



National Risk Assessment Principles for domestic and family violence: Companion resource

*A summary of the evidence-base supporting the development and implementation
of the National Risk Assessment Principles for domestic and family violence*

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for the Commonwealth Department of Social Services

ANROWS

**AUSTRALIA'S NATIONAL RESEARCH
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to Reduce Violence against Women & their Children

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Acknowledgement of Country

ANROWS acknowledges the traditional owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander elders past, present, and future, and we value Aboriginal and Torres Strait Islander history, culture, and knowledge.

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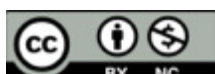
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Introduction

This review provides a summary of the evidence-base for the National Risk Assessment Principles for domestic and family violence (the Principles) developed on behalf of the Commonwealth Department of Social Services. It examines Australian and international peer-reviewed research, “grey literature”, including government reports and inquiries, domestic violence death review reports as well as community-based research and resources reflecting the wisdom of practitioners and victim-survivors.

Building on findings from the Queensland Integrated Services Response to Domestic and Family Violence project undertaken by ANROWS (2016) this summary of literature highlights key aspects of the evidence-base that underpin the development and implementation of the Principles, including literature regarding: risk and safety; need and vulnerability; risk assessment and management approaches; intimate partner sexual violence and sexual assault; and multi-agency integrated service responses.

Risk assessment is “the formal application of instruments to assess the likelihood that intimate partner violence will be repeated and escalated” (Roehl & Guertin, 2000, p.171). Risk assessment is a complex, ongoing and evaluative process conducted by professionals in collaboration with victim-survivors and perpetrators separately, rather than a static, one-off event. Typically, validated tools and practice guides are used to map patterns of abuse and to systematically assess the likelihood of reassault or that the violence will escalate in frequency and/or severity (Breckenridge, Rees, valentine, & Murray, 2015).

A central element of the risk management process is repeatedly conducting risk assessments. As risk can change quickly and unpredictably, it must be continuously assessed, monitored and reviewed, ideally as part of the client’s regular contact with

the specialist domestic and family violence services overseeing their case management and therapeutic needs (Victoria. Department of Human Services, 2012).

In practice, all risk assessment should be followed by effective risk and safety management strategies to avoid becoming a “useless exercise in sharing information to no effect” (Humphreys, Healey, & Diemer, 2015, p.3). Risk management is a dynamic, active and collaborative process that aims to promote the ongoing safety and wellbeing of victim-survivors and their families through an integrated, holistic strategy, and coordinated, multi-agency service response to reduce and prevent future violence (Albuquerque et al., 2013).

All Australian states and territories have implemented, are developing or are reviewing common risk assessment tools for domestic and family violence and/or integrated, multiagency service response frameworks in their jurisdictions. Specific tools and practice guidelines for the screening, assessment and management of domestic and family violence sit within the context of these broader policy frameworks.



Foundations

The concepts of risk, need and safety are fundamental to the design of risk assessment tools and frameworks, their implementation by practitioners and to the lived experiences of victim-survivors of domestic and family violence. The following section outlines the key literature concerning risk, need and safety which informed the development of the Principles.

DOMESTIC AND FAMILY VIOLENCE

Definitions of **domestic and family violence (DFV)** in legislation and policy vary between Australian jurisdictions. In broad terms, DFV is an overt or subtle expression of a power imbalance, resulting in one person living in fear of another and usually involves an ongoing pattern of abuse characterised by coercive and controlling behaviours. The terms “domestic and family violence”, “family violence” and “domestic violence” are used across most policy and service contexts that are responding primarily to violence occurring within a current or past intimate relationship.

Domestic violence usually refers to **intimate partner violence**, a term used to describe violence that occurs between two people in a cohabiting relationship, boyfriends/girlfriends or dating relationships (Australian Bureau of Statistics, 2017). The only strong evidence-base regarding risk factors for DFV is for heterosexual intimate partner violence, and most risk assessment tools and frameworks only address heterosexual violence, which is also the most prevalent form of DFV (McCulloch, Maher, Fitz-Gibbon, Segrave, & Roffee, 2016).

A note on terminology:

The term “victim” is most commonly used in public, legal and criminological discourse to describe people who have experienced violence, while “victim-survivor” and “survivor” are used to reflect the process of victimisation and work survivors do to rebuild their lives after violence. Current literature is also moving towards recognising and referring to children as “victim-survivors” or “survivors” of violence, and away from children as “witnesses”. These terms are used interchangeably here, reflecting their diverse application across the literature on risk assessment for domestic and family violence.

The term “perpetrator” is used consistently in the literature and in Australia’s domestic and family violence policy and legislative environment. The term is used to reinforce the serious nature of violence in intimate or familial relationships. In some contexts, “men who use violence” is preferred, as it is seen to label the behaviour more so than the person. This has particular relevance where inaccurate representations of people from some cultures as “more” violent than people from other cultures, has led to inappropriate interventions and undermined community-led prevention of violence against women efforts (Australia. Department of Social Services, 2015; Chen, 2017).

Family violence includes violence perpetrated against children and older people, and by children and adolescents against parents. The term family violence is sometimes preferred by Aboriginal and Torres Strait Islander people, and in this context it is used to describe a range of violence that takes place within Aboriginal and Torres Strait Islander communities, perpetrated within and between families. The term recognises the broader impacts of violence on extended families, kinship networks and communities (Cripps & Davis, 2012). Family violence is, however, strongly connected to intimate partner or domestic violence and women and children experience the most profound impacts and continue to be most at risk of harm from their intimate partners (Laing & Greer, 2001; Secretariat of National Aboriginal and Islander Child Care, National Family Violence Prevention Legal Services, & National Aboriginal and Torres Strait Islander Legal Services, 2017).

The *National Plan to Reduce Violence Against Women and their Children 2010-2022* (the National Plan) identifies DFV and sexual assault as **gendered crimes** that have an unequal impact on women and as the most pervasive forms of violence experienced by women in Australia (Council of Australian Governments, 2011). Three-quarters (17.3% or 1,625,000) of victim-survivors of intimate partner violence¹ in Australia are women, compared to men who account for one-quarter of victim-survivors (6.1% or 547,600) (ABS, 2017).

Understanding the gendered nature of DFV has been recognised as vital for designing and delivering effective responses to risk (Queensland Government, 2016). However, given that women are not the only victim-survivors of DFV, common risk assessment tools and frameworks for use by generalist or specialist services, should be flexible and

¹ “Intimate partner” is a broad category defined by the ABS (2017) as “a current partner (living with), previous partner (has lived with), boyfriend/girlfriend/date and ex-boyfriend/ex-girlfriend (never lived with).” While “domestic violence” is typically used in the literature, service and policy contexts to refer to violence between intimate partners, the most robust data sources in Australia including the ABS Personal Safety Surveys, are not able to accurately represent the characteristics and dynamics of domestic violence (e.g. coercive control), but rather, collect incident-based information.

adaptable enough to appropriately assess the risks and address the needs of all victim-survivor and perpetrators, no matter their gender or sexual identity.

There are many **types of domestic and family violence**, but all forms are characterised by behaviours that are intended to coerce, control and/or create fear within an intimate or familial relationship. All DFV is considered emotionally abusive (Western Australia. Department of Child Protections and Family Support, 2015). While not an exhaustive list of all behaviours and acts considered as DFV, there are several common categories of DFV described across the literature, including:

- **Physical violence:** including but not limited to slapping, hitting, punching, pushing, choking, burns and use of weapons.
- **Sexual violence:** including but not limited to rape, sexual assault, sexual harassment, forced prostitution, human trafficking, image-based abuse, reproductive coercion (e.g. controlling contraception).
- **Psychological and emotional abuse:** including but not limited to intimidation, humiliation, and the effects of financial, social and other non-physical forms of violence.
- **Coercive control:** including but not limited to social isolation, financial abuse, monitoring movements online and/or offline. Most DFV is coercive control. It is ongoing, cumulative, chronic and routine.
- **Social violence:** including but not limited to controlling or limiting victim-survivors' social activities and relationships with friends and family and preventing victim-survivors from accessing support.
- **Financial violence:** including but not limited to control of victim's access to finances, including welfare theft, preventing the victim from work or study and dowry-related abuse.
- **Spiritual violence:** including but not limited to ridiculing or preventing victim-survivors' practice of faith or culture and/or manipulating religious and spiritual teachings or cultural traditions to excuse the violence.
- **Technology-facilitated abuse:** including but not limited to the use of text, email, phone to abuse, monitor, humiliate or punish, or threats such as to distribute private photos/videos of victim-survivors of a sexual nature (Elliot, 2017; Western Australia. Department of Child Protection and Family Support, 2015; WIRE Women's Information and Referral Exchange, 2016; Women's Legal Services NSW, Domestic Violence Resource Centre Victoria, & WESNET, 2015).

CHILDREN

Australian statistics indicate that 50 percent (60,300) of women who were caring for children while experiencing violence from a current partner, reported that their children either heard or saw the violence. For women who reported experiencing violence from a previous partner, the rates were higher, with an estimated 68 percent (418,200) of women who had children in their care at the time of experiencing violence, reporting that the children saw or heard the violence (ABS, 2017).

The harmful effects on the developmental and emotional wellbeing of exposure to domestic violence are clear and there is increasing attention on children as victim-survivors of family violence in their own right, with their own unique risks and service needs (Fitz-Gibbon, Maher, McCulloch, & Segrave, 2018; Humphreys, 2007; Laing, Heward-Belle, & Toivonen, 2018).

The historical “silos” and different philosophical approaches underpinning responses to violence from the child protection, DFV and family law sectors are well documented in the literature, as are the negative impacts of fragmented service responses on women and children (Fitz-Gibbon et al., 2018; Humphreys, 2007; Humphreys & Healey, 2017; James & Ross, 2016; Laing et al., 2018). Despite the prevalence of women who experience domestic violence while children are in their care, no state or territory in Australia includes children’s risks as a focus of common family violence risk assessment instruments.

A growing body of research indicates that DFV risks for an adult and child may be “linked but separate” and risk assessment may thus require more targeted and possibly distinct approaches in order to respond to the safety, risk and both common and unique wellbeing needs of women and children (Fitz-Gibbon et al., 2018, p.10).

Emerging evidence demonstrates the potential of one international approach to risk assessment of children experiencing family violence in Australia, David Mandel’s *Safe and Together* model. The model encourages a collaborative approach between child protection and domestic violence practitioners and aims to ensure the safety and wellbeing of children experiencing DFV by:

- keeping children “safe and together” with the non-offending parent to ensure safety, stability, nurturing and healing from domestic violence;
- partnering with the non-offending parent to develop a child-centred risk management plan; and
- intervening with the perpetrator to reduce risk and harm to the child through engagement, the justice system and accountability (Fitz-Gibbon et al., 2018; Humphreys, Healey, & Mandel, 2018).

Fitz-Gibbon et al. (2018) found a number of key issues identified by the Victorian family violence sector as critical to developing and building effective family violence risk assessment and responses for children. These are:

- modifying universal practice to better capture family violence risks to children;
- the importance of interagency collaboration and a shared framework of responsibility;
- developing clear pathways and referrals from children’s risk assessment; and
- the need for specialised training for support workers (Fitz-Gibbon et al., 2018).

THE LANGUAGE OF RISK

Understanding “risk” in the context of DFV is a vexed issue. Since the late 1980s, there has been an increase in criminological approaches to addressing the risk of reoffending

and reducing repeat victimisation. Despite the broad embrace of risk by researchers, and its central focus for governments, organisations and individuals, there is some confusion across the literature as to how risk is best understood in the context of prevention and response to violence: either in terms of identifying and addressing risks to victim-survivors, or alternatively, in terms of the risk of perpetrators reoffending based on the identification of certain violent characteristics, which are then used to “sort” individuals using typologies in order to inform proportionate and appropriate responses (Breckenridge et al., 2015; McCulloch et al., 2016; Walklate, 2018).

For the purposes of DFV risk assessment and safety management, “risk” can be generally understood as assessing the likelihood of future harm and/or lethality based on information pertaining to past behaviours. However, there is a lack of consistency about what constitutes risk, what should be done about it, and whose and what risk is being measured. These inconsistencies in both the literature and across risk assessment tools highlight the importance of developing a shared language of risk among professionals responding to DFV.

A range of vocabularies are used by the diverse professionals engaged in the identification, assessment and management of DFV, reflecting a broad spectrum of professional experiences and ideologies including those of employing organisations, as well as of diverse geographical and social services contexts. Separate sets of attitudes, policies and practices inform responses to violence in the criminal justice, family law, child protection and specialist services sectors (Humphreys, 2007; James & Ross, 2016). In their review of the Victorian *Common Risk Assessment Framework* (CRAF), McCulloch et al. (2016) emphasise that building a shared understanding and language of risk is crucial for services to be able to work together to support the safety of victim-survivors.

Ideally, professionals are assisted in developing a shared understanding of risk and safety through supported implementation of common risk assessment tools and safety management frameworks, which include core principles, practice guidance and governance advice, and outline professional roles and responsibilities in responding to risk. Specifically, a shared language of risk is facilitated by common reference to evidence-based risk factors for family and domestic violence in practitioner tools, and through coordinated approaches to information sharing, safety planning, referrals and multiagency case management (Albuquerque et al., 2013; McCulloch et al., 2016).

Vaughan et al. (2016) highlight that the terms “risk” and “vulnerability” are often used interchangeably in literature discussing DFV against immigrant and refugee women. Indeed, the same could be said to different degrees in the context of discussions of violence against all victim-survivors. As Vaughan et al. (2016) emphasise though, it is important to distinguish between the two terms in order to recognise that risk of violence is *caused* by the deliberate behaviours of perpetrators, and that women and children are *made* vulnerable by perpetrators who exploit their personal circumstances, traumas, and experiences of systemic disadvantage and discrimination.

“Risk assessment is an art rather than a science and should be recognised as preventive rather than predictive. Care will need to be taken that needs-led practice with women and children is not overridden inappropriately by risk management strategies which have some potential to disempower women in their decision-making” (Humphreys, et al., 2015, p.3).

RISK AND NEED

“Risk” carries with it a sense of immediacy and crisis. Interventions that follow risk assessments tend to focus on the immediate physical and emotional concerns of victim-survivors such as securing refuge accommodation, assisting with domestic violence orders and securing financial aid. Addressing victim-survivors’ needs speaks to the broader work of considering the “whole person” and the contexts of victim-survivors’ lives to facilitate improved advocacy and referrals and to address often complex needs that may surpass the support available from specialist DFV services (Taylor & Green, 2014, p.13).

Kathy Desmond’s (2011, p.12) *Filling the Gap Service Model* describes a “continuum of care” for women and children, that provides a holistic approach to responding to violence through supported referral and multi-agency coordination, underpinned by the principle that the DFV service system needs to better meet the needs of victim-survivors as they rebuild their lives after violence, making positive and sustainable changes in their situation and circumstances. This approach is particularly important for victim-survivors and their families whose support needs exceed the time limitations in crisis interventions. Linking risk assessment and management processes with post-crisis integrated service responses through partnerships across a broad range of agencies including neighbourhood centres, community health and learning centres, healing and other cultural and specialist services, seeks to contribute to longterm wellbeing, thriving, and to communities that are safe and free from domestic, family and sexual violence (Desmond, 2011).

When risk is understood in totalising and uniform ways through the “operationalisation” of individual risk factors in assessment tools, the importance of understanding the particular contexts, historical and otherwise, in which situations of violence occur, can be missed. Walklate (2018, p. 9) highlights the “messiness” and “tangled interactions” that may constitute the reality of people’s lives when DFV is present, and how risk assessment processes can minimise victim-survivors’ agency and experiences.

Victim-survivors’ risks and needs are best addressed through collaborative approaches that empower them to rebuild their lives, and that are based on the principle that victim-survivors are the experts of their experiences and that when appropriately supported by professionals and robust risk assessment processes, are best placed to lead the development of plans aimed at securing their long-term safety and wellbeing.

SAFETY

Safety is the first priority in any response to domestic, family and sexual violence. **Safety planning** is a vital component of all risk assessment and is the process of identifying and documenting (for example, in case notes or via secure online apps) the steps required and resources available to optimise safety for all victim-survivors in a family. Safety plans

Safety issues to consider in the development of risk assessment and risk management tools

- The priority on the most dangerous perpetrators may leave many women and children without an adequate and safe intervention.
- Risk factors are indicative not predictive and serious cases may be left out of a system which only prioritises intervention to high-risk cases.
- Risk assessment may be seen as an end in itself, rather than a mechanism through which to inform the management of risk.
- Risk assessment and risk management needs to actively enhance the policing response and not overwhelm police with administrative paperwork (Holder, 2008, in Humphreys, et al., 2015).

should be personalised, detailed documents that outline clear and specific strategies and measures that aim to improve safety across a wide range of situations (Albuquerque et al., 2013; Murray, Marsh Pow, Chow, Nemati, & White, 2015).

Safety plans can identify and seek to plan for physical, social, emotional, financial, technological and psychological safety but typically involve planning to avoid serious injury, to escape violence (crisis management) and to ensure the safety of children.

Fundamental to the creation of an appropriate safety plan is the collaborative relationship and process between the victim and the professional supporting her. Many women do not seek help for their experience of violence. Fifty-four percent (149,700) of women who have experienced violence by a current partner, sought advice

or support for the violence, and 82 percent (225,700) had never contacted the police (ABS, 2017). Nine out of ten women who have experienced sexual assault by a male (87% or 553,900) did not contact police about the most recent incident (ABS, 2017).

Through research examining the factors that shape women's decisions to disclose and their perceptions of the impact of screening in health services on theirs and their children's safety, Spangaro, Zwi and Poulos (2011) found that when deciding whether to tell someone about the violence, victim-survivors make judgements about safety across three primary dimensions: safety from the abuser, safety from shame and safety from institutional control (most prevalent for women who have been engaged by child protection services). Victim-survivors who receive supportive responses from those they first tell about the violence, including being asked directly by a trusted person who makes clear that disclosure is not mandatory, are more likely to have increased confidence and to seek support in the future (Spangaro et al., 2011).

Risk to workers: Practitioners may also need to take protective strategies, particularly in cases where there is a high-risk offender. Further, there is some evidence to suggest that when workers are fearful, they minimise the violence in ways similar to some victim-survivors. Appropriate supervision and support are important to prevent increased risk to victim-survivors and workers (Humphreys, 2007).

FOCUSING ON PERPETRATORS' BEHAVIOURS

The National Outcome Standards for Perpetrator Interventions endorsed by the Council of Australian Governments (COAG) emphasise that the burden to protect themselves must be removed from victim-survivors and children, and that responsibility for their safety be placed with systems and services by keeping perpetrators of violence firmly “in view” in all interventions with victim-survivors (Australia, Department of Social Services, 2015, p.2).

Risk assessment across Australian jurisdictions has tended to concentrate on victim-survivors, rather than on the accountability and behaviours of perpetrators. For example, Murry et al. (2015) suggest that a limitation of safety planning is its primary focus on the victim. When dealing with a violent perpetrator, a safety plan is no guarantee of not being harmed, and this limitation should be communicated to victims.

Monitoring the presence of or changes in perpetrator (dynamic) risk factors is essential to the effective risk assessment and safety management of victim-survivors. The most consistently identified risk factor for intimate partner lethality and risk of reassault is a previous history of violence. An 11 city study in the United States undertaken by Campbell, Webster, and Glass (2009) found that 72 percent of intimate partner femicides were preceded by physical violence by the male perpetrator, and that when there was an escalation in frequency or severity of physical violence over time, abused women were five times more likely to be killed.

The Centre for Innovative Justice’s (2015) review *Opportunities for Early Intervention: Bringing perpetrators of family violence into view*, identified the multi-agency risk collaborations that have emerged internationally and in Australia, such as the Risk Assessment and Management Panels (RAMPs) in Victoria, as a crucial aspect of intervening in the escalation of risk (usually those cases assessed as “high-risk”). The RAMPs and other coordinated case management approaches such as the Family Safety Meetings (FSMs) in the Northern Territory or Safety Action Meetings in New South Wales (SAMs) have been highlighted as an effective approach to keeping the focus of risk assessment and safety management “squarely on perpetrators” by bringing together relevant support services including justice and corrections to escalate interventions and monitor perpetrators, prioritising the safety of victim-survivors (Centre for Innovative Justice, 2015, p.31).

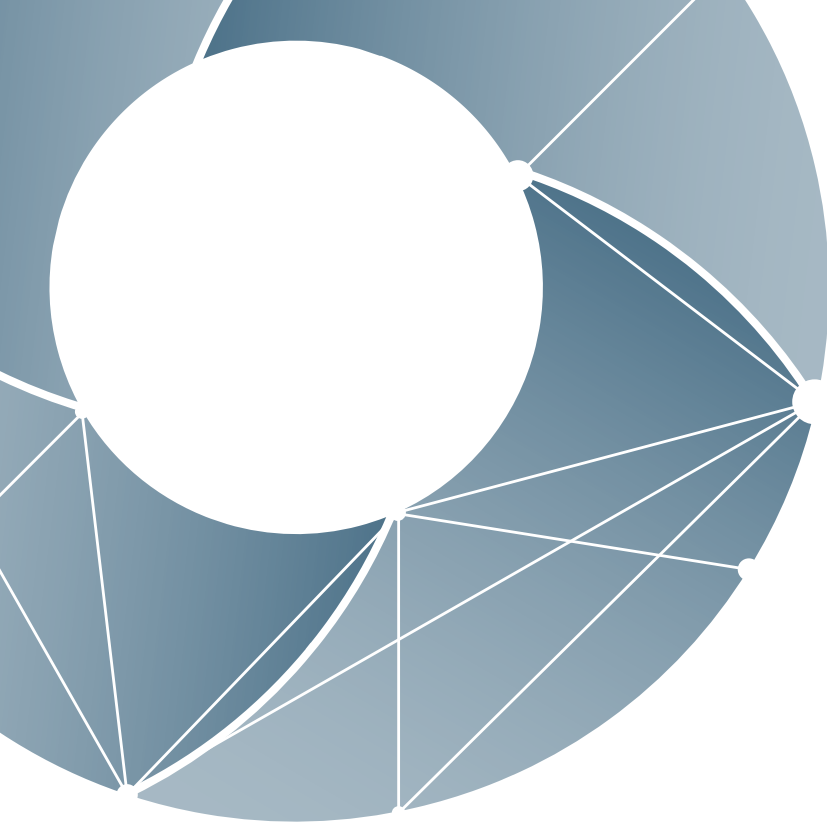
In a comprehensive review of responses to perpetrators of family violence in New Zealand, Polaschek (2016) identifies four essential components of approaches to keeping victim-survivors safe through risk monitoring and integrated perpetrator responses. These are:

- “best practice” risk assessment and reassessment processes that are used consistently with findings documented (e.g. in case notes);
- providing more dangerous “high-risk” perpetrators with greater supervision and service support than less dangerous cases;
- prompt identification of increases or shifts in risk status, with a corresponding

- change in response as appropriate and proportionate; and
- providing case managers for those with high and complex needs (e.g. mental health, alcohol and other drugs, housing) who coordinate and monitor planned multi-agency responses (Polaschek, 2016, p.1).

Shifting focus and responsibility away from victim-survivors and their protective strategies and onto perpetrators' behaviours and circumstances has particularly important implications for mothers and their children in the context of child protection and the family law system. Laing et al. (2018, p.6) highlight that discourses of maternal "failure to protect" in which women are blamed for children's exposure to domestic violence, has led to an over-emphasis on separation from the violent partner as the solution, often involving coercive practices including threats or removal of children, rather than interventions aimed at supporting the adult survivor and children and adequately supervising perpetrators.

Keeping focus firmly on the behaviours of perpetrators is particularly important during times of transition, including during family law proceedings (McCulloch et al., 2016). Women are most at risk of being killed or seriously injured during and/or immediately after separation. The NSW Domestic Violence Death Review Team (2017) reported that two-thirds (65%) of female victims killed by a former intimate partner between 2000-2014, had ended their relationship within three months of being killed.



Priority populations

While DFV is prevalent across all of Australia's communities, there is sufficient evidence to highlight that particular groups and individuals experience multiple challenges that heighten the likelihood, impact or severity of violence, as well as experiencing additional barriers to seeking and obtaining support. These priority population² groups include:

- Aboriginal and Torres Strait Islander women and families;
- migrants, refugees and people who are culturally and linguistically diverse (CALD);
- people with disabilities;
- lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) people;
- people with a mental illness;
- older women;
- women in pregnancy and early motherhood;
- people in regional, rural and remote areas; and
- young women (Australian Institute of Health and Welfare, 2018; Council of Australian Governments, 2011).

For people from these diverse population groups and life stages, the experience of multiple and overlapping factors including gender, ethnicity, ability, sexual orientation, citizenship, migration status, religion, age, economic and geographical status, and the experience of discrimination or disadvantage related to these factors, can compound or exacerbate the impacts of DFV (Sokoloff & Dupont, 2005).

² "Priority populations" refers to diverse groups for whom there is significant evidence of heightened vulnerability to violence, both in frequency and severity, and who may encounter a range of specific barriers to seeking support and securing safety, related to intersecting identity-based and situational factors, and experiences of discrimination. While a range of terminology is used by and to describe these groups, "priority population" is consistent with the national policy landscape, including the National Plan (Council of Australian Governments, 2011).

Reasons survivors don't disclose violence:

- fear of the consequences in disclosing (including involvement of child protection and other social services);
- concerns they won't be believed;
- think that they are to blame for the abuse;
- shame and embarrassment;
- fear of making the violence worse;
- fear of being judged or criticised;
- concerns about confidentiality;
- not recognising the behaviours as abusive;
- prior experiences of negative or blaming responses from services; and
- perpetrator tactics of isolation and control.

(Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Rose, Trevillion, Woodall, Morgan, & Howard, 2011; Spangaro et al., 2011).

The term “**intersectionality**”, used in the context of prevention and response to DFV, refers to the conceptual framework that seeks to understand the dynamics of these different factors for individuals and communities and the unique risks and sometimes competing needs these factors contribute to (The Equality Institute, 2017). Further, taking an intersectional approach also means recognising that the barriers to seeking support and the particular forms of violence and fears that victim-survivors from some groups experience are not only driven by sexism and gender inequality, but experiences of other forms of discrimination including racism, ableism and homophobia (Chen, 2017).

BARRIERS TO SUPPORT AND SAFETY

There is very rarely one single cause or factor that leads to DFV, and each victim's experience of violence and its impacts is unique. Victim-survivors, perpetrators and affected family

members must be carefully assessed on an individual basis, no matter which community they belong to.

In addition to the detail provided for several identified priority population groups below, examples of barriers to support and safety that should be considered in the development and implementation of risk assessment include:

- Dependency on an intimate partner, family member or trusted person for daily care or dependency of the perpetrator on the victim for income, particularly for older women (Lachs & Pillemer, 2004).
- The minimisation of experiences of violence and conflict in relationships due to social stigmas around mental health that are exploited by perpetrators leading some victim-survivors to wrongly believe their poor mental health is “causing” or provoking the violence (Trevillion, Corker, Capron, & Oram, 2016).
- A lack of routine or appropriate screening for DFV in antenatal settings, which may be the only service provider a pregnant victim-survivor comes into contact with who is able to assess for abuse and take actions towards resolving it (Menezes Cooper, 2013).
- Geographical and social isolation from support networks in regional and remote areas, as well as limited access to services, particularly specialist services such as translators, behaviour change programs, and crisis and long-term accommodation (Wendt, Chung, Elder, & Bryant, 2015).

- Heightened experience of gender inequality in youth peer cultures, creating harmful norms in relationships and minimising young women's competency to make decisions and provide consent (Allison & McGaurr, 2015).

ABORIGINAL AND TORRES STRAIT ISLANDER WOMEN AND FAMILIES

Aboriginal and Torres Strait Islander people are significantly more likely to experience family violence than non-Indigenous people (SNAICC et al., 2017). In 2014-15, Indigenous³ women were 32 times more likely than non-Indigenous women to be hospitalised due to family violence (Australia. Productivity Commission, 2016). Intimate partner violence contributes more to the burden of disease (the impact of illness, disability and premature death) for Indigenous women aged 18-44 years than any other risk factor, including smoking, alcohol and obesity (Webster, 2016). Existing data indicate that the prevalence and severity of violence affecting Aboriginal and Torres Strait Islander people increases as geographic remoteness increases (Australian Institute of Health and Welfare, 2018).

"The term "family violence" in an Indigenous context is used to describe the range of violence that takes place in Indigenous communities including the physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that may be perpetrated within a family. The term also recognises the broader impacts of violence on extended families, kinship networks and community relationships. It has also been used in the past decade to encompass acts of self-harm and suicide, and has become widely adopted as part of the shift towards addressing intra-familial violence in all its forms" (Gordon et al. 2002; Robertson 1999; Wild & Anderson 2007, in Cripps & Davis, 2012).

The terminology for "domestic and family violence" is contested by Aboriginal and Torres Strait Islander individuals, communities and researchers, with debate centring on whether emphasis should be placed on violence perpetrated by intimate (domestic) partners or on more broadly occurring violence within families (Laing & Greer, 2001).

It is widely agreed that DFV for Aboriginal and Torres Strait Islander victim-survivors and perpetrators must be understood and responded to with recognition of the contexts of colonisation, systemic disadvantage, intergenerational trauma, forced removal of children, land dispossession and experiences of racism and discrimination (Blagg, Bluett-Boyd, & Williams, 2015; Cripps & Adams, 2014; Laing & Greer, 2001). These factors can exacerbate the severity, frequency

and impacts of family violence in Aboriginal and Torres Strait Islander communities (Cripps & Adams, 2014).

Further, there is substantial evidence that indicates that Aboriginal and Torres Strait Islander women experience significant and specific barriers to reporting violence and accessing support (Cripps & Davis, 2012; Laing & Greer, 2001; SNAICC et al., 2017). These barriers include:

- lack of understanding of legal rights and options and how to access supports when experiencing family violence;

³ The terms "Indigenous" and "non-Indigenous" are sometimes used to categorise data relating to Australia's First Peoples, and all other Australians, respectively. "Aboriginal and/or Torres Strait Islander peoples" is often preferred, as "Indigenous" can detract from the preferred identities of individuals or groups as well as minimise the differences in culture, tradition, beliefs, language, protocols, histories and contexts between Aboriginal and Torres Strait Islander people, families and communities.

- poor police responses and discriminatory practices within police and child protection services;
- fear of child removal if disclosing family violence;
- mistrust of mainstream legal and support services to understand and respect the needs, autonomy and wishes of Aboriginal and Torres Strait Islander victim-survivors;
- community pressure not to go to the police in order to avoid increased criminalisation of Aboriginal men, or removal of men from communities in the absence of appropriate services and support;
- pressure not to leave a violent relationship, stemming from a priority within some parts of the community of maintaining the family unit due to a misconceived fear that parental separation will threaten cultural connection (especially for children) and community cohesion;
- poverty and social isolation; and
- lack of cultural competency and indirect discrimination across the support sector, including for example:
 - discriminatory practices within police and child protection agencies;
 - lack of culturally appropriate housing options; and
 - alienating and deterrent communication and client/patient approaches by medical, legal, community services and other professionals (Aboriginal Family Violence Prevention and Legal Service Victoria, 2015, p.23; SNAICC et al., 2017).

Research also suggests that Aboriginal and Torres Strait Islander women often:

- do not want to leave their family or home;
- seek interventions that allow them to remain in their communities; and
- seek holistic perpetrator interventions rather than those that lead to incarceration or rejection from communities (Blagg et al., 2015).

While there are gaps in the collection and analysis of data, it is clear from the available evidence that the prevention of and response to violence against Aboriginal and Torres Strait Islander women, children and families are most effective when led by or in genuine partnership with Aboriginal and Torres Strait Islander peoples, communities and organisations (Cripps & Adams, 2014; McCulloch et al., 2016; SNAICC et al., 2017).

SNAICC et al. (2017) emphasise the importance of challenging deficit-based thinking by recognising Aboriginal and Torres Strait Islander cultural strength as a key protective factor against family violence, investing in community-led, trauma-informed, cultural healing approaches, and valuing and building on worker expertise that is already in place within existing culturally appropriate frameworks and responses.

Localised, tailored referral processes for Aboriginal and Torres Strait Islander victim-survivors of family violence, which are implemented in consultation with Aboriginal and Torres Strait Islander family violence legal services and other community and specialist organisations, are a central component of appropriately managing the safety

of Aboriginal and Torres Strait Islander victim-survivors. It has been recommended that risk assessment tools and frameworks, particularly those used by first responders, be developed and implemented in partnership with Aboriginal and Torres Strait Islander services with specific protocols and localised referrals to those services (Aboriginal Family Violence Prevention and Legal Service Victoria, 2015; McCulloch et al., 2016).

For Aboriginal and Torres Strait Islander men and women, experiences of family violence, either as a victim-survivor or perpetrator, are intimately linked to incarceration (SNAICC et al., 2017). A report from the Human Rights Law Centre (2017) found that 70-90 percent of Aboriginal and Torres Strait Islander women imprisoned in Australia are survivors of sexual and family violence. Examples of responses to Aboriginal and Torres Strait Islander family violence highlighted in the literature as effective in reducing the prevalence and impacts of violence, as well as reducing the risk or escalation of child protection interventions, include: culturally targeted community legal education, accessible, proactive and appropriate legal advice and assistance; wrap-around risk management service responses; and investment in trauma-informed holistic health and wellbeing services for perpetrators and victim-survivors (Aboriginal Family Violence Prevention and Legal Service Victoria, 2015; Healing Foundation et al., 2017).

IMMIGRANT AND REFUGEE WOMEN

Vaughan et al. (2016) found that for risk assessments of DFV to be relevant for immigrant and refugee populations, they need to recognise and incorporate definitions of family violence that include multi-perpetrator violence, immigration-related abuse, ostracism from community and exploitation of interfamilial financial obligations. Research by Segrave (2017) on temporary migration and family violence in Australia provides further evidence supporting the inclusion of baseline questions in generalist risk assessment and management processes that have specific ramifications for women whose migration status is temporary, but that can also impact all women in family violence situations. These questions should address:

- **Technology:** including the utilisation of technology to enact (or threaten) abuse, but also control over women's use/access to technology.
- **Employment and financial security/control:** assessment should include canvassing control over and access to finances, sharing of household and other financial responsibilities, limitations or control related to accessing employment and the type or nature of that employment.
- **Multiple perpetrators:** questions pertaining to who is enacting violence/harm/threats/control should be gathered to ensure specificity of legal response (for example, Intervention Orders (IVOs) against all relevant parties) and to understand the cultural and familial context of family living arrangements.
- **Counter/cross claim Intervention Orders and other mechanisms to undermine victim accounts:** it is important for risk assessment purposes to capture where

IVOs and/or other intervention mechanisms (such as mental health reports) have been used against the victim-survivor to undermine/challenge the veracity of her account of family violence.

- **Migration status:** if migration status is temporary, this should be a screening question to enable referral to a specialised service, where further, more specialised risk assessment and management should take place. This should be a routine assessment question, as migration status is not directly aligned with language or cultural difference (Segrave, 2017, p.5).

There is also evidence indicating that immigrant and refugee women tend to seek help only after enduring years of abuse, and are prompted by escalating frequency and severity and fears for the impact on their children (Segrave, 2017; Vaughan et al., 2016). Services engaging clients from diverse backgrounds in risk assessment and management should do so in a sensitive and culturally appropriate way to identify any reluctance the victim has to engage with the service system, understand the victim's visa and legal status and facilitate accessibility through the provision of qualified translators and community supports (Bridge, Massie, & Mills, 2008).

WOMEN WITH DISABILITIES

The available research indicates that women with disabilities are 40 percent more likely to experience DFV than other women and that more than 70 percent of women with disabilities have been victim-survivors of sexual violence. Almost all (90%) of women with an intellectual disability had experienced sexual abuse, more than two-thirds (68%) before they were 18 years of age, and low rates of disclosure are widely recognised (Australian Law Reform Commission 2010, in Frohmader, Dowse, & Didi, 2015).

The intersecting challenges experienced by women with disabilities mean that there can be a tension between addressing disability support needs and the risks of domestic, family and sexual violence. While women with disability experience many of the same types of DFV as women without disabilities, violence may also take particular forms, including withholding medications or aids and limiting access to support services (Maher et al., 2018).

Inclusive, integrated responses to risk management, involving referral arrangements across multiple agencies including specialist, client-nominated services, aim to address the “siloeing” of the DFV and disability service sectors. The prevention of and response to violence against women with disabilities should be supported by frameworks of disability policy and service provision that address gendered violence, and should also ensure that women with disabilities are at the centre of violence prevention efforts rather than an “extra” group whose needs are exceptional or additional to mainstream responses (Frawley, Dyson, Robinson, & Dixon, 2015).

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER AND INTERSEX PEOPLE

While research and data are limited, emerging evidence indicates that people who identify as lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI), experience violence in similar rates to those in heterosexual relationships. One in three LGBTQI Australians have reported experiencing abuse in a relationship, including 65 percent of transgender males and 43 percent of intersex females, and lesbian, gay and bisexual people are at greater risk of experiencing sexual coercion than heterosexual females (O'Halloran, 2015).

Risk factors identified in the empirical research for inclusion in risk assessment tools have almost exclusively been developed through analysis of heterosexual samples. Their applicability to people in non-heterosexual LGBTQI relationships remains unclear. One exception is the tool developed and validated by Glass, et al. (2008b) in the United States, the Danger Assessment-Revised (DA-R): For Use in Abusive Female Same Sex Relationships. The DA-R is unique in its assessment of repeat offending and lethality in female same-sex relationships, yet with limited applicability to other LGBTQI relationships.

Some factors are identified in the literature as important to consider when conducting risk assessments with LGBTQI people. These include: experiences of homophobia, transphobia and heterosexism in society and from some service providers; fear of discrimination by the criminal justice system and police; fears of being “outed”; or forced commencement or cessation of medical gender-transition (O'Halloran, 2015; Western Australia. Department for Child Protection and Family Support, 2015). Risk assessment practices and common tools should be adapted in accordance with emerging knowledge about specific risk factors for diverse communities and as further research determines how well the existing evidence-base on risk factors for DFV applies to priority population groups (McCulloch et al., 2016).



Risk assessment and management

APPROACHES TO RISK ASSESSMENT

Risk assessment is a complex, continuing and evaluative process rather than a single event or activity undertaken in response to an incident of violence. Professional tools and frameworks may be used to guide or assist in a conversation. However, this should be part of a broader discussion with the victim about their experiences of violence or with the perpetrator about their beliefs and behaviour, and should include an examination of:

- static risk factors, and dynamic (changing) factors;
- patterns of behaviour;
- patterns of violence;
- coercive control; and
- beliefs of perpetrators (Newman, 2010).

There are three key approaches to the risk assessment of DFV, which have evolved over time. These are:

1. **Actuarial approach:** uses tools to integrate statistical evidence into an assessment to predict specific behaviours. This approach is limited in reference to a fixed set of risk factors, which often involves producing weighted “risk scores” through check-list tools which have been developed through statistical analysis of data such as police records of domestic violence incidents.
2. **Clinical approach:** unstructured clinical decision making using professional judgement which is more informal and subjective. In this approach, the professional has discretion over which information is included in the risk assessment.
3. **Structured professional judgement:** usually combines the first two approaches to gather information from many sources including identifying risk factors through

an evidenced-based framework (tools and practice guidance) and taking into consideration the specific situation and context. In this approach, the goal is to prevent future violence, rather than to predict deaths (McCulloch et al., 2016; Roehl, O’Sullivan, Webster, & Campbell, 2005).

There is also increasing recognition of women’s expertise in their own situation, with research demonstrating that victim-survivors often have the most accurate assessment of their own risk (Albuquerque et al., 2013; Laing, 2004).

VICTIM-SURVIVORS’ SELF-ASSESSMENT

There are multiple examples, particularly from the reports of DFV and child death review committees and Coroner’s Courts, of cases in which a failure to listen to women’s and other victim-survivors’ own voices and self-assessment of the risk of experiencing future violence has led to their subsequent homicide (Walklate, 2018).

In February 2014, Kelly Thompson was stabbed to death in her Point Cook home in Victoria by her recently estranged partner Wayne Wood. At the time of her death, Kelly had a full intervention order against Mr Wood following physical violence towards her and had reported two breaches of the earlier interim intervention order to police. In the weeks preceding her death, Kelly called the police 38 times (Coroner’s Court of Victoria, 2016).

In addition to formalised tools and frameworks, it has been widely established that as women are the experts of their own situation, including perpetrator and relationship dynamics, they are good predictors of their own risk of experiencing future violence (Albuquerque et al., 2013; Campbell, Webster & Glass, 2009; Coroner’s Court of Victoria, 2016; Heckert & Gondolf, 2004; Roehl et al., 2005; Weisz, Tolman, & Saunders, 2000).

One study by Heckert and Gondolf (2004) showed that women’s perceptions of risk by themselves were around as accurate in predicting reassault by their partner as key international risk assessment tools which have undergone predictive validity testing (the SARA, K-SID & DAS). This study also found that the best prediction of repeated violence was obtained when women’s own perceptions of whether experiencing future violence was likely were considered together with an assessment of the victim’s and perpetrator’s risk factors and circumstances.

A victim-survivor led approach to risk assessment and safety management recognises that clients are the experts in their own safety, and have intimate knowledge of their lived experiences of violence (Murray et al. 2015). It is widely recognised that at a minimum, it is important to consult with victim-survivors during risk assessment, as they are best-placed to provide information which is relevant to their safety, and which will assist in identifying risk and contextual factors that can guide appropriate perpetrator interventions (Northcott, 2012; Polaschek, 2016).

This comprehensive approach to risk assessment which collects information from multiple sources including victim-survivors’ perceptions to inform a professional judgement, is

highlighted across the literature and in existing frameworks as a “best practice” approach to risk assessment of DFV. This multi-faceted collection of information is important as some studies have found that abused women may also minimise their experiences of violence and the potential that they may be seriously harmed or killed (Campbell et al., 2009; Murray et al., 2015).

For people in non-heterosexual relationships and for women who identify as lesbian, gay or bisexual, the effects of homophobia and gender stereotypes around intimate partner violence (e.g. that women are incapable of exerting physical power over another woman), can contribute to LGBTQI victim-survivors underestimating risk of reassault or the severity of harm they may experience from intimate partners (Glass et.al., 2008b).

Murray et al. (2015) found that in the experiences of many domestic violence service providers, victim-survivors did not see their safety as a significant concern and so empowering them to understand the dangers of being in an abusive relationship, “is one of the most instrumental roles professionals can play”. Findings from Murray et al. (2015) indicate that certain perceptions and belief systems around abuse lead women to minimise risk, including:

- patterns of desensitisation around abusive dynamics either within their own relationships or from observing abuse in their families from an early age, so that they are no longer able to recognise the dangerousness of those dynamics;
- fear of retaliation for publicly acknowledging the abuse or seeking help;
- fears of judgement – that others would believe them to be “crazy” or think they are overreacting; and
- a lack of self-esteem that in its extreme, manifests in a belief that they “deserve the abuse” or have “no right to seek help” (Murray et al., 2015, pp. 391-392).

WHICH APPROACH TO RISK ASSESSMENT IS BEST?

Which approach to risk assessment is best will depend to some extent on the context and purpose of the risk assessment and the individual needs of victim-survivors and perpetrators. Further, it may not be possible to develop a tool that calculates with absolute certainty the risk of reassault or lethal violence (Kropp, 2004). However, there is broad consensus across both academic and practice-based literature that the **structured professional judgement approach** to risk assessment and safety management is most effective in most circumstances of domestic, family and sexual violence (Newman, 2010; Northcott, 2012).

Through the structured professional judgement approach, investigative checklists, case management tools, practice guidelines and interagency protocols are used to support a thorough assessment of risk and facilitate the development of safety plans and appropriate interventions (McCulloch et al., 2016; Millar, Code & Ha, 2013). The structured professional judgement approach involves the collection of information gathered from multiple sources, including:

- a well-tested actuarial tool which has been proven over time to have strong predictive validity or tool based on evidence-based risk factors which have been identified through empirical research;
- victim statements and narratives, particularly in relation to her level of fear, and her perception of her own risk; and
- expert judgements, clinical wisdom, and the subsequent professional discretion of practitioners, who draw on their specialist knowledge of DFV as well as on information shared by other services in contact with the client, such as perpetrators' police records, to inform coordinated risk management strategies (Campbell et al., 2009; Kropp, 2004; Roehl et al., 2005).

Importantly, the structured professional judgement approach to risk assessment occurs in the context of multi-agency collaboration and information sharing. It provides the foundations for continuous risk assessment and safety management processes, including individually tailored integrated service responses.

SAFETY AND RISK MANAGEMENT

Risk management is a dynamic, active and collaborative process which aims to promote the ongoing safety and wellbeing of victim-survivors and their families through an integrated, holistic strategy and coordinated, multi-agency service responses to reduce and prevent future violence (Albuquerque et al., 2013). A central element of risk management processes is repeatedly conducting risk assessments. As risk can change quickly and unpredictably, it must be continuously assessed, monitored and reviewed, ideally as part of clients' regular contact with specialist DFV services overseeing their case management and therapeutic needs (Victoria. Department of Human Services, 2012).

Albuquerque et al. (2013) identify four key components of risk management. These are:

1. **Monitoring:** risk assessment is conducted continuously so that risk management and safety strategies can be adjusted over time as necessary to respond to changing experiences and contexts of violence. This monitoring can be performed by individual agencies or, ideally, by several services working together in a coordinated case management process.
2. **Support services:** delivery of health and social services to empower victim-survivors and survivors. This might include providing legal, employment, accommodation or educational opportunities and support, as well as responding to people's broader health and wellbeing needs.
3. **Supervision:** supervision and monitoring of perpetrators' behaviours through coordinated risk management processes and appropriate behaviour change programs. This includes ensuring that perpetrators observe the conditions of their intervention orders, and that victim-survivors' safety is promoted by focusing attention on and supervising the behaviours of the perpetrator.
4. **Safety planning:** this is the most important step in the risk management process, as it aims to ensure the minimisation of the impact of violence in case violence continues and involves mobilising resources to actively protect against future

violence and the severity of its impact. Safety planning can be performed by several agencies working together and should be led by or developed in partnership with the victim.

Risk management involves effective referral pathways, governance structures, and assignment of roles and responsibilities across all relevant services engaged in a coordinated, multi-agency response.

“While preventing lethal outcomes is critical, it is also recognised that family violence not involving physical violence or the risk of lethality can have a devastating impact on women’s and children’s lives. Significantly there is increasing evidence that coercive and controlling behaviours that do not include physical violence are a leading risk factor in male-perpetrated intimate homicide” (McCulloch et al., 2016, p.40).

EVIDENCE-BASED RISK FACTORS

Increased use of tools based on risk factors derived from statistical analysis of data such as police records and from the findings of domestic violence death review committees, attempt to direct a proportionate allocation of limited resources to victim-survivors and perpetrators of intimate partner violence, focusing on cases assessed as “high-risk” (Millsteed & Coghlan, 2016).

Central to the process of risk assessment is a recognition that risk factors vary in the extent to which they are changeable, ranging from highly **static risk factors**, such as the history of violence, to highly **dynamic risk factors**, such as substance abuse or availability of weapons (Douglas & Skeem, 2005). The key task to risk assessment processes is to evaluate risk factors and how they change over time, rather than assuming that assessments made at a particular point in time will remain valid indefinitely (Roehl et al., 2005). By identifying risk factors that can be altered through interventions, pathways for changing perpetrator behaviours emerge, and protective strategies for victims can be identified.

Gender remains the most substantial variable when considering differences in patterns of victimisation and perpetration (Cox, 2016). The biggest risk factor for becoming a victim of DFV or sexual assault is being a woman (The National Council to Reduce Violence against Women and their Children, 2009). Men are far more likely than women to perpetrate intimate partner violence (ABS, 2017).

In addition, findings from empirical studies, academic and practice-based literature and reports produced by international and Australian domestic violence death review committees and Coroner’s Courts indicate that some risk factors are associated with a higher likelihood of violence reoccurring, serious injury, or death, in the context of intimate partner violence by men against women.⁴ These high-risk factors and the supporting evidence are outlined in detail in Appendix A.

⁴ Risk factors identified through empirical research have almost exclusively been identified using heterosexual samples, and their applicability to people in non-heterosexual LGBTQI relationships remains unclear. Risk assessment practices and tools should be adapted in accordance with emerging knowledge and as further research determines how well the existing evidence-base applies to diverse communities and priority population groups.

The relationship between risk factors identified through empirical research and the risk of reassault or lethality are not always straightforward and none can be considered singularly “causal”. Importantly, all of these factors are salient in any case of DFV and should be responded to appropriately and proportionately, whether or not there is a clear intent of the most severe form of violence, homicide (Humphreys, 2007). Evidence-based high-risk factors for DFV include:

- history of DFV;
- separation (actual or pending);
- intimate partner sexual violence;
- non-lethal strangulation (choking);
- stalking;
- threats to kill;
- perpetrator’s access to weapons;
- escalation (frequency and/or severity);
- coercive control; and
- pregnancy and new birth (Campbell et al., 2009; Glass et al., 2008a; New South Wales. Domestic Violence Death Review Team, 2017).

Referring to a list of evidence-based risk factors to conduct risk assessment as a “tick-a-box” exercise is insufficient to adequately assess the risk of future violence, which should involve professional judgement based on information collected from a wide range of sources, including the victim-survivor. It is important for services involved in risk assessment and safety management to refer to a common set of evidence-based risk factors to ensure consistent, coordinated responses to cases assessed as “high-risk”.

Robinson, Pinchevsky, and Guthrie (2016) highlight the potential consequences of inconsistent use of risk assessment tools across agencies. For example, while “relationship separation” is routinely treated as an indication of heightened risk of future violence by police and specialist service providers, relationship separation may be seen as the goal of interventions by social workers in child protection cases (Robinson et al., 2016).



Intimate partner sexual violence (IPSV) and sexual assault

Domestic violence and sexual assault can often occur in the same incident, typically referred to as intimate partner sexual violence (IPSV) (Cox, 2015). The 2016 ABS Personal Safety Survey found that since the age of 15, 5.1 percent (480,2000) of Australian women have experienced sexual violence by a partner, and just under nine out of ten women who have experienced sexual assault were sexually assaulted by someone they knew in the most recent incident (ABS, 2017). Heenan (2004) found that Australian domestic violence workers believe that 90-100 percent of their female clients have experienced IPSV.

Key aspects of providing support to survivors of IPSV:

- privacy;
- naming the sexual violence;
- believing;
- compassionate and respectful responses;
- being trauma-informed;
- non-judgemental responses;
- knowledge of IPSV; and
- appropriate referral (Wall, 2012a).

IPSV is a term used to describe sexual activity without consent in heterosexual and non-heterosexual intimate relationships (whether married or not), and includes vaginal, oral or anal sex which is obtained by physical force or psychological/emotional coercion (rape) and any unwanted, painful or humiliating sexual acts and tactics used to control decisions around reproduction, such as refusing to wear a condom (Bagwell-Gray, Messing, & Baldwin-White, 2015).

Typically, risk assessment tools specifically for sexual assault have been used with perpetrators in the criminal justice system to assess the likelihood of recidivism (Rettenberger, Matthes, Boer, & Ether, 2010). The available evidence indicates that IPSV and

sexual assault should be specifically included as part of risk assessment of DFV and not treated as a separate phenomenon.

Campbell et al. (2009) found that physically abused women who also experienced forced sexual activity or rape were seven times more likely than other abused women to be killed. IPSV was the strongest indicator of escalating frequency and severity of violence, more so than stalking, strangulation and abuse during pregnancy.

More so than other factors, IPSV is under-reported and often not disclosed. Commonly held assumptions that IPSV is less serious than sexual violence perpetrated by a stranger, or that discussing sex and sexual assault within relationships is “taboo” and should remain private, contributes to the particularly acute shame that many victim-survivors of IPSV experience, who consequently may not seek the help they need and continue to suffer their trauma in isolation (Wall, 2012b).

IPSV carries with it the same impacts as domestic, family and sexual violence. However, there are also factors that contribute to unique effects that should be taken into account in the risk assessment of IPSV, including but not limited to:

- **Difficulty defining the act of sexual assault:** women are socialised to see rape as occurring between two strangers and may have difficulty naming a partner she loves, a “rapist”.
- **Longer-lasting trauma:** in part, this is because IPSV survivors can face unique challenges around recognising and naming the sexual violence and increased barriers and reluctance to seek support.
- **Higher levels of physical injury:** IPSV victim-survivors often experience repeat abuse, which increases the likelihood of physical injury and trauma, and is associated with, for example, enduring and serious gynaecological conditions (Fredericton Sexual Assault Crisis Centre, n.d.).

Training on IPSV for all workers conducting DFV risk assessment is essential and should include: detail on the myths and dynamics of sexual violence within relationships; guidance on “how to ask” sensitively and building trust; the specific impacts and health consequences of IPSV; and how best to manage victim-survivors’ safety, cultural considerations, legal options and evidence requirements (Braaf, 2011).

Risk assessment tools are used to guide the discussions professionals have with victim-survivors. These tools and their supporting frameworks and practice guides, also have an educational function, for both victim-survivors and professionals undertaking a risk assessment. Asking victim-survivors of DFV about IPSV separately, distinct from physical abuse, will assist in better self-identification and identification by practitioners, and appropriate service responses and referrals.



Integrated responses

Victim-survivors and perpetrators of domestic, family and sexual violence have diverse and complex needs, often requiring multiple interventions provided by a range of services (Breckenridge et al., 2015). *The National Plan* makes clear that its success hinges on that of the sixth outcome area, which is that “the entire system joins seamlessly and that all its parts work together” (Council of Australian Governments, 2011, p.15).

Integrated or multi-agency service responses for victim-survivors and perpetrators of DFV are a key feature of common risk assessment and risk management approaches that aim to enhance safety in coordinated ways and tend to focus on cases assessed as “high-risk” (Polaschek, 2016).

Comprehensive systemic responses to DFV, such as the Duluth model developed in Minnesota in the 1980s, aim to prevent and respond to abuse in a coordinated way between all relevant services to hold perpetrators accountable, and by doing so support victim-survivors and families to be safe and reduce DFV in communities (Polaschek, 2016).

There is a continuum of integrated service delivery, ranging from loose networks of partnerships, streamlined referral pathways, through to co-located service models (Wilcox, 2010). Understanding integration as a continuum is important in thinking about how common risk assessment tools and risk management frameworks including high-risk case management initiatives, can be implemented across diverse service contexts and geographical areas to best meet the needs of individual clients. There is broad acceptance however that integration often involves formalised agreements between agencies usually through Memoranda of Understanding (MOU), referral agreements and explicit sharing of service provision principles and approaches (Humphreys & Healey, 2017).

Collaboration between services is not a goal in itself, but a means to enhancing the safety and wellbeing of victim-survivors. Humphreys & Healey (2017) identify three key principles in the literature which underpin integrated service delivery for DFV and sexual assault, of which coordinated and active risk assessment and management processes are central to their implementation. These are:

- A focus on enhancing victim-survivors' emotional, psychological and physical safety in the short to long-term.
- Minimising secondary victimisation, which can occur through services treating victim-survivors in a way that disempowers them or subjects them to further trauma, such as having to retell their experiences of violence to each different service provider.
- Holding perpetrators accountable for their actions (Humphreys & Healey, 2017).

BENEFITS AND CHALLENGES

Common benefits to integrated responses to both clients and services identified across the literature include:

- increased focus on victim safety through gathering information from a range of sources to inform risk assessment and contain perpetrator behaviours;
- reduction in secondary (system-created) victimisation, by limiting the need for victim-survivors to repeat the account of their experiences;
- increased perpetrator accountability;
- facilitation of a common language between responding organisations;
- cost-effectiveness through minimising duplication of services; and
- supporting formalised information sharing between agencies (Humphreys & Healey, 2017; Polaschek, 2016).

Further, Millar et al. (2013) found that while the investigative checklists, case management tools and interagency protocols that increasingly accompany risk assessment instruments do not have predictive value, they provide significant benefit in:

- facilitating the development of appropriate safety plans with victim-survivors;
- educating frontline police on the risks and issues involved in domestic violence;
- providing the evidence-base to inform pre-trial and post-sentencing conditions on perpetrators; and
- assisting in the development and implement appropriate interventions for perpetrators.

A recent meta-evaluation involving evaluations of 33 Australian integrated service responses to DFV initiatives found that there can also be significant implementation challenges which should be taken into account in the design of risk assessment and management mechanisms such as referral pathways and providing appropriate support to priority population groups (Breckenridge et al., 2015). These are:

- Different philosophical approaches and power imbalances between agencies.
- Loss of specialisation and tailored responses, including adequate responses for victim-survivors with complex service needs.

- Individual (client) perceptions of cross-agency control, communication and information sharing concerns and frustrations.
- A lack of properly directed resources.

ROLES, RESPONSIBILITIES AND GOVERNANCE

Spangaro and Ruane (2014) highlight the importance of active leadership and robust governance structures to the success of integrated responses, of which risk assessment of DFV is central. Governance arrangements between participating services in coordinated responses should operate at multiple levels, including frontline workers through to senior management, “champions” of multi-agency collaboration and preventing violence at senior levels of management, and should include clearly defined outcomes, monitoring and accountability strategies (Spangaro & Ruane, 2014, p.41).

Clearly defined roles and responsibilities among services and practitioners involved in multi-agency risk assessment must be based on clear protocols including formal agreements of cooperation, information sharing guidelines and an appointed lead of case management (Albuquerque et al., 2013). However, which professionals, services, community members or organisations uptake these roles is best determined in response to localised settings and the particular risks and needs of the individual client.

Examples of common roles and responsibilities in risk assessment and management of “high-risk” cases through multi-agency case management meetings include:

- **meeting chair**, responsible for monitoring imminent risk, scheduling meetings, chairing and reviewing minutes;
- **specialist DFV service meeting coordinator**, responsible for receiving referrals from police, collaboration and information sharing with victim-survivors, and coordination of referral to and engagement with support services; and
- **other core and as-needed members**, including from Centrelink, police, health, men’s behaviour change programs, Aboriginal and Torres Strait Islander health, advocacy and legal agencies, settlement services, sexual assault support services, community organisations, disability, homelessness, education, maternal and child health services (Victoria. Department of Health and Human Services, 2016).



The Principles

The National Risk Assessment Principles for domestic and family violence aim to provide an overarching conceptual understanding of risk and managing risk in the context of DFV. The Principles are based on the evidence summarised in this resource, as well as the significant input provided during the development of the Principles by practitioners, policy-makers, relevant government agencies, peak bodies and key thought leaders and researchers from across all Australia's states and territories. The list of Principles, along with the High-risk factors for domestic and family violence, are included as Appendix A: A Quick Reference Guide for Practitioners.

The Principles do not replace existing state and territory frameworks. Instead, they provide a guide for policy-makers, practitioners and services in the development, review and refinements of risk assessment tools and resources. The evidence is clear: inconsistent and fragmented service responses to victim-survivors and perpetrators of DFV can have fatal consequences. This companion resource provides additional evidence to support the development of a shared understanding of, and approaches to, risk and managing risk in the context of DFV, with the primary intention of keeping all survivors safe.

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National Risk Assessment Principles for domestic and family violence

QUICK REFERENCE GUIDE FOR PRACTITIONERS

PRINCIPLE 1

Survivors' safety is the core priority of all risk assessment frameworks and tools.

The safety and wellbeing of adult and child survivors of domestic and family violence (DFV) is the first priority of any response. Risk must be identified, comprehensively assessed and appropriately responded to by holding the perpetrator responsible and accountable for their behaviour and actions.

PRINCIPLE 2

A perpetrator's current and past actions and behaviours bear significant weight in determining risk.

While the safety of adult and child survivors of DFV is prioritised, workers must also reorient risk assessment and safety management processes onto the behaviour of perpetrators, rather than focusing solely on the protective strategies of survivors.

PRINCIPLE 3

A survivor's knowledge of their own risk is central to any risk assessment.

A survivor's assessment of their own risk should be considered one of the primary elements of any risk assessment, as it provides intimate knowledge of their lived experience of violence and patterns of coercive control.

Service providers need to approach risk assessment and safety management with adult and child survivors through a collaborative process which respects and builds on the survivor's own assessment of their safety, as well as drawing on other sources of information. These sources may include: the use of a well tested actuarial risk assessment tool; professional judgement and practice wisdom drawn from workers' specialist knowledge of domestic and family violence; and information gathered from other organisations.

PRINCIPLE 4

Heightened risk and diverse needs of particular cohorts are taken into account in risk assessment and safety management.

Some members of diverse communities are more vulnerable to DFV, experience violence more frequently and with more severity than others and face a range of specific barriers to safety. An understanding of the effect of the intersections of gender, ethnicity, sexuality, disability, culture, mental health issues, citizenship, age, economic status, geographical isolation and other identity-based and situational factors are critical when undertaking risk assessment and managing safety.



National Risk Assessment Principles for domestic and family violence

QUICK REFERENCE GUIDE FOR PRACTITIONERS

PRINCIPLE 5

Risk assessment tools and safety management strategies for Aboriginal and Torres Strait Islander peoples are community-led, culturally safe and acknowledge the significant impact of intergenerational trauma on communities and families.

It is important to work with extended families and communities in responding to Aboriginal and Torres Strait Islander family violence. Workers need to respond to the whole family rather than to individuals. Healing for adult and child survivors, as well as for the perpetrators of violence, is key to all responses, including risk assessment and management.

Community-driven, trauma-informed approaches to family violence, which prioritise cultural healing and are based on the understanding that culture is a key protective factor supporting Aboriginal and Torres Strait Islander families to live free from violence, are critical.

PRINCIPLE 6

To ensure survivors' safety, an integrated, systemic response to risk assessment and management, whereby all relevant agencies work together, is critical.

Working collaboratively across agencies is fundamental to improving the safety and wellbeing of adult and child survivors. This can be best achieved through an integrated, systemic response that ensures all relevant agencies work together on risk assessment and risk management processes in partnership with the survivor. Effective leadership and governance arrangements which support collaboration and partnerships are essential for collaborative service delivery.

PRINCIPLE 7

Risk assessment and safety management work as part of a continuum of service delivery.

Risk assessment should always form part of a safety management approach which moves with the adult or child survivor on their journey away from violence. The development of a continuum of service responses which addresses survivor safety, perpetrators taking responsibility for their violence and aspects of prevention and healing is critical. As risk factors change over time, ongoing risk assessment and management along the service continuum also changes.



National Risk Assessment Principles for domestic and family violence

QUICK REFERENCE GUIDE FOR PRACTITIONERS

PRINCIPLE 8

Intimate partner sexual violence must be specifically considered in all risk assessment processes.

Intimate partner sexual violence (IPSV) is a uniquely dangerous form of DFV which must be specifically considered in all risk assessment and safety management processes and practices. Survivors' who are sexually abused by their partners are at a much higher risk of being killed, particularly if they are also being physically assaulted, and IPSV is a significant indicator of escalating frequency and severity of domestic and family violence.

More so than other factors, IPSV is under-reported and often not disclosed. Training on IPSV for all workers conducting DFV risk assessment is essential. Training should include:

- details on the myths and dynamics of sexual violence within relationships;
- guidance on "how to ask" sensitively and building trust;
- the specific effects and health consequences of IPSV;
- how best to manage victim survivors' safety;
- cultural considerations; and
- legal options and evidence requirements.

PRINCIPLE 9

All risk assessment tools and frameworks are built from evidence-based risk factors.

The factors critical to developing a shared understanding of risk and safety include:

- Evidence-based risk factors: variables which assist in assessing the likelihood that violence will be repeated or escalate and responding appropriately to that violence.
- Conditions of vulnerability: identity-based and situational factors which may indicate heightened vulnerability to violence, and which may intersect with other factors to compound the risks and effects of violence.
- Protective factors: characteristics which mitigate or eliminate risk, or which reduce conditions of vulnerability.
- Determining a risk threshold: identification of "risk" or "high-risk" through a thorough assessment, so that the allocation of support and treatment interventions address the specific needs of individual survivors and perpetrators.

Specific evidence-based risk factors and their impact on determining risk thresholds are outlined in the following table: *High-risk factors for domestic and family violence*.

High-risk factors for domestic and family violence

NATIONAL RISK ASSESSMENT PRINCIPLES QUICK REFERENCE GUIDE FOR PRACTITIONERS

There are many factors which contribute to the risk of domestic and family violence (DFV). However, findings from empirical studies, academic and practice-based literature, and reports produced by international and Australian domestic violence death review committees and Coroner's Courts indicate that some risk factors are associated with a higher likelihood of violence reoccurring, serious injury, or death, in the context of intimate partner violence by men against women.⁵ The relationship between these factors and risk of reassault or lethality are not always straightforward, and no one factor can be considered singularly "causal". Importantly, there are diverse forms of DFV that do not necessarily involve risk of physical violence or lethality, but which can have a devastating impact on victims' lives. While there is significant evidence that the below risk factors indicate high risk of serious harm or death when mediated by other risk factors or an individual's situation, all of these factors are salient in any case of DFV and should be responded to appropriately and proportionately, whether or not there is a clear intent of homicide.



Lethality/High-risk factors

Key facts

History of family and domestic violence

- The most consistently identified risk factor for intimate partner lethality and risk of reassault is the previous history of violence by the perpetrator against the victim.
- In their 11-city study in the United States (US), Campbell et al. (2003) found that 72 percent of intimate partner femicides were preceded by physical violence by the male perpetrator. When there was an escalation in frequency or severity of physical violence over time, abused women were five times more likely to be killed.
- Smith, Moracco, & Butts (1998) found that for 75 percent of homicides perpetrated by women, the relationship was characterised by a history of abuse by her male partner and the homicide was preceded by male-initiated violence.
- Homicide is rarely a random act and often occurs after repeated patterns of physical and sexual abuse and psychologically coercive and controlling behaviours.

Separation (actual or pending)

- Women are most at risk of being killed or seriously harmed during and/or immediately after separation.
- The NSW Domestic Violence Death Review Team recorded that two-thirds (65%) of female victims killed by a former intimate partner between 2000-2014, had ended their relationship within three months of the homicide.
- Separation is particularly dangerous when the perpetrator has been highly controlling during the relationship and continues or escalates his violence following separation in an attempt to reassert control or punish the victim.
- Children are also at heightened risk of harm during and post-separation.

⁵ Risk factors identified through empirical research have almost exclusively been identified using heterosexual, intimate partner samples, and their applicability to people in non-heterosexual LGBTQI relationships, or for violence occurring more broadly within families, remains unclear. In this resource, the terms "intimate partner violence" or "intimate partner lethality" have sometimes been used instead of "DFV" to accurately reflect the nature of the data source (such as the ABS Personal Safety Survey). Risk assessment practices and tools should be adapted in accordance with emerging knowledge and as further research determines how well the existing evidence-base applies to diverse relationships, families, communities and priority population groups.

High-risk factors for domestic and family violence

NATIONAL RISK ASSESSMENT PRINCIPLES QUICK REFERENCE GUIDE FOR PRACTITIONERS

Intimate partner sexual violence

- Intimate partner sexual violence (IPSV) is a uniquely dangerous form of exerting power and control due to its invasive attack on victims' bodies and the severity of mental health, physical injury and gynaecological consequences.
- Campbell et al. (2003) found that physically abused women who also experienced forced sexual activity or rape, were seven times more likely than other abused women to be killed and IPSV was the strongest indicator of escalating frequency and severity of violence, more so than stalking, strangulation and abuse during pregnancy.
- The 2016 ABS *Personal Safety Survey* (PSS) found that since the age of 15, 5.1 percent (480,200) of Australian women have experienced sexual violence by a partner. Heenan (2004) found that Australian domestic violence workers believe that 90-100 percent of their female clients have experienced IPSV.
- More than other factors, IPSV is under-reported by victims. Shame and stigma caused by commonly held assumptions that discussing sex or sexual assault within relationships is "taboo", are significant barriers to seeking help for IPSV.

Non-lethal strangulation (or choking)

- Strangulation is one of the most lethal forms of intimate partner violence. When a victim is strangled, whether by choking or other means of obstructing blood vessels and/or airflow to the neck, they may lose consciousness within seconds and die within minutes.
- Glass et al. (2008) found that women whose partner had tried to strangle or choke them were over seven times more likely than other abused women to be killed, whether by repeat strangulation or another violent act.
- The seriousness of strangulation as an indicator of future lethality is often misidentified, or not responded to proportionately, as a consequence of the often minimal visibility of physical injury. However, many victims suffer internal injuries which may result in subsequent serious or fatal harm.
- Most perpetrators do not strangle to kill but to show that they *can* kill. Non-lethal strangulation is a powerful method of exerting control over victims. Through credible threat of death, perpetrators coerce compliance.

Stalking

- Stalking behaviours (repeated, persistent and unwanted) including technology-facilitated surveillance, GPS tracking, interferences with property, persistent phoning/texting and contact against court order conditions, increases risk of male-perpetrated homicide.
- The 2016 ABS PSS found that since the age of 15, one in six Australian women (17% or 1.6 million) have experienced at least one episode of stalking.
- McFarlane et al. (1999) found that stalking was a factor in 85 percent of attempted femicides and for 76 percent of femicide victims.
- The vast majority of perpetrators of stalking, and the most dangerous, are intimate partners of the victim, and not a stranger.

High-risk factors for domestic and family violence

NATIONAL RISK ASSESSMENT PRINCIPLES QUICK REFERENCE GUIDE FOR PRACTITIONERS

Threats to kill

- Perpetrators who threaten to kill their partner or former partner, themselves or others including their children, are particularly dangerous. Threats of this nature are psychologically abusive.
- Campbell et al. (2003) found that women whose partners threatened them with murder were 15 times more likely than other women experiencing abuse to be killed.
- Humphreys (2007) found that actual attempts to kill are difficult to separate from serious physical and sexual abuse, and that as above, attempted strangulation is of particular concern given the prevalence of femicide through strangulation.

Perpetrator's access to, or use of weapons

- Use of a weapon (any tool used by the perpetrator that could injure, kill or destroy property) indicates high risk, particularly if used in the most recent violent incident, as past behaviour strongly predicts future behaviour.
- Campbell et al. (2003) found that women who are threatened or assaulted with a gun or other weapon, are 20 times more likely than other abused women to be killed. The severity of abuse-related harm is significantly heightened when weapons are involved.
- While the availability of firearms is much greater in the US, in Australia Millstead & Coghlan's (2016) study of the predictive validity of Victorian Police's L17 risk assessment form, still found a significant relationship between perpetrators possession of a gun, or firearm licence and risk of reassault.

Escalation (frequency and/or severity)

- The escalation in frequency and severity of violence over time is linked to lethality and often occurs when there are shifts in other dynamic risk factors, such as the attempts by the victim to leave the relationship.
- Campbell et al. (2003) found that when there is an escalation in either frequency or severity of physical violence over time, abused women are more than five times more likely to be killed.
- Dwyer and Miller (2014) found that police investigations and family, criminal or civil court proceedings can trigger an escalation in the aggressive and violent behaviour of the perpetrator and heighten risk to the partner and children. Transition points such as this should be treated with great caution.

Coercive control

- Reports from death review committees and Coroner's Courts highlight the prevalence of patterns of coercive and controlling behaviours prior to male-perpetrated intimate partner homicide, including verbal and financial abuse, psychologically controlling acts and social isolation.
- Elliott (2017) found through a synthesis of key empirical research, that coercive control is a gendered pattern of abuse, and is the primary strategy used to coerce and exercise control over female survivors by a current or former male partner. Understanding violence as coercive control, highlights that it is ongoing, cumulative, chronic and routine.
- Coercive and controlling patterns of behaviours are particularly dangerous and can heighten the risk of lethality, in contexts where other high-risk factors are present, such as attempts by the victim to leave the relationship.

High-risk factors for domestic and family violence

NATIONAL RISK ASSESSMENT PRINCIPLES QUICK REFERENCE GUIDE FOR PRACTITIONERS

Pregnancy and new birth	<ul style="list-style-type: none">• Violence perpetrated against pregnant women by a partner is a significant indicator of future harm to the woman and child, and is the primary cause of death to mothers during pregnancy, both in Australia and internationally.• The 2016 ABS PSS found that nearly half (48% or 325,900) of women who have experienced violence by a previous partner and who were pregnant during that relationship, experienced violence from their partner while pregnant.• Humphreys (2007) highlights this violence as “double-intentioned”, where perpetrators may aim physical violence at their partner’s abdomen, genitals or breasts, so that abuse is both of the mother and child.• Women with a disability, women aged 18-24 years and Indigenous women are at particularly significant risk of experiencing severe violence from their partner during pregnancy.• Violence often begins when women are pregnant, and when previously occurring, it often escalates in frequency and severity.
Other Risk factors	Key facts
Victim’s self-perception of risk	<ul style="list-style-type: none">• A victim’s perception of their own risk of experiencing future violence is not sufficient by itself to accurately determine severity or incidence of violence. However, there is significant consensus across the literature that it is important to consider the victim’s own assessment as at a minimum, they can provide information relevant to their safety management.
Suicide threats and attempts	<ul style="list-style-type: none">• Hart’s (1988) study found that the combination of attempts, threats or fantasies of suicide, availability of weapons, obsessiveness, perpetrator isolation and drug and alcohol consumption indicates severe or lethal future violence.• Threats of suicide, like most threats in the context of DFV, are a strategy used by perpetrators to exert control. The NSW Domestic Violence Death Review Team recorded that 24 percent of men who killed an intimate partner in NSW between 2000-2014 suicided following the murder.
Court orders and parenting proceedings	<ul style="list-style-type: none">• In their review of the <i>Victorian Common Risk Assessment Framework</i> (CRAF), McCulloch et al. (2016) found that from their experience, victims/survivors considered Family Law proceedings and intervention orders a critical and often overlooked indicator of DFV risk.• DFV is common and often escalates among separating parents. Perpetrators may use their joint parenting role or judicial options as a way of exercising control over their former partner.

High-risk factors for domestic and family violence

NATIONAL RISK ASSESSMENT PRINCIPLES QUICK REFERENCE GUIDE FOR PRACTITIONERS

Misuse of drugs or excessive alcohol consumption

- Alcohol and/or drug misuse and abuse are often exacerbating or moderating factors in predicting the dangerousness of a perpetrator, and may increase the severity of future violence.
- Recent cessation of drug or alcohol use, particularly where addiction was present, can also exacerbate violent behaviour when the perpetrator is not actively involved in a recovery and rehabilitation process.

Isolation and barriers to help-seeking

- Isolation, including limiting interactions with family, friends, social supports and community support programs is a control strategy used by some perpetrators and increases the risk of severe harm.
- A victim is at increased risk of future violence if she has had no prior engagement with services and is presenting with DFV. A systematic review by Capaldi et al. (2012) found that social support and tangible help are protective against both perpetration and victimisation and that a lack of support is a significant risk factor for victims.

Abuse of pets and other animals

- Cruelty and harm directed to pets and other animals can indicate risk of future or more severe violence and are often used as a control tactic by perpetrators.
- Having to leave pets behind is a recognised barrier to victim-survivors leaving their violent partners.

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