referral and support. The tools and practice guides in the RAMF are evidence-based and comprehensive, however, the risk assessment and safety planning components tend to be targeted toward specialist DFV workers. There is a lack of clarity on how front-line health services should adapt the RAMF, the extent to which screening questions reflect remote women's experiences, and how to best capture indicators in health information systems.

Preceding the RAMF, commonly used guides for asking about and responding to DFV in primary care are the Remote Primary Health Care Manuals - CARPA Standard Treatment Manual and Women's Business Manual (Remote Primary Health Care Manuals 2022a,b); and Healthy Under 5 Kids (HU5K) Relationships Form (NTG 2016). Across these sources, there are commonalities in broad principles of DFV response, including opening and screening questions, risk assessment, safety planning, referral, follow-up and medical examination and documentation (Appendix 1). The specific questions vary considerably, and do not all include key areas of risk assessment, follow-up and documentation, or describe women's experiences of different forms of violence.

Maternal and Early Childhood Sustained Home-visiting program

The Maternal and Early Childhood Sustained Home-visiting program (MECSH) was implemented by Katherine West Health Board, Miwatj Health Aboriginal Corporation and Sunrise Health Service Aboriginal Corporation between 2019 and 2024. MECSH is a nurse-led home visiting program that supports families from pregnancy through to toddlerhood. It provides preventative support, with a focus on maternal aspirations and wellbeing, child development and responsive parenting (Kemp et al., 2012).

Originally developed and implemented in metropolitan Sydney, MECSH has since been adopted in various settings across Australia and internationally (Goldfeld et al., 2017; Kemp et al., 2022; Khang et al., 2024). In 2019, the program was implemented for the first time with Aboriginal families in very remote NT communities by three Aboriginal Community Controlled Health Services (ACCHS).

Between 2020 and 2024, Menzies undertook mixed-methods research to evaluate the implementation of the Maternal and Early Childhood Sustained Home-visiting (MECSH) program in the NT (Robinson et al 2025). The evaluation drew on qualitative and quantitative data about screening and responses to disclosure of DFV and experiences of DFV by women in remote communities.

This report is provided in response to discussions with the Aboriginal Community Controlled Health Service (ACCHS) partners in the MECSH evaluation about how the data generated in the evaluation research could inform their efforts to align the RAMF in primary healthcare practice and enhance recording of information about DFV in Communicare.

The specific objectives of this report are to draw on mixed-methods data from women and practitioners in the program to:

1) describe women's experiences of different forms of violence
2) describe how MECSH practitioners and maternity care providers are asking about and responding to disclosure of DFV, and
3) identify current challenges in recording DFV in Communicare

Methods

The NT MECSH evaluation includes elements of developmental evaluation (Patton 2010), using data and evidence to inform strategy and decision-making as part of the implementation process.

The mixed-methods design of the evaluation includes:

1. quantitative data derived from de-identified extracts of primary health care records of eligible women and their children
2. interviews with health service practitioners, and
3. interviews with women who were eligible to enrol in MECSH

Interviews with women comprised two parts – a series of surveys about individual health and wellbeing and household characteristics, partner and family support, and parental self-efficacy, followed by open ended questions about parenting strengths and challenges, family relationships and sources of support through MECSH and other programs.

Questions about DFV

The surveys included specific questions about women's experience of violence. These were refined over time to reflect the way in which women talked about their experience of harm[1] and to include the multiple types of DFV (Signorelli et al. 2022) (see Box 1 below).

In the last 12 months…

1) Did your partner stop you doing things?
2) Did your partner make you feel bad about yourself?
3) Has there been any jealousy in your relationship?
4) Have you ever felt frightened by what your partner says or does?
5) Has there been any physical violence towards you from anyone?

BOX 1. Questions used to ask about domestic and family violence in MECSH evaluation interviews with women

Interviews were audio recorded when participants gave permission. If they preferred not to be audio recorded, near verbatim notes were typed into an iPad during the conversation. Transcripts and notes were coded according to conceptual categories in the data. For this research brief, thematic analysis of the data was conducted on the categories of women's experiences of 'conflict and harm' and practitioners' experiences of 'asking' and 'responding' to DFV. Example quotes were extracted to illustrate themes, with [C] denoting Client and [P] denoting Practitioner, together with their unique participant identifier.

[1] The evaluation interviews intentionally did not ask specific questions about experiences of sexual violence or violence toward the children. These are dangerous forms of harm commonly perpetrated in violent relationships and often under-reported (Lievore 2003, Brown & Leung 2023). However for the purposes of this evaluation research, the research team agreed that questions on these forms of violence could affect rapport and participation in the interviews and they were omitted.

Findings: Practitioner responses to DFV

Asking about violence

Practitioners emphasised the importance of timing when asking about violence or undertaking 'screening' for DFV. While all practitioners should feel comfortable to start a conversation about DFV, several highlighted the importance of establishing a relationship with the client first and not screening for DFV on the first visit (P8, P21). They also felt that when women knew their provider and there was a trusting relationship, women were more likely to feel safe to disclose violence and talk about their experience (P1, P9, P11, P25). This was particularly important for young women who may find it hard to speak up, or for those who do not want the police involved, as there was a sense that women generally knew that health providers had an obligation to report to the police.

"I guess with DV in general, it's quite a sensitive subject. You, um, people aren't gonna tell you really what's going on anyway...unless they really, really trust you."

(MECSH Practitioner P9)

Some practitioners acknowledged the importance of only asking women about DFV when they are on their own (P8, P9). However, for home visiting practitioners, it was challenging when controlling partners were around during visits. Women's safety was paramount, and this meant waiting until the timing was right.

"One of the big hurdles I found was her partner. Um, I was originally told, we think there's domestic violence, but we are not sure. And, you know, I'm meeting him. Everything was about him. Um, so there was, it took a lot of visits...for him to then become comfortable for me to be around, and for him to leave me with her"

(MECSH Practitioner P8)

There was some concern the specific questions in the Relationships Form (HU5K) screening tool may not be capturing the dynamics of women's situations, in terms of creating a shared understanding across language, but also reflecting the types of harm women are experiencing. For example, women may answer 'no' to experiencing physical violence, when in fact they may be experiencing serious *threats* of harm.

"We did a domestic violence [screen] and it wasn't until after I was sort of packing up to go, I said, 'So where's your partner?' And she said, 'Oh, he's in jail. He went last week...It [screening tool] says, 'Have you experienced violence in the last year?' And then I said to her, 'Why is he in jail? She said, 'Oh, he was threatening me'. But it didn't come up in the thing [screening]."

(MECSH Practitioner P10)

Practitioners who were new to remote work had to build confidence in their own practice, and this could be a barrier to feeling comfortable asking women about violence (P8, P25). One participant noted that she found it easier to have an honest conversation rather than rely on the screening questions.

"There's lots of difficult conversations, but half the time it's me that feels more difficult than them. Um, and I just gotta get over that. I've gotta do the right thing by clients ... I've discovered that over the last few months, it's just be honest and truthful, and they can see that, if I'm honest, they can be honest back to me and we can try and have an actual proper conversation and then help each other."

(MECSH Practitioner P8)

Some practitioners began the conversation about violence by acknowledging that it is a difficult topic to talk about and that "this is a safe space" (P8). One midwife who refers clients to MECSH described how her version of screening was more of an informal conversation, drawing on notes from her health record, and asking the woman about her current relationship with her partner.

"Firstly, I'll find out if it's the same partner, because often it's not. And then I say, 'I realise you've had a few problems in the past and you know, are you still with, do you still live together? And is he a manymak [good] man?' and you just try and sense what she's thinking about that relationship or about that person? And they're pretty honest."

(Midwife P22)

Two practitioners emphasised that it was important to ask about violence from a partner, as well as from anyone else in the family or community, for example "is there anyone you don't feel safe with?" (P8, P9). It can be more difficult to assist women at risk of violence from visiting families, or when people come into the community drinking, as this is something women are less able to predict or control.

Enhancing women and children's safety

In addition to screening, practitioners became aware that women were experiencing violence through several other pathways, such as women coming to them after a crisis, being referred to MECSH, or 'checking in' when the violence is already known. Most of the response to violence described by practitioners was supporting women's immediate safety. This usually involved helping women to connect with the police and safe house or evacuate to a different community to stay with other family (P1, P8, P10, P22). It appears practitioners were doing this in an instinctive way, building on women's own safety strategies and following their lead (P10, P11, P25), rather than using any formal risk assessment or safety planning tools.

"So I just went around there and she was out in the front and she packed up all her four bags of belongings and was waiting at the front and she was crying. He was yelling from the house, You're useless...So then I took her to MECSH, bath, cleaned, sat down, cup of tea...we can work out whether you wanna go to the safe house or you wanna call someone, or what are you gonna do?"

(MECSH Practitioner P10).

Engaging partners and advocacy within families

Some practitioners were reluctant to get involved with issues of DFV out of fear of backlash from partners and extended family (P2, P10). Other, more experienced practitioners described how they engaged directly with violent partners to address upstream factors that contribute to violence (P1, P12).

"...it's always checking with the woman first, as someone who has experienced that violence, if it's appropriate for me to speak with that man, and then, you know, checking with the man if it's appropriate. Um, but then often, I'll try and support that man, in terms, if there was any mental health or AOD and referrals there. And then, um, legally are you getting any support...

(MECSH Practitioner P12)

These kinds of engagement with the partner were client-led, and tended to be orientated toward practice support (e.g. referral to AOD services). Engagement with the partner also had an emotionally supportive dimension for the person using violence

"So I just went around and I just acknowledged it. I was like, 'I don't wanna shame you, and I know what you have done. I know you know what you've done is not good way'. And he was like,' Yeah, I know'. And I was like, 'So how can we work together so that this doesn't have to happen?' And it was like, 'I know you are able to stop this. Cause I know there was so much time when you weren't doing that'."

(MECSH Practitioner P12)

Although safety planning traditionally centres on discussion with individual survivors of violence, some practitioners drew on the trusting relationships established with the couple and family more broadly to find safety for women and children. Importantly, these conversations centred around practical safety strategies and not any form of couples counselling.

"I sat down with both of them face to face and I said, 'Listen, we made that big safety plan so that this baby could come home with you... but we need to be very serious about this domestic violence and this fighting. And I said, 'What is your plan in advance if you're getting angry?' I said, 'You have to have a plan in advance because when you are angry, you can't think of a plan. It's too late, you're already crazy'...And so they made a plan themselves... I probably wouldn't get in a room with an angry DV man and tell him what to do. But in relationship with, having been working with her and [partner] and knowing them."

(MECSH Practitioner P1)

In some situations, family may not be supportive of the relationship or the mother's capacity to care for her children within the relationship. In such cases, practitioners who took time to understand complexity within the woman's own life history and family circumstances were able to advocate for the woman and sensitively work with difficulties within the family.

The advocacy role and relational way of working with partners and families evident by some practitioners goes well beyond 'first-line support' for DFV expected of primary health providers (WHO 2018). Case material from practitioner interviews demonstrates the unique potential of a multidisciplinary team of home-visiting practitioners to provide a range of supports that recognise needs of the different parties and are prepared to engage with perpetrators of violence as preventative strategies.

Referral and lack of services

Being able to refer women to services for immediate safety and longer-term well-being is a key component of first-line support. However, there was a distinct lack of DFV crisis services in remote communities and regional areas (P3, P15, P21, P25). For example, most of the communities where MECSH is delivered do not have a safe house, some do not have police, and services that had been established were not functioning.

"we have no overnight accommodation here...normally I just ring the girls in [nearest large town]...and they often don't have space, or they don't want to go to [that community] because they've already, they've got family there as well, which can be a problem...this community is so small, that even if they go to other family, to another house, it's so obvious where they are, it's just like, there's no hiding."

(MECSH Practitioner P25)

In addition to lack of crisis services, providers called for specific support for men prone to jealousy, violence and controlling behaviour (P7, P20, P22). Suggestions included men's groups, or having male workers that could engage with men about managing strong emotions and alternatives to aggressive and controlling behaviour.

"What I would like to see to try and help with the domestic violence issues here, I'd really like to see a program for fathers, which is apparently a thing in some communities. Really helping men with anger management and stuff like that...Because the thing is that nothing's happening when people go to prison. I don't know what they're doing in there, but when they come out it's just like the cycle just starts all over again..."

(Service collaborator P20)

It was very clear that the human resources, skills mix, and coordination required to address violence was inadequate to comprehensively support families.

Findings: Women's experience of harm

Women's perceptions and experience of harm are presented quantitatively from survey responses and qualitatively through narratives around different forms of violence. These perspectives are useful for informing how practitioners can ask about and promote women's well-being in ways that are meaningful to their experiences.

Survey data: Disclosed frequency and types of violence

At first interview with the researchers, 14% of women disclosed some form of violence in the past 12 months through the survey questions. The most frequent type of violence experienced was emotional abuse, where 16% of women who were asked this question said their partner made them feel bad about themselves (Table 1). This was followed by controlling behaviours, with 12% of women reporting jealousy in their relationship, or that their partner stopped them doing things. A similar proportion (11%) of women said they had felt frightened by what their partner says or does or had experienced physical violence from anyone (Table 1).

During second (n=42) or third (n=9) interviews a greater proportion of women disclosed violence, 31% and 33% of participants, respectively. This may be a result of selection bias, or rapport building through previous interviews where women felt more comfortable to disclose.

Survey data: Factors associated with experience of harm

In addition to routine inquiry or 'screening' for DFV, health providers should always ask about violence when there are signs or symptoms present.

These 'DFV indicators' are well-established in the international literature and included in the RAMF, however, there may be additional indicators for women in remote NT.

To explore associations between experience of violence and outcomes in other MECSH survey items, we developed a composite "experience of harm" variable (i.e. if a woman answered "yes" to experiencing one or more types of DFV, they were considered to have experienced harm) and measured correlations with the other survey items.

The statistically significant associations between experience of harm were: lack of support from their partner, using drugs, poor self-reported health, and low emotional well-being scores (especially feelings of sadness).

TABLE 1: Frequency of "yes" responses to survey questions about experience of DFV harm at first evaluation interview

Type of harm in past 12 months	N		% (n)
	Valid	Missing	
Partner stopped her doing things	25	167	12% (3)
Partner made her feel bad about herself	25	167	16% (4)
Jealousy in the relationship	25	167	12% (3)
Felt frightened by what partner says or does	45	147	11% (5)
Experienced physical violence from anyone	186	6	11% (21)
Any experience of harm	**186**	**6**	**14% (26)**

This suggests that in addition to known physical, behavioural, social and emotional indicators of DFV, women presenting with the following concerns may alert providers to enquire about whether they are experiencing violence from their partner.

- The item related to family support that was most strongly correlated with experience of harm was: *I feel sure that my partner will be there for me when I need support* (r_{pb}= -0.47 [-0.76, -0.06], p = 0.002). This indicates women who have experienced violence have **lower belief that their partner will support them**
- For emotional (psychological) distress, experience of harm was weak-moderately associated with **feeling "sad"** (r_{pb}= 0.27 [0.15, 0.40], p < .001) but not "anxious" (r_{pb}= 0.07 [-0.07, 0.21], p = 0.377). For participants who completed the Mayi Kuwayu-Kessler 5 (MK-K5) (Brinckley et al 2021) there was a weak-moderate significant association between experience of harm and **full-scale scores of psychological distress** (r_{pb}= 0.31 [0.07, 0.57], p = 0.028).
- Experience of harm was weakly associated with health, with women who experienced violence **self-rating their health as poorer** (r_{pb}= -0.21 [-0.42, -0.02], p = 0.007).
- There were significant associations between experiences of harm and drug use. Using Fisher's exact test ($\chi^2(1)$ = 14.01, p = 0.004) suggests that women who experienced violence were 14.09 times **more likely to use drugs**.

Although asking about the effects of violence was not a specific interview question, some women raised this spontaneously. These impacts of violence from the qualitative data were analysed independently from the survey data but are very similar to factors associated with experience of harm, including women feeling sad and overwhelmed (C219), especially when they had no help or other family support (C49), the children feeling scared (C52, C212) or sad (C219), feeling like she is 'suffocating' during arguments (C179), and long-term chronic pain from injuries (C110).

Qualitative data: Women's experiences of DFV

Power and control

The way in which women spoke about a harmful relationship centred largely on their partner's controlling behaviour. This frequently included jealousy, which could be used as a way to provoke arguments or stop her from going out; following her around/keeping her close; financial abuse or 'owning' her things; and manipulating her or the system.

Jealousy

Jealousy was a strong theme when women talked about problematic relationships, where he would accuse her of wanting other men (C56, C166, C208, C212, C219). Or he was unfaithful and projected that onto her, worrying she would do the same (C117, C179). Women described how he then used this as an excuse to try and stop her from seeing family (C179, C212), going to work (C59, C219), playing cards (C117, C191), or taking the baby to playgroup (C179).

> Participant: ...I stop it to go out to the playgroup, because of [partner] when he was thinking wrong way for me. That's why I never take [baby] to the playgroup.
>
> Researcher: When you say 'thinking wrong way', what was he thinking?
>
> Participant: That there's man there walking around, he like to see every man in the road, and he point that, that's man for me for myself, he like to jealous every man. (C179)

Some women described their own jealousy (C221), how they were particularly worried about infidelity when he was away in town (C110), and that jealousy can be normalised

within relationships (C208). When he was unfaithful, this could lead to physical violence between her and his new partner (C191).

"If I want to go visit my family in [another community], he never let me. He say maybe you can go, get divorced and kids will stay with me. But I don't want the kids to stay with him because he's aggressive. I always want to talk to him...Let me and the kids visit my mother...He's a jealous type of person...he thinks that I'll cheat on him. But I never done that." (C212)

Following her around/keeping her close

Women explained how their violent partner would follow them around as a form of surveillance, including following her to another community when she left him (C179), or harassing her at work (C192). Women also followed their partner to other communities, either because he makes her (C110), she does not want to leave the children with him (C110, C212), or she wants her children to have a father (C56, C179, C212).

Financial abuse/control

Several women described how a violent partner would get her to do everything for him (C179), including buying cigarettes and marijuana for him (C195) and forcing her to clean up the house (C212). These women also said he threatened other family members for money, yelling at them if they did not comply (C179, C212). Women spoke about how he was possessive of her things or would not share his things with her and the children (C110, C179, C185, C193).

"...he always say this is his fridge, his couch, everything here. Me and my kids, we just own these stuff here in this table. And maybe its two or three blanket and sheet and two pillow, that's all. The rest belongs to him...Everything that I buy. That's his, yeah. And I told him to stop owning my stuff. He's on my phone every day. He can't even leave it. We just keep on making the talk. It's like, just like a deaf person sitting there just ignoring you." (C110)

Manipulation

Manipulation included behaviours that involved 'getting back at her' when he did not get what he wanted. Two women described how their partner would present their story to police in a way that made it look like she was the perpetrator (C179, C185). For one of these women, this resulted in the police threatening her with court action. They had refused to help her, until the MECSH nurse advocated for her and explained the situation to the police from the woman's perspective. Another woman described how her partner would purposely wake up the baby during sleep/naps and would not listen to her or family when they tried to talk with him about it (C212). Another woman explained how her partner would not look after their child or 'nurse him' when she asked him not to take her things (C110).

Physical violence

Thirteen women spoke about the physical violence they had experienced from a partner. This included quite severe forms of violence such as throwing boiling water on her back, hitting her with a baseball bat, threatening her with a weapon, threatening to stab her and the baby, or throwing things as a threat of harm (C212, C110, C187, C192, C200, C221, C224, C179, C187). Several women described being hit when they were pregnant (C179, C212, C219), with care taken to avoid the abdomen so that he could not be blamed. Some women were also hit when they were holding the baby (C141,C191). These severe forms of violence could be a breaking point for women.

"Last time we was drinking and he came and started to kick me and hit me while I was breast feeding [baby] and that pissed me off, that was last time, long time [ago]." (C191)

Emotional abuse

Women reported experiencing emotional abuse from their partner, mostly in relation to him 'talking too much' in an attempt to promote arguments with her (C49, C92, C96, C117, C179). Emotional abuse was framed as him always 'growling' (C221) or swearing at

her (C117), that he actively tries to hurt her feelings (C185), or does not listen to anything she says (C110). Other women described more 'mutual' arguing, where they would judge each other or put each other down (C126, C185, C221).

"He just gonna sit there and talk, talk, talk until we start a fight...And he want to fight with my older, all, all, all my brothers. That's how he think." (C179)

In addition to emotional violence from a partner, some women described emotional abuse from their partner's family, which included being mean to her and her children (C224, C96).

"I don't like how they [in-laws] chat to my kids. You know, like in a rough way...I be quiet and every time when [partner] comes back home, I talk to [him], he is going talk to them...If I do talk myself, my partner will get angry to me....He just get rough, and he doesn't hit me, but he's just talk at me. That's why I get really pissed off ... and I just walk away." (C96)

Findings: Information in Communicare

As part of the dataset preparation and development of explanatory and outcome variables for the MECSH evaluation we explored the information available about domestic and family violence screening, risk assessment and responses in the de-identified extracts of primary health care data. The dataset included all service encounters at MECSH implementing health services for women who were pregnant or had a newborn baby between January 2019 and April 2024, and so provides a snapshot of how data on DFV screening, risk assessment and action is recorded for pregnant women and mothers with young children. From this data exploration we noted the following:

1. There were two standalone clinical items specifically for recording details of DFV screening and no data recorded on level of risk. The main screening clinical item present in the dataset was the item developed through the MECSH implementation and used only by MECSH practitioners. Some qualifiers indicating whether a screening was offered and/or the disclosures from that screen were embedded in other clinical items (e.g. antenatal checks).
2. There were several options for indicating whether information, education or advice about DFV had been provided, however it is not clear from the data whether this is general information or specific support in response to a disclosure or incident.
3. Data items for recording the types of action taken in response to disclosure of violence were embedded in screening clinical items. MECSH practitioners noted that they did not use that clinical item to record actions taken when women disclosed DFV in other ways (i.e. not through screening). They tended to use free text notes in other clinical items.
4. None of the data items provided information on whether a risk assessment had been done and the level of risk.
5. Extractable data on types of violence disclosed did not comprehensively capture all forms (see Appendix for areas lacking in the Relationship Form)

Data types extracted were restricted to numeric and pre-coded items (e.g. yes/no or dropdown choices). Free text fields were excluded as de-identification cannot be assured for free text. It is possible more comprehensive information about DFV is recorded in free text fields. This is appropriate for documentation of clinical care, however for monitoring of population trends and evaluation of programs a standardised set of extractable variables is needed.

The analysis of the clinical records of 1412 women who living in communities where MECSH was being implemented during pregnancy or up to 8 weeks postpartum, found that **43% had a record of a DFV screen** during this period (pregnancy to 8 weeks postpartum). One quarter of women in the evaluation cohort had a record of DFSV-related harm. DFSV-related harm was derived from data item from screening and other data items indicating that DFSV had been disclosed, referrals to safe houses, safety plans, or mandatory reports were made (see Appendix 2 for clinical items used to derive screening and harm variables). Screening for DFV and DFSV harm differed according to women's age (Table 2). This data suggests screening is prioritised for younger women, and that more younger women are reporting DSFV than older women.

TABLE 2: Proportion of women in MECSH evaluation dataset who had DFV screen recorded or indication of DFV disclosure, by age

	< 20 years	20-34 years	≥ 35 years
DFV screen*	50%	42%	37%
DFSV harm*	31%	24%	21%

* Proportion of women with a record of DFV screening and proportion of women with a record of DFV-related harm was significantly different between age groups

Implications for practice

Opening the conversation

The findings bring to light key issues for sensitively asking about violence in primary care and home visiting services. Practitioners emphasised the importance of establishing rapport with their client before asking about violence, and not asking the DFV screening questions on the first visit. This is consistent with research both with Aboriginal women and women globally, that finds building a relationship, trust and going slowly before women feel safe to disclose (Spangaro et al. 2016, Heron and Eisma 2021). Women may be more likely to disclose violence over time and as the client-provider relationship develops, therefore it is important to regularly check in with her about. It should be noted that the ideal frequency and timing of DFV screening was not assessed as part of this research and should be the subject of further inquiry with women.

Creating a safe space for women and practitioners to talk about sensitive topics was important. Practitioners did this by prioritising the woman's safety, only asking about violence when the woman was on her own, acknowledging that violence can be a difficult thing to talk about, and building their own confidence in ways of raising the topic. The way in which practitioners talked about inquiring about violence was more of a casual conversation, asking about their relationship, and being honest and transparent. This differs from the Relationship Form (HU5K), which is highly structured and includes specific points to explain to women up front. A more conversational style of inquiry is encouraged in the RAMF (Appendix 1). Based on this research, alternative ways of raising the topic of relationships before moving into specific questions on experiences of violence could be:

- Do you have a partner or ex-partner?
- How is your relationship with them?
- How much is your ex/partner there for you when you need support?
- Is it ok if I ask you more about your relationship, you don't have to answer any questions you don't want to?

Asking about experiences of violence

The qualitative stories that women shared about their experiences of violence can

provide some preliminary guidance on common experiences and what forms of violence to ask about, in ways that might resonate with other women in remote settings. Drawing on the way women described experiencing each broad category of violence, some possible questions that could be incorporated into screening, or used to explore the range of other forms of harm when a woman discloses, are presented in Table 2 below. The emphasis women placed on coercive control in their interviews resonates with the recent coronial inquest into the deaths of four NT Aboriginal women, for whom the violence began with coercive control (Parkinson 2024)[1]. Given this is exploratory research with a small number of women, these questions would benefit from further testing and refinement in remote NT contexts.

Assessing risk and supporting safety

Risk assessment questions are designed to identify the level of danger a woman may be in and the likelihood of future violence. The RAMF common risk assessment tool (the CRAT) includes questions about the history of violence, impact on children and her situational factors, to come up with an overall assessment of level of risk. The more questions she answers yes to, the greater her risk of serious harm. They are important for health providers understanding the broader context and severity of the violence, to prompt women to see patterns of behaviour in the lead up to serious harm, and to start a discussion about her immediate and longer-term safety.

TABLE 3: Categories of violence and possible screening questions based on women's stories of partner violence

Type of violence	Possible questions "In the past 12 months…"
Controlling behaviour	• Has there been any jealousy in your relationship? • Did your partner stop you doing things? • Has he followed you around? • Has he made you buy everything for him, tried to own your stuff, or not sharing with you or the kids? • Does he do things to 'get back at you' when he doesn't get what he wants?
Emotional violence	• Did your partner talk too much and try to start arguments? • Has your partner been mean to you or put you down? • Has your partner growled or sworn at you a lot?
Physical violence	• Has your partner hit you or thrown anything at you? • Has he threatened you with a weapon? • Has he hit you while you were pregnant or holding the baby?
Sexual violence	• [Requires further specific research. Based on WHO guidance it could be something like, "Has your partner forced you into sex, or made you do something sexual you didn't want?"]
Fear	• Have you ever felt frightened by what your partner says or does?
Children's safety	• Have the children ever felt scared by what they have seen or heard?
Violence from other people	• Have other people in the family hurt you? • Has anyone else hurt you or the children?

[1] https://nit.com.au/21-08-2024/13224/coroner-investigating-horrific-deaths-of-northern-territory-women-urged-to-back-sweeping-reforms-to-curb-domestic-viiolence

Under the RAMF, universal services such as health services, are required to screen for DFV, refer to specialist services, make a mandatory report of domestic violence and/or child abuse or neglect, and document and share information as appropriate. It suggests the more detailed risk assessment using the CRAT be completed by a DFV specialist after one or more conversations with a client. However, in remote areas the specialised services recommended to do this work are often not available.

Asking women about imminent risk of harm is a core part of first-line support that all health professionals should be able to provide (WHO 2018). However, there was no evidence that practitioners interviewed in our MECSH evaluation research were doing any formal risk assessment when women disclosed violence. This highlights the importance of further awareness and training for providers on the interconnected nature of different forms of violence, the significance of overlapping exposure, the patterns of violence that are likely to lead to serious harm, and how to talk with women about their risk and safety.

As projects to operationalise the RAMF in the participating ACCHS are fairly recent, our data does not include comments from practitioners specifically about the CRAT nor the feasibility for adapting it as a risk assessment tool in the context of healthcare provision. Anecdotal feedback from providers in primary health and hospital settings, however, is that the CRAT is too detailed for most frontline health providers to prepare.

Frontline health providers are likely to need a more manageable set of risk assessment questions to empower them with knowledge of high-risk indicators, help guide discussions with women about their safety, and to make appropriate referrals. Specific indicators to support risk assessment should be based on evidence from the NT. There may be insights into appropriate indicators of serious harm from the recent Coronial Inquests into the deaths of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kumanjayi Haywood (2024). The WHO (2018) (see Appendix 1) also provides guidance on a shorter set of risk assessment questions that may be more manageable for front line health providers to ask. Based on the CRAT, WHO and without duplicating the questions in 'types of violence', a possible short set of risk assessment questions could include:

- Has the violence happened more often or gotten worse over the past 6 months?
- Has he ever used a weapon or threatened you with a weapon?
- Has he ever tried to strangle or suffocate you?
- Do you believe he could kill you?
- Has he ever hurt the children?
- Has he ever threatened to kill the children?

Regardless of the level of risk, all women should be supported to think about a safety plan for themselves and their children. The RAMF provides guidance on safety planning, which is a comprehensive 5-page form. The feasibility of health providers using this detailed form was not part of this research and should be further assessed.

Implications for documenting in Communicare

Based on the preliminary research presented here, we suggest a redesign of clinical items to record both screening and support for violence when it is otherwise disclosed (i.e. client disclosed, referred in, or follow-up support). Understanding the types of violence women are experiencing, addressing imminent risk of harm and providing psychosocial support and referral should be part of routine health practice,

regardless of whether violence is disclosed after screening, after a violent event, or as part of a referral to the health service (for example, by police).

Standalone clinical items that can be used by all primary health providers should be developed so as not to restrict information on DFV inquiry and response to maternal and child health services or program specific encounters. This will support better information-sharing about DFV between providers and enable better quality reporting at the service and population level.

In addition to basic documentation around DFV screening and support outlined above, comprehensive medical records are critical. Comprehensive records enable sharing information with others involved in her care, reduces the need for the woman to repeat her story to multiple providers, documents patterns of abuse over time and any escalations of violence, and are important for any legal process women may go through in the future. Some guidance on medical documentation for DFV is provided in CARPA (Appendix 1). Structured tools using Communicare architecture should be developed for medical documentation of violence, in line with good practice clinical care. This includes collating information in the medical record and in DFV-specific Communicare clinical items about injuries, health and psychosocial impacts, recording her story about the abuse in her own words, recording evidence such as photographs of injuries, and safe handling of information (WHO 2018; NTG 2020).

Conclusion

Despite the various ways in which DFV may be disclosed, current MECSH Communicare items only capture provider responses in relation to 'screening'. However, women may disclose in many ways, and all health professionals should be able to provide basic first-line support for DFV, which includes responding with empathy, assessing immediate risk of harm, planning for safety, referral, documentation and reporting. Having DFV action items only documented in screening or free-text notes risks the critical work of providing helpful support being missed. For these reasons, both 'screening' and DFV 'support' need to link clearly to 'actions taken' in Communicare.

It is important that risk assessment and safety planning are incorporated into information systems to prompt health professionals to assist beyond screening. Auto-recalls to follow-up with women who have experienced violence may be useful, or these critical elements of care can be overlooked. It is unclear whether the detailed risk assessment and safety planning tools available in the RAMF are likely to be suitable to the role and capacities of frontline health care providers. It would be useful to examine further evidence from NT remote community contexts about what key risk factors constitute immediate threats to a victim-survivor's life and health, and what actions are most helpful in promoting her safety.

The questions and framework for Communicare items presented here brings together the recommendations in the RAMF, with the lived experience of women who have been subjected to violence and the primary care practitioners who support them. It should be seen as a starting point for further refinement and discussion with practitioners, advocates and women who have experienced violence in remote NT settings. The final framework that is decided upon by health services should be further tested and validated and improved through trialling in routine practice.

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Prepared by: Kayli Wild[1], Danielle Aquino[1], Alexandra Gregory[1], Siobhan Tootell[2], Kerry Barker[2]
Statistical analysis of primary health care data by Jiunn Yih Su[1]

[1] Menzies School of Health Research
[2] Katherine West Health Board

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Contact: danielle.aquino@menzies.edu.au

Appendix 1: Summary of some of the existing guidance for NT primary health providers identifying and responding to DFV

	Risk Assessment and Management Framework (NTG, 2020)	Remote Health Primary Health Care Manuals (2022a,b)	Healthy Under 5 Kids Partnering Families program (NTG, 2016)	World Health Organization (WHO, 2018)
Opening questions	**Suggested conversation starters to lead into the topic of DFV.** "Many people/women have problems with their family, their husband or partner or someone they live with, so we ask questions about the safety of all our clients so that we can work out what kind of help you need to keep you (and your children) safe" " I am worried because [list the DFV indicators that are present]. I would like to ask you some questions about how you feel about your safety so that we can work out what kind of help you need to keep you safe" "Sometimes people can hurt other people. Can I ask you some questions about this?"	**Prompt to build rapport through general conversation as well as questions to find out about undisclosed DFV** "Can I help you with anything today, are you worried or upset about anything?" "Are you feeling OK in your body?" "Do you have any pain or are you sore anywhere?" "Are you worried about anything or anyone in your family?"	**'Script' to use when opening a discussion or screening for DFV** "Because we care about your wellbeing, we also would like to find out • if you have ever been hurt or frightened by your partner or a family member • if you or anyone else in your home uses alcohol, prescribed medication or any other drugs • if there are times when emotionally you don't feel well" "We ask everyone this because we want everyone to be safe as possible. This will help us to provide the best support. • How do you and your partner work out arguments? • Do arguments ever result in hitting, kicking or pushing? • Has anyone ever made you feel frightened or scared at home? • Do you ever feel controlled by your partner?"	**Suggested statements to raise the raise the subject of violence before asking direct questions** "Many women experience problems with their husband or partner, or someone else they live with." "I have seen women with problems like yours who have been experiencing trouble at home."

	Risk Assessment and Management Framework (NTG, 2020)	Remote Health Primary Health Care Manuals (2022a,b)	Healthy Under 5 Kids Partnering Families program (NTG, 2016)	World Health Organization (WHO, 2018)
Asking about types of violence	**Questions covering** • **Physical harm** • **Threats/fear** • **Jealousy/control** • **Verbal abuse** • **Safety of children/others in household** "Has your partner/husband, ex-partner/husband or someone in your family hurt you or threatened to hurt you; yelled at you, talked down to you or called you bad names?" "Has your partner/husband, ex-partner/husband or someone in your family become jealous and tried to control what you can or cannot do?" "Are you worried about the safety of your children or someone else in your family or household?"	**Questions covering:** • **Physical harm** • **Fear/threats** • **Sexual violence** • **Children' safety and exposure** **Includes note to always ask about strangulation in intimate relationship assaults** "How does your partner treat you? Are you having any problems?" "Are you afraid of your partner – for yourself or your children" "Does your partner ever threaten to hurt you or your family?" "Has anyone at home hit you or your children or tried to injure you or your children in any way?" "Have you ever been slapped, pushed or shoved by your partner?" "Have you ever been touched in a way that made you feel uncomfortable?" "Has anyone ever made you do something sexual when you did not want to?"	**Questions covering:** • **Physical harm** • **Fear/threats** • **Verbal abuse** • **Sexual violence** • **Children' safety and exposure** "Are you frightened of your partner or ex-partner or someone else important to you?" "Within the last year have you been hit, punched, kicked, slapped or hurt in other ways by your partner or ex-partner or someone else important to you?" "Within the last year have you been forced to have sex (oral, vaginal or anal) with your partner/ex-partner or someone else important to you?" "Does your partner or someone else important to you scream at your or talk down to you?" "Are you worried about the safety of your child/children?" "Has your child/children been hurt; seen or heard violence in your home?"	**Questions covering:** • **Physical harm** • **Fear/threats** • **Verbal abuse** • **Sexual violence** • **Control** "Are you afraid of your husband (or partner)?" "Has your husband (or partner) or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened?" "Does your husband (or partner) or someone at home bully you or insult you? "Does your husband (or partner) try to control you, for example not letting you have money or go out of the house?" "Has your husband (or partner) forced you into sex or forced you to have any sexual contact you did not want?" "Has your husband (or partner) threatened to kill you?"

	Risk Assessment and Management Framework (NTG, 2020)	Remote Health Primary Health Care Manuals (2022a,b)	Healthy Under 5 Kids Partnering Families program (NTG, 2016)	World Health Organization (WHO, 2018)
Risk Assessment	**Specific risk assessment tool with scoring matrix to determine level of risk.** Common Risk Assessment Tool (CRAT). Tool comprises sections including: • Victim-survivor, children and perpetrator details; • Evidence-based risk factors (perpetrators behaviour, violence toward children, situational factors) • Survivor's assessment of risk • Worker's professional judgement and assessment of survivor's situation • Overall risk assessment	**Assess clinical risk** **Questions to ask about household safety and prompts to ask about self harm** • Have you got somewhere safe to stay? • Where are you staying now? Do you always live there? • Is it your house or someone else's • Who is staying with you? How many people live there? • Does everyone in your house get along OK? • Do you feel happy staying in the house with the people who are there? Prompts to ask about social and emotional concerns: • Self-harm or thoughts of self-harm • Drug and/or alcohol misuse • Sleeping or eating problems • Loneliness or isolation from family and friends • Sexual problems or STIs	**Questions about general and immediate safety at home and involvement with services/agencies** • Do you feel safe with people who usually live in your home? • Do you feel safe with other people who come to visit or stay in your home? • Are you safe to go home when you leave here? • Have there been any previous referrals to another worker/service for this family for services related to domestic and family violence? • Is DCF currently involved with any other children? • Has DCF ever been involved with any other children of this mother/carer? Includes a prompt for practitioner to indicate whether they need to take any immediate action based on woman's responses	**Specific questions to assess immediate risk of violence.** • Has the physical violence happened more often or gotten worse over the past 6 months? • Has he ever used a weapon or threatened you with a weapon? • Has he ever tried to strangle you? • Do you believe he could kill you? • Has he ever beaten you when you were pregnant? • Is he violently and constantly jealous of you? **Women answering 'yes' to 3 or more questions are at high immediate risk.**

	Risk Assessment and Management Framework (NTG, 2020)	Remote Health Primary Health Care Manuals (2022a,b)	Healthy Under 5 Kids Partnering Families program (NTG, 2016)	World Health Organization (WHO, 2018)
Safety Planning	**Questions to start a conversation about safety and specific Safety Plan tool that includes sections on:** • Worker safety planning checklist • Escape bag checklist • Immediate safety planning action table • Ongoing safety planning action table	**Management plan for if person stays in community** • Check they have a safe place to stay • Record who support people are • Make sure they know who to contact and how to get help quickly **Discuss following aspects of safety planning:** • Warning signs for when violence is likely to happen • Ways to avoid violence • Plan for children's safety • Involving family/relatives • Getting a restraining order or Apprehended Violence Order (AVO)	**Safety Action Plan template that covers the following aspects:** • What the person doesn't like/what makes them feel unsafe • Safety during violence – where to go, trusted person, code words • Checklist for packing emergency bag • Safety after violence – when is it safe to return home, how to stay safe and strong	**Discuss the following aspects of safety planning: Safety planning based** • Safe place to go • Planning for children - • Transport • Items to take • Financial – access to money • Support of someone close to call the police or come with assistance **Alert to identify safe place if it is not safe for the woman to return home**
Referrals	**Detailed Practice Guide covering information about referrals.** • Why DFV referrals are important • Who and when should DFV referrals be made • How to make referrals • What needs to happen after referrals • Referrals and people who commit DFV • Related resources linking to NT DFV services site.	**Prompts to offer referral and assist person to talk with services if needed** • Women's shelter • Police • Specialist support services	**Section to indicate whether referrals made or declined** **Mandatory reporting obligations**	**Guidance on providing support and prioritising immediate support** **Includes sections about:** • Resources • Tips on giving referrals

	Risk Assessment and Management Framework (NTG, 2020)	Remote Health Primary Health Care Manuals (2022a,b)	Healthy Under 5 Kids Partnering Families program (NTG, 2016)	World Health Organization (WHO, 2018)
Follow-up	**Prompts in Referrals Practice Guide.** • Maintain engagement or continue to 'check in' • Develop a safety plan to ensure their immediate safety • Check in on status of referrals, whether person has attended	**Prompts for Follow-up** • Review person within 24 hours and often until crisis has passed • Offer referrals for counselling and support • Offered routine health checks – Adult health check (including STI check, Mental health assessment, School-aged health check, Child health	**Not included**	**Detailed guidance on follow-up after sexual assault and refers to follow-up care throughout**
Medical examination and documentation	**Practice guide on Record Keeping (5 pages) covering:** • What is record keeping? • Why is DFV recording keeping important? • Who should do DFV record keeping • When should DFV record keeping occur? • How should record keeping be done? • Keeping client information private and safe • Case notes • Client access to their records • Related resources link to	**Guidance includes:** • Clinical examination • Treatment of injuries • Requirements for recording injuries and details of presentation	**Not included**	**Guidance includes:** • How to do a head-to-toe medical examination after sexual assault and/or physical injury. • Example history and examination form for documenting cases of violence.

	Risk Assessment and Management Framework (NTG, 2020)	Remote Health Primary Health Care Manuals (2022a,b)	Healthy Under 5 Kids Partnering Families program (NTG, 2016)	World Health Organization (WHO, 2018)
Reporting	**Practice Guide on Shared Legal Responsibilities covering:** • Rationale, responsibilities and processes for information sharing and mandatory reporting • Information sharing when there is serious risk identified from CRAT • Information sharing about person who has committed DFV • Related resources	**Prompts to confirm confidentiality and explain mandatory reporting**	**Includes notes on mandatory reporting obligations for health professionals:** • Guides to report child abuse to Child protection hotline (DCF) • Guides to report violence against women to the police	**Guidance on:** • Explaining limits to confidentiality, • The need to understand local laws and reporting requirements • What if she decides not to report "What you tell me is confidential, that means I won't tell anyone else about what you share with me. The only exception to this is..."
Additional notes	Includes guidance on validating and empathic responses Screening questions are double/triple-barreled Screening does not ask about sexual violence	Does not include questions about coercive control or emotional/psychological violence. Risk assessment not clearly defined Does not include guidance on first-line support (empathic responses) Some guidance on how to respond to children but advises questions are asked by a trained interviewer.	Includes some guidance on validating and empathic responses Risk assessment not clearly defined Does not include guidance on follow-up support, medical examination or documentation (practitioners would also use CARPA) Safety planning not comprehensive	Does not ask about violence toward children Succinct memory aid for first-line support (LIVES). Risk assessment questions may not be specific to risk factors for serious harm from NT remote context. Good procedures for follow-up after sexual assault that could be broadened.

Appendix 2: Data items used to derive indicators of DFSV screening and DFSV harm

During data cleaning and preparation for analysis we identified various ways in which data related to DFV appeared in the de-identified datasets provided by ACCHS for the MECSH evaluation. From the available data we derived two variables, one relating to whether DFV screening had been done, and one relating to whether there was a record of domestic family and sexual violence (DFSV)-related harm. Free text fields were not extracted so any data about DFV in those fields is not captured in our dataset. Persons included in the MECSH evaluation extracts were pregnant or parenting a young child (up to 3 years of age). DFV among individuals not meeting that criteria (e.g. adolescents, women parenting older children, men) may be recorded in different ways that were not captured in the data extracts received for the MESCH evaluation. We included sexual violence in the composite variable of DSFV harm. We did not include other types of assault or injury as these do not necessarily constitute DFSV.

Only data items included in the woman's record are included. There are indicators of whether a DFV screen was offered as part of HU5K-PF routine checks that are recorded in the child's record.

Variable	Definition
Record of DFV screen	A woman was considered to have a record of a DFV screen if there were any of the following **procedure** or **qualifiers** in her service data: mecsh;family & domestic violence screen mh;family & domestic violence screen family violence screen mecsh (mecsh) family/domestic violence screen (mecsh) family violence screen; and/or (preg) family/partner violence are you ever afraid violence towards you put downs unwanted sex
Record of DFSV related harm	A woman was considered to have disclosed DFSV if there was a record of the following in her service data: 1. Yes result for any of the following **qualifiers**: are you ever afraid violence towards you put downs unwanted sex (DVS) Question four (DVS) Question five (DVS) Question six (DVS) Question seven (DVS) Question eight (DVS) Question nine (dvs) q4 frightened of family member/s (dvs) q5 hurt by family member last year (dvs) q6 forced sex with others (dvs) q7 partner yells/talks down to you (dvs) q8 worried about child (dvs) q9 child experienced violence (dvs) have any of the responses been yes Is there a current DVO in place Has a mandatory report been completed?

Variable	Definition
	2. A **condition** of: domestic violence assault(s);sexual;victim victim of sexual abuse emotional abuse by relative victim of sexual assault(s) 3. A **referral** of "domestic family violence" 4. One of the following **procedures**: referral to women's shelter SFSC Occasion of Service mandatory report-domestic violence domestic violence support mandatory reporting referral to sex assault service 5. Results to the **qualifier 'have any of these responses been yes?** of: b. yes, would like referral to appropriate service c. yes, declines referral to appropriate service 6. Results to the qualifier **(mecsh) patterns of domestic violence** of b.current 7. Any result except "a. none required" for the **qualifier (dvs) action taken**