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DISCLAIMER
The information contained in this manual was current at the time of publication. Certain aspects and details of the service system may change, however the principles, values and key elements of practice outlined herein will endure.
Family and domestic violence continues to be the most common form of violence experienced by women throughout the world. The serious nature of family and domestic violence cannot be underestimated. Between 2000 and 2009, 180 domestic homicides were perpetrated in Western Australia (an average of 18 per year).

Of these cases, 59% of the victims were female and 76% of the offenders were male. On average, two of the victims each year were children. The complex nature of family and domestic violence continues to be a challenge, calling for more effective approaches and coordinated effort.

The best results for victims are achieved when we work together in a coordinated and integrated way. The WA Strategic Plan for Family and Domestic Violence 2009-2013 outlines the need for an integrated response as critical in addressing family and domestic violence issues that are prevalent in the community.

Establishing a Family and Domestic Violence Common Risk Assessment and Risk Management Framework will promote a uniform approach to screening, risk assessment and referral across the State, for the multitude of family and domestic violence services that coordinate the integrated response. This Framework sets a minimum standard of screening, assessment and response for all services in WA, both specialist and mainstream. By setting a minimum standard, we can ensure that through risk assessment and risk management we are addressing the violence and offering greater protection to victims, including children.

The implementation of this Framework is intended to improve support for and consistency in the integrated response to family and domestic violence in WA. I encourage all service providers to support the implementation of the Framework so together we can reduce the incidence of family and domestic violence impacting on the lives of so many people.

Robyn McSweeney MLC
MINISTER FOR CHILD PROTECTION; COMMUNITY SERVICES;
SENIORS AND VOLUNTEERING; WOMEN’S INTERESTS; YOUTH
Acknowledgements

The Department for Child Protection acknowledges and thanks the Family Violence Reform Coordination Unit, Office of Women’s Policy in the Victorian Department of Planning and Community Development, for allowing their publication Family Violence Risk Assessment and Risk Management Framework Manual to inform this publication. The Family and Domestic Violence Common Risk Assessment and Risk Management Framework presents an important tool in the efforts to work collaboratively to combat the most common and devastating crimes—family and domestic violence. No part of society escapes the reaches of this form of violence, and no single effort can stop it. It is only when we combine our efforts and work towards a common goal that we can really make a difference. Thanks are extended to members of the Steering Group, who offered their support and expertise in the development of the Framework.

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The development and endorsement of the Family and Domestic Violence Common Risk Assessment and Risk Management Framework has been undertaken with the support of a Senior Officers’ Group comprising representation from the following agencies:

STATE GOVERNMENT

Department of the Attorney General  Department for Child Protection
Department of Corrective Services  Department of Education
Department of Health  Department of Housing
Department of Indigenous Affairs  Disability Services Commission
Drug and Alcohol Office  Legal Aid WA
Western Australia Police

COMMONWEALTH GOVERNMENT

Attorney General’s Department
Centrelink
Department of Families, Housing, Community Services and Indigenous Affairs

COMMUNITY SECTOR

Women’s Council for Domestic and Family Violence Services (WA)
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Introduction

Anywhere between one in three (Mouzos & Makkai, 2004) and one in five (Australian Bureau of Statistics, 2006) women are abused by an intimate partner in their adult life, and one in four children grow up witnessing this violence (Indermaur, 2001). Western Australia Police attend over 30,000 call-outs for family and domestic violence every year and on average investigate 18 domestic homicides.

Effective responses to family and domestic violence are complex, requiring involvement of multiple service systems and agencies. These include police, specialist family and domestic violence services, courts, child protection, housing and health. The involvement of so many different departments and organisations can make it difficult for clients to navigate the system. This is particularly the case when agencies operate in isolation from others, as was demonstrated by the Western Australian Safety and Accountability Audit of the Armadale Domestic Violence Intervention Project (2007) (the Audit).

The Audit clearly demonstrated the shortfalls of not working collaboratively, finding that the collective capacity and processes of the intervening agencies was profoundly inadequate for:

- collecting meaningful information
- sharing information in a timely and cautious manner with other interveners
- linking information to the actual experiences of victims of abuse
- crafting interventions that would maximise the protective nature of interventions.

The Audit states:

“Institutions document and share information to accomplish a number of case-management goals… practitioners intervening in cases always gather information through a particular lens. The child protection worker, responding police officer, prosecutor, advocate and community corrections officer all deal with the same people, the same situation, the same past events, and the impact those events have had on peoples’ lives; however, each worker gathers information and records events, but do not attempt to record everything that happened. Instead, they are ‘charged’ with documenting issues of institutional relevance.” (p. 26)

“There was very little engagement of victims in discussions, which would have increased the practitioners’ understanding of a case and may have lead to a partnership between the practitioner and the victim in responding to the violence.” (p. 44)

To address these shortfalls and achieve more cohesive and effective responses to family and domestic violence, one of the key strategies in the WA Strategic Plan for Family and Domestic Violence 2009–2013 is to develop a “Statewide integrated response to those experiencing family and domestic violence.” To support this strategy, the Annual Action Plan 2009–10 identified 10 key actions for achieving integration.

Note:¹ This figure represents only a small fraction of those actually experiencing violence in Western Australia.
These key actions included development of a Memorandum of Understanding to enable information sharing in high risk cases of family and domestic violence, development of guidelines for multi-agency case management and regional coordination and the introduction of standardised risk assessment and referral processes.

Standardised (common) risk assessment and risk management is critical for an integrated response as it ensures that responses are consistent, regardless of where the client enters the system, it creates a shared understanding of risk across all service systems and a common language to communicate risk. Common risk assessment and risk management also provide a framework for information sharing and response.

This manual provides an outline of Western Australia’s *Family and Domestic Violence Common Risk Assessment and Risk Management Framework*, how it was developed and what it will look like across service sectors.

The *Family and Domestic Violence Common Risk Assessment and Risk Management Framework* is based on the Victorian Framework, with special consideration given to its application in the Western Australia context, its unique population, geography and service system.

This manual includes six sections:

1. **Background to the Framework**—outlines the policy context, the underpinning principles and the operating environment for Western Australia’s *Family and Domestic Violence Common Risk Assessment and Risk Management Framework*.

2. **Risk Assessment**—details the history of risk assessment and evidence-based good practice.

3. **Introduction to Family and Domestic Violence**—outlines the key information that any service provider would need to be aware of when undertaking screening or assessment for family and domestic violence.

4. **The Framework**—describes Western Australia’s *Family and Domestic Violence Common Risk Assessment and Risk Management Framework*, supportive legislation and information about integrated responses to manage risk and improve safety.

5. **Practice Guide**—a guide for family and domestic violence screening and risk assessment.

6. **Appendices**—a Common Screening Tool, Key Risk Indicators and Referral Form.
SECTION 1

Background to the Framework
Common Risk Assessment and Risk Management FRAMEWORK

Background to the Framework

FAMILY AND DOMESTIC VIOLENCE COMMON RISK ASSESSMENT AND RISK MANAGEMENT FRAMEWORK

Family and Domestic Violence Common Risk Assessment and Risk Management Framework refers to a standardised approach to identifying, assessing and responding to family and domestic violence. All service providers, mainstream and specialist, operate under the ‘common framework’ to ensure service responses are client and safety focused, seamless and streamlined.

Purpose

Development and implementation of a family and domestic violence common risk assessment and risk management framework is critical to the success of an integrated response to family and domestic violence, particularly in supporting the following three outcomes:

- eliminating service gaps—a common framework for risk assessment and risk management sets a minimum standard of response for all service providers who identify a victim of family and domestic violence. This means that regardless of which service a victim presents and discloses to, a consistent response from the service provider will be elicited. By setting this minimum standard we can reduce the number who are ignored, who ‘fall through the cracks’ or are given inappropriate information

- keeping responses client and safety focused—agencies working with victims or perpetrators of family and domestic violence tend to focus on the information that is relevant to their mandate. This can lead to the gathering of incomplete information and, as a result, decision-making that is not informed by a complete assessment of the risk. By introducing a common framework for risk assessment and risk management, we can ensure that all the relevant information is captured and the focus of responses remains on the victim's safety

- supporting multi-agency collaboration and coordination—a common framework for risk assessment and risk management ensures that all service providers share a common understanding about risk in family and domestic violence situations and use common language when communicating this risk. This is critical for ensuring that service providers make accurate and transparent risk assessments, make informed referrals and share information in a timely manner.

Developing a Common Framework for Western Australia

Victoria introduced a family and domestic violence common risk assessment and risk management framework in 2007. The Department for Child Protection in WA received permission from the Family Violence Reform Coordination Unit, Office of Women’s Policy in the Victorian Department of Planning and Community Development to adapt this Framework for use in Western Australia.

To do this, a steering group with representation from the following agencies was formed:

- Department of the Attorney General
- Department for Child Protection
- Department of Corrective Services
- Western Australia Police
- Women’s Council for Domestic and Family Violence Services (WA).
Dr Carolyn Harris Johnson, social worker and expert on domestic homicide, was also a member of the Steering Group.

To adapt the Victorian Framework to suit Western Australia’s unique context, the Steering Group considered Western Australia’s policy context and operating environment for family and domestic violence responses. A summary of this operating environment is provided below.

**POLICY CONTEXT**

International, national and state laws and policies informed the development of the *Family and Domestic Violence Common Risk Assessment and Risk Management Framework*.

**International context**

At the international level, Australia has human rights obligations under international laws and universal human rights instruments, including the:

- Universal Declaration of Human Rights
- Convention on the Elimination of All Forms of Discrimination Against Women
- Convention on the Rights of the Child
- Declaration on the Elimination of Violence Against Women
- Vienna Declaration and Program of Action of the World Conference on Human Rights
- Millennium Development Goals
- United Nations Convention on the Rights of Persons with Disabilities, the Beijing Platform for Action

**National context**

Commonwealth, State and Territory Governments are working in partnership to develop and implement the *National Plan to Reduce Violence Against Women and their Children 2010-2022*. The National Plan will be supported by four, three-year Action Plans identifying specific actions, responsibilities and timeframes for implementation.

The National Action Plans provide a staged approach to achieving the necessary reforms identified within the National Plan and allow governments to select and address current and emerging priorities as resources permit.

The National Plan builds on previous government initiatives and is consistent with other Commonwealth Government reforms such as the COAG Early Years Agenda, the National Affordable Housing Agreement, the COAG Closing the Gap Agenda, the National Disability Strategy, the development phase of the Northern Territory Emergency Response, the National Framework to Protect Australia’s Children, Australia’s Future Tax System Review, the Australian Government’s Pension Review and the work of the Social Inclusion Board.
Western Australian context

In Western Australia, government and non-government agencies are working towards integrating responses to family and domestic violence, including collaborative case management and coordinated regional and state planning. A key driver of this reform is the *WA Strategic Plan for Family and Domestic Violence 2009–2013*, which identifies the need to “develop a Statewide integrated interagency response to ensure early identification of violence and timely access to information and services” as a key strategy. Work towards an integrated response was prioritised in the *Annual Action Plan 2009–10* with the following supportive initiatives:

- A Memorandum of Understanding to support the sharing of information that will assist in keeping a victim safe.
- A common risk assessment and risk management framework.
- Standards of practice for working with adult victims, children and perpetrators.
- Case coordination and case management guidelines and procedures.
- Data collection standards and processes.
- A monitoring and evaluation framework to support quality assurance.

THE OPERATING ENVIRONMENT

The *Family and Domestic Violence Common Risk Assessment and Risk Management Framework* will be used by a range of service providers. These services can be broadly grouped into three categories: family violence services, mainstream services and legal and statutory services. The figure below provides an outline of these ‘service groups’.

![Diagram of service ‘groups’ operating in Western Australia.](image-url)
Victims of family and domestic violence should be able to access support for their experiences of violence and abuse through any of these three service groups. However historically, these multiple access points have created an artificial division between the sectors involved in providing family and domestic violence services; this has resulted in inconsistent screening for, and assessment of, family and domestic violence and inconsistent responses to clients.

While it is important that these multiple entry points continue to be provided, integrated service delivery aims to ensure that all service providers adhere to a minimum standard of screening, assessment and response to victims of family and domestic violence, regardless of where they enter the system. To adhere to this minimum standard, all service providers must be aware of the prevalence of family and domestic violence and be prepared to respond if necessary.

An outline of the three service groups, their current risk assessment procedures and responses to family and domestic violence are provided below.

**Specialist Family and Domestic Violence Services**

The specialist family and domestic violence services currently funded in Western Australia include:

- crisis accommodation and support services
- outreach services
- advocacy services
- counselling services for women and children
- support services for Aboriginal women and children
- support services for Culturally and Linguistically Diverse women and children
- 24 hour help lines for victims and perpetrators
- behaviour change programs for perpetrators of violence
- case management and coordination services.

Specialist family and domestic violence services operate across Western Australia to support women and children to escape violent relationships, remain safe following separation and to deal with the trauma of living with abusive partners or family members. Much of their contact with women and children is during times of crisis. The ability to quickly and effectively assess the level of risk and secure the safety of victims is critical.

At present, risk assessment practices in specialist family and domestic violence services are varied in terms of the tools or instruments used and the approach taken to conduct the risk assessment.
Family and Domestic Violence Case Management and Coordination Services

One exception are the Family and Domestic Violence Case Management and Coordination Services (CMCS) who use a standardised risk assessment instrument. The CMCSs are a key feature of the integrated response to family and domestic violence in Western Australia, providing the forum for multi-agency collaboration in high-risk cases.

The CMCSs are two tiered: facilitating multi-agency case management of high-risk domestic violence cases; and regional coordination in relation to victim safety and perpetrator accountability.

Any agency referring a case into a CMCS must use the prescribed risk assessment tool, which forms part of the referral and assessment form.

For the CMCS to be successful, informed and ongoing risk assessment is critical to all aspects of case management. This covers acceptance of a referral, decision-making about strategies or actions to increase safety and achieve perpetrator accountability, through to deciding when to close a case.

A Memorandum of Understanding signed by all relevant State and Commonwealth Government departments and non-government agencies, supports the CMCS by providing the impetus for agencies to share information about high-risk cases and participate in multi-agency safety planning.

Legal and Statutory Services

Police

In 2009, WA Police introduced their Family and Domestic Violence Strategy 2009-2011 (the Strategy). The Strategy addressed the areas of victim safety, both in the immediate and longer term, quality first response, timely commencement and completion of an investigation, harm minimisation through referral to agencies for victim support, and behaviour modification and prosecution of offenders.

One of the key initiatives introduced under this Strategy was a risk management framework (the framework). The framework was developed to ensure WA Police had a standardised approach to victim risk identification, assessment and management.

The framework included the development of a family and domestic violence aide memoire and an improved recording template (commonly referred to as DVIR 1-9).

The focus of the framework is on identifying and recording vulnerability (danger) indicators by front line police when they attend a domestic violence incident to help identify underlying issues which will assist with recognising ‘intervention opportunities’.

The framework and in particular the DVIR 1-9 helps improve consistency in police information gathering and response and ensures that responses are client and risk focused. It also ensures that responses are informed by the history of family and domestic violence in addition to the immediate incident and provides agencies who receive referrals from police with sufficient information to inform their initial assessments.

In addition, families identified as being ‘at risk’ due to recidivist (repeated incidents) or serious family and domestic violence can be case managed by police. Case management involves ongoing contact with victims and perpetrators in an attempt to reduce the risk of physical and psychological harm to victims and their children.
Magistrate Courts

In Western Australia, the Department of the Attorney General operates seven specialist Family Violence Courts. The Family Violence Courts are presided over by a magistrate and hear criminal matters related to family and domestic violence. They are currently operating in the following locations: Geraldton, Joondalup, Perth Central, Armadale, Midland, Fremantle and Rockingham. To achieve perpetrator accountability and reduce the likelihood of re-assault, the Family Violence Courts use pre-sentence diversion to a behaviour change program and interagency case management of the offender. A thorough risk assessment informs the Family Violence Court process, including whether offenders are eligible to participate in the program.

Co-located with each of these courts is a Family Violence Service. The Family Violence Services:

- support victims in their applications for Violence Restraining Orders
- provide information about safety planning, court processes and family violence services
- support victims to produce a victim impact statement
- provide referral to other specialist services.

In addition, the Family Violence Services maintain contact with the partners of men who are being case managed through the Family Violence Courts. Ongoing victim contact is critical for accurately assessing the effectiveness of perpetrator intervention. Similar to the Family Violence Courts, the Family Violence Services use a thorough risk assessment to inform referrals and case planning.

The remainder of the Magistrates Courts accommodate family and domestic violence matters that come before them in a variety of ways, but they do not currently have specialist resources nor do they use specialist-listing practices for family and domestic violence.

Court Registrars, located in all courts, can often be the first person to whom family and domestic violence is reported when women require a Violence Restraining Order. While there is a high correlation in the information required for a Violence Restraining Order and that which would be collected in a risk assessment, a family and domestic violence risk assessment ‘proper’ is not currently undertaken.

Family and domestic violence issues may also arise in other courts, incidental to the focus of those proceedings; for example, the Children’s Court and the Family Court.
Family Law Sector

Within the Family Law sector, family and domestic violence is assessed in matters concerning children at the point of entry in each of the Family Relationship Centres, within Legal Aid at the Family Court and other agencies. Specialist legal and counselling services address family and domestic violence using common screening and intake tools, and information sharing protocols to manage (in particular) high-risk cases. Families where risk issues have been assessed in Family Court cases are managed jointly between the Judicial Officer and the Family Consultant in collaboration with Legal Aid and relevant treatment and child protection agencies, to minimise the level of risk to children and victims of family and domestic violence.

Significant information sharing protocols have been developed between the Family Court and the Magistrates Court, (which includes Family Violence Court), Department for Child Protection, Legal aid, and the three key non-government counselling agencies (Centrecare, Anglicare and Relationships Australia) to enable referrals to family and domestic violence (and other) treatment programs, with processes in place to provide treatment feedback.

Child Protection

The *Children and Community Services Act 2004* provides the legislative basis for services provided to children, young people and families.

All interventions with children and families across the child and family services sector (which includes child protection, out-of-home care and family services) are guided by the *Signs of Safety Framework*.

The *Signs of Safety* Framework provides a consistent approach to child protection assessment, planning and action. Specifically, the Framework asks practitioners to consider what they are worried about, what is working well for a family and what needs to change. The Framework is designed to provide a holistic and balanced picture of what is going on for any given child or family.

Within this Framework, there is room to incorporate family and domestic violence risk assessment if and when this is raised as an issue.

Family Support Networks

The Department for Child Protection, in partnership with the community services sector, will implement a Secondary Family Support Network Innovations Site late in 2011. This site will comprise a range of community sector and government services collaborating to provide high quality and integrated services to vulnerable families. A lead agency will be selected and provided funding to coordinate service delivery. An evaluation of the Innovations Site has been planned as an action learning process in line with the development of the site in Armadale. A final report of the evaluation is scheduled for late in 2012.
Other Mainstream Services
Mainstream services relate to:

- education
- alcohol and other drugs
- mental health
- health, e.g. General Practitioners, hospital and community health nurses
- disability
- legal
- housing
- parenting
- employment support
- financial counselling/support.

There is no consistent approach to family and domestic violence screening or assessment across mainstream services, and the extent to which any form of screening or assessment takes place is unknown.

Whether a mainstream service undertakes screening only or screening and assessment depends very much on the qualifications, skills and experience of the professionals. For example, general practitioners, education staff and maternal and child health nurses may undertake screening only with referral for further assessment. Other professionals such as community legal service staff, social workers or psychologists within hospitals or community services, may feel that they have the skills and experience to undertake screening, assessment and response/referral.

At a minimum, all mainstream services will be required to introduce family and domestic violence screening protocols into their standard intake procedures and ensure staff know appropriate referral pathways for clients identified as experiencing family and domestic violence.
SECTION 2
Risk Assessment
Risk Assessment

Roehl and Guertin (2000) define risk assessment as:

“…the formal application of instruments to assess the likelihood that intimate partner violence will be repeated and escalated. The term is synonymous with dangerousness assessment and encompasses lethality assessment, the use of instruments specifically developed to identify potentially lethal situations.”

In the family and domestic violence field, risk assessment is conducted to:

• evaluate the risk of re-assault
• evaluate the risk of homicide
• inform service responses and criminal justice approaches
• help victims understand their own level of risk and/or validate their fears/own assessment
• provide a basis from which a case can be monitored by service providers (Laing, 2004).

Despite the importance of risk assessment, the practice is relatively new within the family and domestic violence field in Western Australia. Prior to the introduction of this Family and Domestic Violence Common Risk Assessment and Risk Management Framework, there has been no consistent standard for approaching risk assessment or a consensus on which key indicators should be included.

IDENTIFYING RISK

Understandings about risk in situations of family and domestic violence have largely been derived from examinations of domestic homicides and the common events and behaviours that occurred in the lead-up.

The first of these studies was conducted in Philadelphia in 1958 when Marvin Wolfgang examined police records of criminal homicides that had occurred between 1948 and 1952, finding that in cases of domestic homicide (n=100), common antecedents were previous intimate partner violence, access to a firearm, stalking and estrangement.

The risk indicators identified in this early study have held true in most examinations of family and domestic violence and domestic homicide, and form the basis of most risk assessment tools today.
Other risk indicators that have been repeatedly identified through research are:

- attempted choking or strangulation
- forced sex
- threats to harm children
- escalation in the frequency and severity of violent incidents
- access to firearms or other weapons
- threats to kill
- breach of criminal orders
- obsessive or controlling behaviour
- violence during pregnancy
- perpetrator use of substances
- perpetrator mental health issues
- perpetrator threats of suicide
- pending or completed separation

In addition to these risk indicators, the following factors can also be considered when undertaking risk assessment:

- the perpetrator’s history of arrest and incarceration
- violence in the perpetrator’s family of origin
- the perpetrator’s hostility levels
- supportive attitudes to violence against women
- perpetrator resistance to change and lack of motivation for treatment
- presence of other life stressors for the perpetrator, such as unemployment or recent loss
- presence of behaviours in the perpetrator that are disruptive of normal standards of social behaviour and affiliation with peer and similar behaviour (Laing, 2004).
**APPROACHES TO RISK ASSESSMENT**

The human services field develops risk assessment tools via several approaches:

- **The clinical approach** (historically the most common approach) involves the use of professional opinion or judgement in determining risk. The professional has complete discretion over which information is considered and there are no constraints on the information that can be used to reach a decision.

- **The actuarial approach** integrates statistical evidence into assessment. The tools used involve scales or matrices developed on retrospective evidence-based analysis of factors associated with the outcome of interest (for example, episodes of violence). When all factors in the risk assessment instrument are complete, the individual’s level of risk can be determined.

- **Structured professional judgement approach** (also known as structured decision making) in which clinical and actuarial approaches are used in combination, and where the emphasis is on developing evidence-based frameworks that promote consistency, yet are flexible enough to take account of case specific situations and contexts.

In the area of family and domestic violence, most practitioners use either clinical approaches or structured professional judgement when assessing risk. In addition, it is also common practice to consider the victim’s assessment of the risk. Many practitioners consider victims to be good assessors of risk, as they intimately know the perpetrator and the relationship dynamics. Research supports this practice, demonstrating that victim assessment added to structured professional judgement produces the most accurate predictions of risk and likelihood of re-assault (Cattaneo & Goodman, 2003; Weisz, Tolman & Saunders, 2000).

**ELEMENTS OF AN EFFECTIVE RISK ASSESSMENT**

Any risk assessment tool must be administered within a framework that has underpinning principles, and involves a common understanding and approach.

Regardless of the tool used to assess risk of future family and domestic violence, the policies and protocols that accompany the tool are as important as the tool itself, if not more so.

Any assessment of risk to victims of family and domestic violence must be structured and informed by:

- the victim’s own assessment of their safety and risk levels
- a sound evidence base, which identifies factors that indicate an increased risk of reoccurrence of family and domestic violence
- the professional judgement of the person making the assessment, which takes nto account the above and includes all other information known about the victim and their situation.
Key considerations for determining the supportive policies and protocols include:

- the purpose of risk assessment
- the amount of time that is reasonable to spend doing an assessment
- what is said to the victim to encourage participation in the assessment
- what is said to the victim regarding use of the information
- the limits and promises of confidentiality of information
- who conducts the risk assessment, that is, first responders, advocates or other professionals
- the credentials and training required for people conducting the risk assessment
- what will happen to the information
- what will be communicated to victims and what directions or advice will accompany that communication
- what is to be communicated to the more formal system; that is, what information (and in what form) is appropriate for court proceedings, probation or correction departments, and advocates
- where the assessment will be stored and who will have access to it.

These issues were considered in the development of the *Family and Domestic Violence Common Risk Assessment and Risk Management Framework for Western Australia*, and are addressed in the Framework (section 4), and practice guide (section 5).
SECTION 3
An Introduction to Family and Domestic Violence
An Introduction to Family and Domestic Violence

This section provides an overview to family and domestic violence, the experiences of victims, indicators of violence, and information about particular groups that experience unique risks and/or barriers to escape. At a minimum, services operating under this Family and Domestic Violence Common Risk Assessment and Risk Management Framework will need to be familiar with this literature, as the information will directly inform practitioners’ screening and risk assessments.

NB: It is not intended that this information, on its own, will be sufficient to enable an inexperienced worker in any setting to be competent in understanding the considerable complexities of violent intimate relationships.

WHAT IS FAMILY AND DOMESTIC VIOLENCE?

Behaviour, which results in physical, sexual and/or psychological damage, forced social isolation, economic deprivation, or behaviour that causes the victim to live in fear.

The term is usually used where abuse and violence take place in relationships including; intimate partner relationships, same sex relationships, between siblings, from adolescents to parents, or from family carers to a relative, or a relative with a disability. A key characteristic of family and domestic violence is the use of violence or other forms of abuse to control someone with whom the perpetrator has an intimate or family relationship.

The term domestic violence usually refers to abuse against an intimate partner, while family violence is a broader expression encompassing domestic violence and the abuse of children, the elderly and other family members.

Aboriginal and Torres Strait Islander people generally prefer to use the term “family violence”. This concept describes a matrix of harmful, violent and aggressive behaviours. However, the use of the term “family violence” should not obscure the fact that Aboriginal women and children bear the brunt of family violence.

There are seven broad categories of abuse that are usually referred to when discussing family and domestic violence and these are outlined below. The key characteristics for any kind of behaviour to be characterised as family and domestic violence is the intent to dominate, control and create fear. Any action/behaviour that is conducted with this intent can be included as a form of abuse:

- physical assault—any behaviour that is intended to cause harm e.g. pushing, slapping, punching, choking and kicking
- sexual assault—forced sexual contact/activity. “Forced” in this context refers to individuals who are physically coerced to participate or who are not in a position to say no as a result of fear, threats or intimidation
- verbal abuse—threats, put-downs, insults, shouting
- emotional/psychological abuse—mind games, manipulation, humiliation, making the person feel worthless or no good
- social isolation—keeping the victim away from friends, family, work and/or other social opportunities
- financial abuse—controlling the money and decisions around its use, taking or limiting money, stealing
- spiritual abuse—keeping someone away from places of worship or forcing them to participate in spiritual or religious practice that they do not want to be involved with (Carrington & Phillips, 2003; Tually, et al., 2008).
PREVALENCE

Family and domestic violence is prevalent in all communities, cultures and countries and pervades social and economic boundaries. It is mainly perpetrated by men against women and as a result is often referred to as a *gendered crime*. Australian surveys suggest that anywhere between one in three (Mouzos & Makkai, 2004) and one in five women (ABS, 2006) have experienced family and domestic violence in their adult life and one in four children have grown up witnessing this violence (Indermaur, 2001).

KEY MODELS

Power and Control

The *Power and Control Wheel* (Figure 1) was developed in consultation with over 200 women at the Duluth Battered Women’s Shelter in the United States following discussions about their experiences of family and domestic violence (Pence & Paymar, 1986).

The model is intended to depict the primary abusive behaviours experienced by women living with abusive partners. It illustrates that violence is part of a pattern of behaviours rather than isolated incidents of abuse or cyclical explosions of pent-up anger, frustration or painful feelings (Pence & Paymar, 1986).

The inclusion of non-physical forms of abuse within the wheel, bordered by physical and sexual assault demonstrates that the non-physical forms of violence are only effective in controlling and creating fear when there is an overarching threat of physical or sexual violence. This interplay between physical and non-physical abuse explains why family and domestic violence is a gendered crime, as men, more so than women, are able to impose a physical threat and as a result, effectively dominate and control their partners through both physical and non-physical actions.
Common Risk Assessment and Risk Management FRAMEWORK

Figure 1. The Power and Control Wheel (Pence & Paymar, 1986).
The Cycle of Violence

*The Cycle of Violence* (Figure 2) was developed by Lenore Walker in 1979 following interviews with 1500 victims of family and domestic violence. The Cycle of Violence depicts a common pattern of perpetrator behaviour. It is used to explain the relationship dynamics in violent relationships and victim’s experiences (Walker, 1986).

The Cycle has six phases, which are outlined below.

**Honeymoon**—for new couples, the relationship usually begins in the ‘honeymoon phase’. During this time, the relationship is ‘okay’ and there is no physical or sexual violence.

**Tension building**—the honeymoon phase may only last a short time before everyday life stressors (e.g. bad day at work, job loss, money troubles etc.) contribute to increasing tension in the relationship.

It is important to note, that all couples have disagreements or times of increased pressure. In healthy relationships, these issues are resolved amicably without use of intimidation, threats and fear. In contrast, the perpetrator’s need for power and control underlies anger and blaming during the tension phase, disputes go unresolved, and the tension continues to escalate. Most victims describe this time as feeling that they are “walking on eggshells”.

**Standover**—during this time, the perpetrator uses tactics to maintain control such as anger, threats and jealousy. The victim is in fear and is often compliant in an attempt to maintain harmony and prevent a violent outburst. The victim’s efforts to prevent violence are usually ineffective. No matter what they do, the ‘explosion’ will occur.

**Explosion**—an incident of physical, sexual, emotional or verbal assault. During this phase, the perpetrator is in total control of his actions. This is not a loss of control but rather the perpetrator taking control.

**Remorse**—the perpetrator justifies or rationalises their behaviour by blaming the victim e.g. “I wouldn’t have done it if you had ...” and minimises the violence.

**Buyback**—this involves the perpetrator attempting to ‘reconnect’ with the victim. This might involve apologies, gifts, promises they will change and demonstrations of helplessness. Some perpetrators may use threats of harm to ensure their partner does not leave (e.g. suicide, threats against the children or victim).

After the buyback phase, the couple returns to the honeymoon phase. During this time there is usually total denial of abuse, the couple are mutually dependent and socially isolated from friends and family.

The longer the relationship continues, the quicker the Cycle of violence occurs and the more severe the explosions become. The Cycle rarely stops without intervention.
Figure 2. The Cycle of Violence (Walker, 1986).
IMPACTS OF FAMILY AND DOMESTIC VIOLENCE

Victims

Victims, primarily women, experiencing family and domestic violence are subject to the worst forms of violence, degradation and cruelty perpetrated in our community. As a result, the impacts on physical and emotional wellbeing, behaviour and financial position are immense.

Some of the physical consequences include:
- assault-related injuries
- sexually transmitted infections
- miscarriage or pregnancy complications
- stress-related illness
- disability

Although the costs to physical health are high, most survivors of family and domestic violence say that the emotional effects are far more damaging and long lasting.

Some of the emotional impacts experienced by victims of family and domestic violence include:
- self-blame
- low self-esteem and loss of a sense of self
- increased anxiety or depression (symptoms of)
- loss of independence and assertiveness
- feeling like a poor or bad parent
- feelings of shame and embarrassment
- increased vulnerability to substance misuse and/or mental health disorders (Chan, 2005; Tually, et al., 2008; WHO, 2000).

Other common consequences of family and domestic violence for the adult victim include isolation from friends and family, financial dependence on the perpetrator and fragmented employment or tertiary studies (Sheehan & Smyth, 2000; WHO, 2000).

In addition, there are a number of consequences that occur during and after separation including ongoing violence and harassment, protracted legal and custody dispute and inequitable division of assets (Sheehan & Smyth, 2000; Stubbs & Tolmie, 2003).
Children and Young People

The world of a child or young person growing up with family and domestic violence is characterised by fear, constant worry and unpredictability, confusion about their feelings for the victim and perpetrator and threats to physical wellbeing. Overtime, these experiences can have significant consequences for children and young people’s social and emotional health. In fact, research suggests that exposure to violence (hearing, seeing, knowing) is just as damaging to a young person as being the direct target of abuse (Indermaur, 1998; Kitzmann, Gaylord, Holt & Kenny, 2004).

Some of the common consequences for children and young people are:

- increased risk of physical harm or injury—60 per cent of child abuse cases occur in homes where there is family and domestic violence
- developmental regression—for example regression in language, toilet training etc.
- emotional/psychological—self-blame, stress, anxiety, depression, maladaptive coping, (substance use, self-harm, disordered eating) and post-traumatic stress disorder
- behavioural—inappropriate use of violence and aggression, trouble sleeping, and children might be withdrawn or hyperactive (Kitzmann, et al., 2004; Moloney, et al., 2007; Osofsky, 1999.

Infants and toddlers are susceptible to even further harm through the impacts of family and domestic violence on parent-child attachment. Research suggests that 60 per cent of infants born into situations of family and domestic violence exhibit insecure and/or disorganised attachment (Buchanan, 2008). This is significant because secure attachment is a strong protective factor, meaning that it buffers the child (to a degree) from adverse situations. Therefore, for children born into an abusive relationship, insecure or disorganised attachment can increase their vulnerability to the emotional and behavioural consequences outlined above. In addition, the attachment style adopted by infants forms the ‘template’ or basis for their future relationships. Therefore, insecure or disorganised attachment during infancy and childhood might predispose the child to having difficulties with future relationships.

Neurological development is also significantly affected by family and domestic violence. Children who grow up with severe violence and/or neglect are often not provided with the repetition and stimulation in their environment that is needed for optimal brain development. This can ‘stunt’ brain development in terms of size and connectedness and as a result, cause delays in cognitive and emotional development (Bogat, DeJonghe, Levendosky & Davidson, 2006; Perry, 2007). In addition, the repeated experience of trauma can lead to trauma responses becoming conditioned. This means that whenever the child encounters a reminder of the violence they have been exposed to, it can trigger a trauma response, even in the absence of the perpetrator or a tangible threat (Bogat, et al., 2006; Perry, 2007).

Research has also demonstrated that the impacts of family and domestic violence on children and young people can be long lasting, increasing the child’s vulnerability to learning difficulties, substance use, involvement in crime, poor physical and mental health and poor parenting practices in later life (Holt, Buckley & Whelan, 2008).
Poor school attendance may also be associated with the impact of living with family and domestic violence and may result in a poor achievement resulting in fewer life chances.

Children exposed to violence are one-and-a-half times more likely to be involved in violent relationships as adults (Indermaur, 2001; Mouzos & Makkai, 2004).

**Vulnerable Groups**

Although family and domestic violence transcends cultural, social and economic boundaries, there are groups in Western Australia who are more vulnerable to experiencing violence and who encounter unique barriers to disclosure and safety. These groups/communities include Aboriginal women and children, women from culturally and linguistically diverse backgrounds, women from rural and remote communities, women from mining communities (regional and fly-in-fly-out), women with disabilities, women with mental health issues and people of diverse sexuality and gender. The unique issues for each of these groups are outlined below.

**Aboriginal Communities**

Violence is a significant cause of morbidity and mortality in Australia’s Aboriginal population, with women and children the predominant victims. Research suggests that Aboriginal women are 35 times more likely to be hospitalised due to family violence (NATSiSS, 2002) and nine times more likely to be the victim of domestic homicide compared to non-Aboriginal women (Loh & Ferrante, 2003; Mouzos & Rushforth, 2002). Similarly, over 40 per cent of Aboriginal children grow up witnessing family and domestic violence (Indermaur, 2001).

The causes of family and domestic violence in Aboriginal communities are complex and must be understood in the context of a long history of racism, dispossession, marginalisation and poverty. In particular, the separation of Indigenous children from their families over generations, and practices of moving groups of Aboriginal people from their traditional lands is recognised to have led to the breakdown of kinship systems, family relationships and Aboriginal law (NATSiSS, 2002).

The close-knit nature of Aboriginal communities can mean that family violence affects a wide range of people and that those involved might be unwilling to act in a way that will disrupt their community membership, especially through the involvement of outside agencies. In rural and remote regions, the limited access to police and other services can also present barriers to Aboriginal women seeking help. Some Aboriginal women are reluctant to speak out because they fear it will result in their children being removed from their care, or fear that their partner will be taken away from their community and imprisoned.

It is essential to ensure that there is substantive equality and equitable responses to Aboriginal family and domestic violence in all service responses. However, regardless of the historical antecedents of family and domestic violence in Aboriginal communities and the cultural complexities involved in responding sensitively, the safety and security of victims of violence must always be the highest priority.
When considering safety for an Aboriginal woman experiencing family and domestic violence, particularly someone from a remote community, the following challenges must be considered:

- Is the language of the risk assessment relevant and appropriate for the client?
- Is it likely that the client is minimising or denying violence for cultural/community reasons?
- How will client confidentiality be maintained?
- What are the sources of safety in the community?
- How far away is the nearest police response?
- Does the client have access to a phone to contact the police?
- Does the client have access to safe and secure (lockable) accommodation?
- How effective are mainstream interventions or ‘safety measures’ likely to be, for example a Violence Restraining Order?
- Is the referral culturally appropriate and relevant for the client’s needs?
- Is the client at risk of family retribution or ostracism from the community if statutory or legal intervention is initiated?

Culturally and Linguistically Diverse Community Groups

Australian research investigating family and domestic violence in culturally and linguistically diverse (CaLD) communities has been unable to reliably estimate its prevalence; however, researchers agree that family and domestic violence is a serious and prevalent issue often suffered in silence by women and children from CaLD backgrounds.

Some of the barriers to help-seeking for CaLD women include:

- reluctance to use mainstream services due to a perception that these services will not be responsive to, or understanding of their situation
- poor English language skills, which might prevent them from seeking support from the police, support services and the courts
- lack of social and family support, and/or lack of knowledge about available services
- cultural beliefs that, for example, forbid separation and divorce, or result in women who speak out about family and domestic violence being ostracised from their communities
- fear of deportation, for example, the belief that reporting family and domestic violence will jeopardise future residency, or the lack of a visa that enables victims to access support services
- lack of financial support if they leave the relationship
- use of interpreters from the victim’s community. This can be dangerous for women experiencing violence as there may be risks to confidentiality or it might prevent the victim from disclosing (Erez, 2000; Fisher, 2009; Immigrant Women’s Speakout Association, 2000; Pittaway, 2004).
In addition to the barriers to help seeking for CaLD women outlined above, CaLD women entering Australia as humanitarian entrants or on a temporary visa, experience additional unique risks and barriers. Humanitarian entrants have often experienced or witnessed high levels of sexual and gender-based violence in their home countries and/or in refugee camps prior to their resettlement. For these women and children, their trauma histories, legal status and circumstances of resettlement pose additional challenges to them being identified and supported as victims of family and domestic violence.

Similarly, women who are sponsored by Australian residents to enter the country on a temporary visa (e.g. a fiancé visa) are particularly vulnerable to abuse due to their fear of deportation if they speak out. Women in these situations are often completely dependent upon their partner for information about services available in Australia and what is acceptable in Australian relationships.

**Rural and Remote Communities**

Research is divided as to whether the rate of family and domestic violence is higher in Western Australia’s rural and remote communities (Bureau of Transport and Regional Economics, 2006; Cripps et al, 2009; Henstridge et al., 2007). However, it is agreed that there are unique barriers that keep victims in these relationships and perpetuate a culture of silence.

Some of these factors include:

- isolation, both geographically and from appropriate supports such as family and friends
- financial insecurity and/or financial dependence on the perpetrator
- limited access to services, specifically specialist programs
- lack of behaviour change programs for perpetrators and general reluctance among rural men to seek any kind of advice and support
- lack of transport options or alternative accommodation
- poor telecommunications
- perceived difficulties maintaining confidentiality and safety
- fear of not being believed, particularly in situations where the perpetrator is a prominent and valued member of the community
- access to interpreters for women from diverse backgrounds or women with a communication difficulty
- beliefs about masculinity that encourage stoicism and repressed emotions (Carrington, 2007; Jamieson & Wendt, 2008; Wendt, 2009; Women’s Health Victoria, 2009).

Firearms are often more accessible in rural and remote communities, particularly in farming areas. This must be considered in risk assessments as it can significantly increase the risk for a victim.
Remote Mining Communities

Similar to the experiences of family and domestic violence victims in rural and remote communities, victims in remote mining communities experience isolation, poor telecommunications, financial dependence on the partner and lack of support services and/or escape options (to name just a few). In addition, escape from violence can be compounded by the provision of housing being linked to the ongoing employment and residence of the perpetrator.

Research on family and domestic violence in mining communities is limited, but what is available suggests high rates of emotional/psychological abuse (Nancarrow, Lockie & Sharma, 2009). Nancarrow, Lockie and Sharma (2009) surveyed over 500 women in a remote mining community in Queensland finding that 11.5 per cent of respondents had experienced physical violence and 31.4 per cent of respondents had experienced non-physical forms of abuse.

The Nancarrow study was prompted by anecdotal reports that family and domestic violence occurs at higher rates in mining communities due to excess strain on relationships as a result of shift work, the association of mining with a culture of male dominance and a high prevalence of alcohol abuse.

To some extent, these propositions were supported by the Nancarrow study which demonstrated that physical and non-physical abuse were associated with the perpetrator’s alcohol and cannabis use and also whether the perpetrator grew up in the mining town (with those who did being more likely to perpetrate family and domestic violence).

Women with a Disability

Women with a disability are among the most vulnerable in the community.

Disabilities can be:

- a physical or sensory disability that restricts capacity to move freely, and/or to communicate and/or to understand
- an intellectual or cognitive disability or an acquired brain injury that impedes understanding and communication.

Research suggests that:

- Women with an intellectual disability are 10 times more likely to be assaulted than other women (Wilson & Brewer, 1992).
- 90 per cent of women with intellectual disabilities have been sexually abused. 68 per cent of women with an intellectual disability will be subjected to sexual abuse before they reach 18 years (Frohmader, 2002).
- Canadian-based research suggests found that 33 per cent of women with disabilities are assaulted by their intimate partners (Nosek, 1996).
In addition to being subject to higher rates of violence, disabled women are also faced with a number of barriers to disclosure and escape, including:

- financial dependence on the perpetrator
- social isolation—lack of education, lack of employment, and resultant poverty results in a high degree of social isolation. This isolation can be compounded if the victim experiences restrictions to their mobility
- low self-esteem and lack of assertiveness—women whose bodies are affected by disabilities often experience low self-esteem and as a result lack assertiveness
- dependence on perpetrator for day-to-day care and support—women with disabilities who are abused by their primary care giver are increasingly vulnerable and powerless
- credibility—women with intellectual disabilities or communication difficulties, can be regarded as unreliable when they make allegations of family and domestic violence
- fear of consequences—if a victim with a disability tries to leave a relationship with a non-disabled violent partner, they may fear that the partner will still be seen by authorities as having better parenting capacity because they are not disabled. Sometimes the costs of putting in the necessary supports to enable a disabled victim to be a single primary caregiver to a child cannot be met via conventional family support services and this may be an additional fear for the victim
- access to services and support—women with disabilities may perceive that mainstream services will not understand their experience nor be able to provide them with adequate support. In addition, crisis accommodation services located in older buildings may not be accessible for women with disabilities that affect their mobility (Morgan & Chadwick, 2009; Salthouse & Frohmader, 2004; Tually, et al., 2008).

Responses to family and domestic violence when the victim has a disability have to be sensitive to the special issues and vulnerabilities that come with disclosure. They need to ensure that safety needs are addressed in the context of the violence, but also in the context of the victim’s disabilities and physical support needs.

**Women with Mental Health Issues**

Mental health disorders such as anxiety, depression and post-traumatic stress disorder are common consequences of family and domestic violence for women and children. Indeed, as many as 47 per cent of women who experience family and domestic violence suffer from depression and 63 per cent exhibit traumatic stress symptoms (Golding, 1999).

Ironically, the product of their abuse (anxiety, depression, self-harm, substance use etc.) increases barriers to services and can also affect the quality of the response they receive. For example, many women with mental health disorders disclosing a history of violence are not believed and/or fear they won’t be believed so resist disclosing the abuse. In addition, women with mental health issues engaging with statutory responses e.g. child protection and courts, fear that they will come across as the less able or competent parent/witness/victim.
It is also important to note that depending on the mental health issue, victims of family violence might be less able to accurately assess the risks to their safety and/or less able to escape or exit an escalating situation. They may also shoulder the responsibility for the violence, looking to change things about themselves to end the abuse.

**People of Diverse Sexuality and Gender**

Available evidence suggests that family and domestic violence is experienced at higher rates by people who are of diverse sexuality and gender. Specifically:

- 27.9 per cent of men in same sex relationships experience intimate partner violence.
- 40.7 per cent of women in same sex relationships experience intimate partner violence.
- 61.8 per cent of transgender men and 36.4 per cent of transgender women experience intimate partner violence.
- 36.4 per cent of intersex males and 42.9 per cent of intersex females experience intimate partner violence (Pitts, Smith, Mitchell & Patel, 2006).

Some of the specific barriers that prevent people of diverse sexuality and gender from disclosing violence include:

- fear of negative, stereotypical responses from mainstream service providers
- the limited availability of suitable crisis accommodation options
- perceived prejudice from support services, health services, police and courts.

**Conclusion**

The challenge associated with developing a common risk assessment and risk management framework is to create a framework that is flexible to be responsive to the diverse needs of multiple client groups and emerging trends or issues.

That said, it is critical that practitioners using the *Family and Domestic Violence Common Risk Assessment and Risk Management Framework* assess and respond to victims or perpetrators of family and domestic violence as individuals, informed by their individual history and experiences, rather than as a member of a particular cultural or demographic group. Trends identified in research identifying the unique vulnerabilities or barriers experienced by certain groups should inform risk assessment enquiry and safety planning, but ultimately all assessments and responses must be able to respond to each person’s unique circumstance.
SECTION 4
The Framework
The Framework

This section outlines the Family and Domestic Violence Common Risk Assessment and Risk Management Framework for Western Australia. The key components of the Framework that are included in this section are:

- shared principles
- a response continuum
- common minimum standard
- referral and information sharing
- shared commitment to perpetrator accountability and risk management.

SHARED PRINCIPLES

During the development of the WA Strategic Plan for Family and Domestic Violence 2009–2013, the Family and Domestic Violence Senior Officers’ Group agreed that the following principles would underpin the development and implementation of policies, programs and practices in the area of family and domestic violence. These are:

1. Family and domestic violence and abuse is a fundamental violation of human rights and will not be tolerated in any community or culture.

2. Preventing family and domestic violence and abuse is the responsibility of the whole community and requires a shared understanding that it must not be tolerated under any circumstance.

3. The safety and wellbeing of those affected by family and domestic violence and abuse will be the first priority of any response.

4. Perpetrators of family and domestic violence and abuse will be held accountable for their behaviour and acts that constitute a criminal offence will be dealt with accordingly.

5. Responses to family and domestic violence and abuse can be improved through the development of an all-inclusive approach in which responses are integrated and specifically designed to address safety and accountability.

6. An effective system will acknowledge that to achieve substantive equality, partnerships must be developed in consultation with specific communities of interest including people with a disability, people from Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds.

7. Victims of family and domestic violence and abuse will not be held responsible for the perpetrator’s behaviour.

8. Children have unique vulnerabilities in family and domestic violence situations, and all efforts must be made to protect them from short and long-term harm.
A RESPONSE CONTINUUM

Western Australia’s Family and Domestic Violence Common Risk Assessment and Risk Management Framework sets screening, risk assessment, risk management and risk monitoring on a response continuum. This is intended to reflect a client’s journey through the service sector, as well as illustrate that a client may enter the service sector at any point through any service type.

The diagram below provides a visual representation of the response continuum as well as the different service types and their role in responding to cases of family and domestic violence as outlined in the Family and Domestic Violence Common Risk Assessment and Risk Management Framework.

Service Types and their Role in the Response Continuum:
FAMILY AND DOMESTIC VIOLENCE COMMON MINIMUM STANDARD

Western Australia’s *Family and Domestic Violence Common Risk Assessment and Risk Management Framework* sets a minimum standard for the **screening, assessment** and **response** to victims of family and domestic violence.

The minimum standards have been developed to ensure that all agencies work in a consistent, collaborative and integrated way when responding to victims and perpetrators of family and domestic violence.

All agencies, mainstream and specialist, are required to evaluate their existing family and domestic violence responses to ensure that they comply with the minimum standards outlined in this Framework.

**Minimum Standard for Screening**

All agencies - government, non-government, mainstream or specialist - will screen for family and domestic violence as a part of their standard intake procedures. To do this, they will use a common tool (see Section 6—Appendices for a copy of the Common Screening Tool).

To support the screening tool, all service providers must be familiar with ‘key indicators’ of family and domestic violence so they can identify when family and domestic violence is occurring in the absence of a positive or affirmative response to the screening questions.

If family and domestic violence is identified through the screening process the agency will take all necessary steps to ensure the immediate safety of the victim and any accompanying children.

If family and domestic violence is part of the agency’s core business, they will conduct a risk assessment and depending on the outcome will make arrangements for safety planning, referral and case management as necessary (see Minimum Standards for Risk Assessment and Response for more detail).

If family and domestic violence is not part of the agency’s core business, a referral for a risk assessment is made to a specialist agency. In instances where an identified victim declines referral, the agency provides standard written information about available support resources and how to access them, should they want to get help at a later time. If you have serious concerns about the safety of the victim, consider a referral to the Family and Domestic Violence Case Management and Coordination Service for interagency case management. Processes are in place to allow agencies to refer a case to this service without the consent of the victim.

*These are the minimum standards of practice for screening.*
Minimum Standard for Risk Assessment

Agencies that have a role in responding to family and domestic violence are required to use a common approach to risk assessment and ensure that key risk indicators are included in their risk assessment procedures. The common approach includes:

- victim assessment of the risk
- consideration of key indicators
- professional judgement.

The Key Risk Indicators that must be incorporated into family and domestic violence risk assessments are outlined in Section 6—Appendices.

Professionals conducting risk assessments must have a solid understanding of family and domestic violence, its common patterns and dynamics, factors that affect risk and issues or factors that may make some population groups more vulnerable to family and domestic violence and severe harm than others.

Once a risk assessment is complete the outcome should be used to inform the response (risk management). See the Minimum Standards for Response (Risk Management) for further information.

Where immediate safety concerns are identified the agency will take all necessary steps to ensure the immediate safety of the victim and any accompanying children.

These are the minimum practice standards for risk assessment.
Minimum Standard for Response (Risk Management)

To manage identified risk agencies are required to:

- work with the victim to design, implement and monitor a personal safety plan
- work collaboratively with other agencies identified to be involved in supporting the victim in a formalised interagency response
- work with other agencies according to agreed support roles to design, implement and monitor an interagency safety plan
- monitor and review the risk on a regular basis.

If referral or other offers of support are declined, services must:

- provide standard written information about sources of help and how to access them and make it clear that the victim can return to the service at any time
- consider a referral to the local Family and Domestic Violence Case Management and Coordination Service (CMCS). CMCSs facilitate interagency case management of high-risk cases. Processes are in place to allow agencies to refer a case to this service without consent
- ensure processes are in place within your agency to allow referral to the CMCS without the consent of the victim.

These are the minimum practice standards for response.
REFERRAL AND INFORMATION SHARING

Referrals

Service providers must be clear about their area of expertise and their understanding of family and domestic violence, and make appropriate referrals to provide victim support and/or to facilitate perpetrator accountability. This is particularly important for mainstream services that may encounter victims and perpetrators of family and domestic violence less frequently.

Referrals for victims may be from mainstream services to justice, police, child protection or specialist family and domestic violence services, or from family and domestic violence services to specialist programs with expertise in drug and alcohol problems, counselling, mental health or community legal services.

Referrals for perpetrators of family and domestic violence may be from police, courts, child protection or family violence services to men’s behaviour change programs or other counselling services. Mainstream services may report perpetrators of family and domestic violence to the police if evidence of a crime is present, or to child protection if they have significant concerns about a child/ren’s safety.

Service providers should be aware of other service providers in their region, and their role and purpose, so that when situations outside of their expertise arise, victims can be referred (with their consent) to another service. Referral processes for other services in the region must also be established and networking between the services should be encouraged.

Referrals to other services may be necessary when the assessor considers that:

- the life of the victim or child is at risk if they stay in the current environment
- a crime has been, or is likely to be, committed (criminal offences include physical and sexual assault, threats, property damage, stalking, breach of protection orders and deprivation of liberty)
- urgent psychiatric or medical care is required
- other factors such as drugs and alcohol are contributing to risk and compromising safety
- appropriate cultural support is required
- interpreter services are needed for women from culturally and linguistically diverse backgrounds
- people with a disability require advocacy or practical support
- legal advice is required to ensure victim safety and wellbeing
- a Violence Restraining Order or other criminal justice response is required
- the perpetrator requires help and support to stop using violence
- support such as family and parenting support or counselling is required for the victim and children
- the safety or wellbeing of the victim or child is being compromised.

All referrals should be made in consultation with the client. Informed consent to share information is always required, except when the safety of the victim or others is in question.
Information Sharing

Sharing information between services ensures maximum protection for vulnerable women and children. It also enables earlier intervention and prevention strategies to be implemented by enhancing case management and coordination and providing services with clear roles and expectations for service provision. Importantly, the client is more likely to gain a sense of confidence that their situation is understood and is being actioned across a range of service providers. The client is also spared the stress of having to repeat often difficult and personal information.

Before any information is shared or referrals are made, however, the client's consent must be obtained. Ideally, consent must be in writing. Sharing information without the client’s consent can only occur when:

- a case is assessed to be high-risk
- a crime has been committed or is going to be committed—police must be contacted
- it is believed a child is likely to suffer significant harm—child protection must be contacted
- a client is in need of urgent medical or psychiatric care—a hospital or mental health crisis assessment and treatment team must be contacted.

Supporting Legislation and Frameworks

Legislation restricts the sharing of information between service providers to circumstances in which the victim has provided consent, except in those circumstances described above. While written consent is preferable to verbal consent, verbal consent must be clearly documented in the victim’s case notes.

The sharing of information between Western Australia’s service providers is governed by four main pieces of legislation:

- The Privacy Act 1988 (Cwlth)
- The Children and Community Services Act 2004
- The Restraining Orders Act 1997
- The Sentence Administration Act 2003

A Memorandum of Understanding: Information sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia has also been developed to facilitate information sharing between State and Commonwealth Government departments and non-government agencies.
Privacy Act 1988
The Privacy Act 1988 and the Privacy Amendment (Private Sector) Act 2000 govern the way Commonwealth and Australian Capital Territory Government public sector agencies and private sector organisations handle personal information. The Privacy Amendment (Private Sector) Act 2000 established minimum standards for the private sector, including organisations that provide health services.

‘Health services’ are broadly defined to include all services involved in assessing, recording, maintaining or improving a person’s health; diagnosing or treating a person’s illness or disability; or dispensing a prescription drug or medical preparation. Providers of private sector health services include doctors, pharmacists, naturopaths, dentists, masseurs, private hospitals, chiropractors, disability services, physiotherapists, osteopaths, counsellors, child care services, social workers, nurses and psychologists.

Children And Community Services Act 2004
Section 23 of the Children and Community Services Act 2004 enables staff of the Department for Child Protection to disclose and request relevant information involving a public authority, a corresponding authority, a service provider or an interested person. Relevant information means information that, in the Department for Child Protection’s opinion, is or is likely to be relevant to the wellbeing of a child or children or to perform a function under the Children and Community Services Act 2004. It also enables other public authorities, service providers or interested persons to share information on concerns about the wellbeing of a child where requested by the Department for Child Protection.

Amendments which came into effect in 2011:
- confirm the ability for the Department to exchange information with Commonwealth agencies [section 23]
- allow for the exchange of relevant information between prescribed authorities, provided the information is relevant to the wellbeing of a child or a class or group of children [new section 24A].

Restraining Orders Act 1997
Section 70A of the Restraining Orders Act 1997 enables police in WA to exchange information in certain circumstances in relation to those protected by a Violence Restraining Order.

Sentence Administration Act 2003
Section 97 of the Sentence Administration Act 2003 enables corrective services staff to share information about an offender to the public if it is necessary to do so for the safety of the community. Information may be shared if it is relevant for the management of an offender.
Memorandum Of Understanding

The Memorandum of Understanding: Information sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia (MOU) was developed to support the State’s integrated response to family and domestic violence. The MOU allows for the sharing of information between signatory agencies in relation to incidents of family and domestic violence, where an assessment indicates a high-risk of harm to an adult and any children in their care. Client consent is not required for agencies to share information.

The agencies that are party to this agreement include State and Commonwealth Government and non-government agencies in WA.

**SHARED COMMITMENT TO RISK MANAGEMENT AND PERPETRATOR ACCOUNTABILITY**

**Risk Management**

Risk management is the process of identifying, assessing and prioritising risks followed by coordinating efforts to minimise, monitor and control the likelihood of an adverse outcome. In relation to family and domestic violence, identification and assessment of risk is carried out through the screening and risk assessment processes outlined in this framework. Responses to minimise, monitor and control risk are also covered in this framework through the requirement of services to provide a ‘minimum response’ to disclosures of family and domestic violence. The responses of most service providers, mainstream and specialist, are victim focused, for example advocacy, safety planning or case management. In order to effectively manage the risk and create victim safety services must consider how they can contribute to perpetrator accountability.

**Perpetrator Accountability**

Perpetrators of family and domestic violence are unlikely to change their behaviour without targeted intervention. Often perpetrators will continue abusive dynamics and behaviours within relationships and after separation, in addition to repeating the same behaviour in new relationships. Therefore, the best and only way to eliminate family and domestic violence is to target the perpetrator for intervention and change.

Perpetrator accountability can be achieved through both statutory and voluntary system responses. Examples of perpetrator accountability within statutory responses include case management of recidivist files by police, civil or criminal proceedings (eg. a Violence Restraining Order or criminal charges), court responses (eg. mandated counselling, child contact) or child protection (eg. a focus on the perpetrator to change behaviour). Within voluntary/consent-driven systems, perpetrator accountability can be achieved through individual or group counselling, perpetrator-focused advocacy (eg. helping victims to initiate statutory protections) and other processes/mechanisms within service responses that are perpetrator focused (eg. exclusion orders through the Department of Education).
Achieving Risk Management and Perpetrator Accountability

Risk management and perpetrator accountability is best achieved by integrated responses to family and domestic violence. Integrated response refers to multi-agency collaboration with the view to achieving both victim safety and perpetrator accountability. The move towards integrated responses to family and domestic violence recognises the complexities inherent in achieving victim safety and perpetrator accountability, a task that in most instances is too big for one agency to adequately manage.

For high-risk cases, an integrated response can be achieved through the Family and Domestic Violence Case Management and Coordination Services, which have been established across the State. For low to medium-risk cases, integrated responses can be achieved via inter-agency consultation and coordination.
Practice Guide to Screening and Risk Assessment for Family and Domestic Violence

Purpose of the Family and Domestic Violence Common Risk Assessment and Risk Management Framework and Practice Guide

The purpose of the Family and Domestic Violence Common Risk Assessment and Risk Management Framework is to achieve three outcomes:

1. Victims receive service responses that are respectful, informed, and holistic regardless of their background, the culture of the organisation that is supporting them, and where they live.

2. Minimum standards of practice are understood and met by all providers of services to victims of family and domestic violence, regardless of where and how they enter the service system. These minimum standards are to include:
   - a consistent approach to screening, assessing and managing family and domestic violence risk throughout the entire service system, so that the focus of intervention and support remains on the safety of victims
   - clear and consistent referral practices across the service system.

3. Service providers across the whole of the service system, from mainstream services to those providing specialist family and domestic violence services, are better informed and educated.

The purpose of this Practice Guide is to provide all service providers—from mainstream to those with specialist family and domestic violence responsibilities, across both the government and non-government sectors—with information to implement the Family and Domestic Violence Common Risk Assessment and Risk Management Framework in their agency.

Many agencies already have risk assessment and risk management frameworks and evidenced-based risk management practices in place. However, these differ according to the agencies’ primary service target groups and statutory responsibilities, with most of them having some applicability to, but not being specifically designed for, family and domestic violence risk assessment and risk management.

The Practice Guide is intended to support agencies to adapt their existing risk assessment and risk management arrangements (whatever their primary focus) to incorporate common practices for family and domestic violence screening, risk assessment and risk management.
Who Should Use the Practice Guide?

The Guide is intended to be used by:

- government agencies with statutory and legal responsibilities for services and target groups that include victims and/or perpetrators of family and domestic violence
- other government and non-government agencies with broader responsibilities for supporting families and children
- specialist non-government family and domestic violence service providers.

SCREENING

There is evidence that in some settings, routine screening for family and domestic violence carried out in the course of intake or initial needs assessments results in victims being identified who have not previously been identified as, or recognised themselves to be victims of family and domestic violence (Braaf & Sneddon, 2007).

Minimum Standard for Screening

All agencies - government, non-government, mainstream or specialist - will screen for family and domestic violence as a part of their standard intake procedures. To do this, they will use a common tool (see Section 6—Appendices for a copy of the Common Screening Tool).

To support the screening tool, all service providers must be familiar with ‘key indicators’ of family and domestic violence so they can identify when family and domestic violence is occurring in the absence of a positive or affirmative response to the screening questions.

If family and domestic violence is identified through the screening process the agency will take all necessary steps to ensure the immediate safety of the victim and any accompanying children.

If family and domestic violence is part of the agency’s core business, they will conduct a risk assessment and depending on the outcome will make arrangements for safety planning, referral and case management as necessary (see Minimum Standards for Risk Assessment and Response for more detail).

If family and domestic violence is not part of the agency’s core business, a referral for a risk assessment is made to a specialist agency. In instances where an identified victim declines referral, the agency provides standard written information about available support resources and how to access them, should they want to get help at a later time. If you have serious concerns about the safety of the victim, consider a referral to the Family and Domestic Violence Case Management and Coordination Service for interagency case management. Processes are in place to allow agencies to refer a case to this service without the consent of the victim.

These are the minimum standards of practice for screening.
What is Screening?
Screening is a systematic process that:

- enables early identification of people who are affected by family and domestic violence, often before the situation has escalated and before they (and/or their children) have suffered serious physical or psychological harm
- provides an opportunity for further action to be taken to assist them to be safe.

This further action could include:

- assisting a victim to ensure their immediate safety through a personal safety plan
- the provision of advice, information and resources
- conducting a risk assessment to better understand the level of risk to safety
- referring to a specialist agency, if the screening agency does not have the expertise to conduct a risk assessment and implement strategies to manage and mitigate the risks identified. Referral might be to one agency or a number of agencies to collaborate through strategies such as an interagency safety plan or case management.

Why is Screening Important?
For a range of complex reasons such as fear, shame, embarrassment or cultural barriers many victims of family and domestic violence do not seek early help when they experience violence.

Sometimes, violence is a hidden issue when a person presents for help with another issue, such as a health issue, a financial crisis, a legal issue or a parenting issue that is not at first recognised as being linked to underlying family and domestic violence. Some victims might not recognise or identify themselves as victims, and only come to the attention of service providers when they or their children are seriously harmed, or when someone else reports concerns to the police or the Department for Child Protection. It is often the case that victims in these circumstances have had contact with a range of mainstream community agencies that—had they known about the violence—could have offered the victim support and safety through their own resources or through referral to a family and domestic violence service, before the situation escalated and serious harm occurred.

Until now, a barrier to early identification and response to family and domestic violence has been no common or coordinated tools and practices to assist agencies to conduct a simple screening of women who have sought their services for reasons other than family and domestic violence. This Practice Guide addresses that gap.

The Guide to Screening
This Guide provides the following information for agencies conducting family and domestic violence screening assessments as part of their routine intake/initial assessment interview:

- Who should be screened?
- Possible indicators of family and domestic violence.
- Perpetrators of family and domestic violence.
- Conducting a screening interview.
- Referral.
Who should be screened?

It is intended that as many people as possible (particularly women) who present to a government or non-government agency for a service will routinely be asked family and domestic violence screening questions. Most will present for assistance in relation to a matter that is the core business of the service (a health or mental health issue, pregnancy, a parenting issue, a legal issue, a housing issue etc) and not primarily in relation to family and domestic violence. Without asking the screening questions, few of these women will be identified as victims.

Possible indicators of family and domestic violence

It is important to note that the indicators below do not by themselves provide firm evidence that violence has occurred. However, in some situations and combinations, when some of these indicators are observed, it should raise a suspicion that family and domestic violence might be the underlying cause, or a contributing factor to the presenting issue—regardless of responses to screening questions. Indicators could include the following:

- **demeanour**
  - nervousness or evasiveness in answering questions
  - responses to questions that are guarded or inconsistent
  - unconvincing explanations for any injuries
  - agitation, trembling
  - reluctance to follow advice

- **physical appearance**
  - signs of violence might be observable for example, bruising (including in areas covered by clothing, bruising at different stages of resolution, minor cuts, small fresh scars, patches of hair missing, limping etc.)

- **medical**
  - patterns of repeat injury
  - injuries that are not new and should have been treated earlier
  - vague aches and pains
  - headaches, gastro-intestinal symptoms, muscular pain, gynaecological problems

- **mental health**
  - anxiety, panic attacks, stress and/or depression
  - alcohol and/or drug misuse
  - a sleeping and/or eating disorder
  - a suicide attempt and/or a history of suicide attempts
  - a diagnosed psychiatric illness
Perpetrator of family and domestic violence

To effectively identify family and domestic violence, it is important to understand the tactics used by perpetrators.

As is the case with victims of family and domestic violence, perpetrators can be anyone and come from every age, sex, socio-economic, ethnic, occupational, educational and religious group. Perpetrators are not always angry and hostile, but can be charming, agreeable and kind. Perpetrators will also differ in patterns of abuse and levels of dangerousness. While there is not an agreed universal psychological profile, perpetrators do share a behavioural profile that is described as “an ongoing pattern of coercive control involving various forms of intimidation, and psychological and physical abuse”.

While many people think violent and abusive people are mentally ill, research shows that perpetrators do not share a set of personality characteristics or a psychiatric diagnosis that distinguishes them from people who are not abusive. There are some perpetrators who suffer from psychiatric problems such as depression, post-traumatic stress disorder, or psychopathology. Yet most do not have psychiatric illnesses, and caution is advised in attributing mental illness as a cause of family and domestic violence. Mental illness should be viewed as a factor that can influence the severity and nature of the abuse.

Examples of the most prevalent behavioural tactics by perpetrators include the following:

- **abusing power and control**
  The perpetrator’s primary goal is to achieve power and control over their intimate partner. In order to do this, perpetrators often plan and use a pattern of coercive tactics aimed at instilling fear, shame, and helplessness in the victim. Another part of this strategy is to randomly change the list of “rules” or expectations the victim must meet to avoid abuse. The abuser’s incessant degradation, intimidation, and demands on their partner are effective in establishing fear and dependence. It is important to note that perpetrators may also engage in impulsive acts of family and domestic violence and that not all perpetrators act in such a planned or systematic way.

- **having different public and private behaviour**
  Usually, people outside the immediate family are not aware of and do not witness the perpetrator’s abusive behaviour. Perpetrators who maintain an amiable public image accomplish the important task of deceiving others into thinking they are loving, “normal,” and incapable of family and domestic violence. This allows perpetrators to escape accountability for their violence and often reinforces the victims’ fears that no-one will believe them.

- **projecting blame**
  Perpetrators often engage in an insidious type of manipulation that involves blaming the victim for the violent behaviour. Such perpetrators may accuse the victim of “pushing buttons” or “provoking” the abuse. By diverting attention to the victim’s actions, the perpetrator avoids taking responsibility for the abusive behaviour. In addition to projecting blame on the victim, abusers may also project blame on circumstances, such as making the excuse that alcohol or stress caused the violence.
• **claiming loss of control or anger problems**

There is a common belief that family and domestic violence is a result of poor impulse control or anger management problems. Perpetrators routinely claim that they just lost it, suggesting that the violence was an impulsive and rare event beyond their control. Family and domestic violence is not typically a singular incident, nor does it simply involve physical attacks. It is a deliberate set of tactics where physical violence is used to solidify the abuser’s power in the relationship. In reality, only an estimated 5 to 10 per-cent of perpetrators have difficulty controlling their aggression. Most perpetrators do not assault others outside the family, such as police officers, co-workers or neighbours, but direct their abuse toward the victim or children—distinction challenges claims that they cannot manage their anger.

• **minimising and denying the abuse**

Perpetrators rarely view themselves or their actions as violent or abusive. As a result, they often deny, justify, and minimise their behaviour. For example, an abuser might forcibly push the victim down a flight of stairs, then tell others that the victim tripped. Perpetrators also rationalise serious physical assaults, such as punching or choking, as “self-defence”. Perpetrators who refuse to admit they are harming their partner present enormous challenges to service providers who are trying to intervene. Some perpetrators do acknowledge to the victim that the abusive behaviour is wrong, then plead for forgiveness or make promises to refrain from any future abuse. Even in situations such as this, the perpetrator commonly minimises the severity or impact of the abuse.

It is equally important to acknowledge that perpetrators also possess positive qualities. There are perpetrators who are remorseful, accept responsibility for their violence, and eventually stop their abusive behaviour. Perpetrators are not necessarily “bad” people, but their abusive behaviour is unacceptable. Some perpetrators have childhood histories where they were physically or sexually abused, neglected, or exposed to family and domestic violence. Some suffer from substance abuse and mental health problems. All of these factors can influence their psychological functioning and contribute to the complexity and severity of the abusive behaviour. Perpetrators need support and intervention to end their violent behaviour and any additional problems that compound their abusive behaviour. Through specialised interventions, community services and sanctions, some perpetrators can change and become nonviolent (Children’s Bureau, 2002).

**Conducting a screening interview**

The introduction preamble below is intended to be a guide. Exactly how the practitioner approaches the screening questions will depend on whether they are incorporated into the agency’s existing initial interview and assessment procedures. The precise words the practitioner uses before asking the questions will also depend on the setting, the victim’s circumstances, and the cultural context. The approach will also reflect each practitioner’s own experience and their skill in creating a safe, non-judgmental environment in which the victim feels comfortable to answer the questions honestly.

Screening questions should not be asked in the presence of a partner.
Questioning about possible family and domestic violence should begin with an explanation that sets the context for such personal probing. This might be along the lines of:

*I am a little concerned about you because (list family and domestic violence indicators that are present) and would just like to ask you some questions about how things are at home. Is that okay with you?*

Using the Common Screening Tool in Section 6—Appendices to guide your questions, begin a dialogue with the victim to determine if family and domestic violence is a factor. Continue a conversation with the victim and gather as much information as possible about their current situation.

If the responses to the screening questions indicate an immediate threat to the victim’s safety, or the safety of others in your agency or in the vicinity of your agency (for example, if a violent partner is waiting outside or has a weapon) duty of care requires that the agency’s emergency protocol is immediately implemented.

The focus must be on ensuring the immediate safety of the victim (and their children when they are involved) and others while they are at the agency and when they leave. If what is required for immediate safety does not fit within the service’s normal operating arrangements, it should never be left to the victim to make arrangements for themselves, even if they offer or agree to do so. In this event, the agency must accept responsibility and meet their duty of care with responses that are flexible and directly address the victim’s immediate fears and safety needs, as well as those of others who are potentially at immediate risk in the situation, including agency staff.

If the victim does not feel that it is safe for them and/or the children to go home, you could respond as follows:

*You aren’t alone in finding yourself in this situation, but it must be very difficult for you right now. No-one should have to feel unsafe in this way, but help is available for you. I’d like to talk to you about how we can help you to be safe for now, and then to (either) assess the risks you are facing so that we can assist you to be safe (or) help you with a referral to a specialist agency that can assist you. There will be a number of things they can talk over with you that will help to ensure your safety. Can we go ahead with this for you now?*

If the victim agrees and your agency has a role in responding to family and domestic violence, you may proceed with an immediate response to the client’s safety.

If the victim agrees and your agency does not have family and domestic violence as one of its areas of responsibility, in collaboration with the victim, do whatever is necessary to ensure their immediate safety until they can be referred to and seen by an appropriate family and domestic violence agency. Then proceed with the referral. A referral template is provided in Section 6—Appendices.

It is important to understand that referral alone will generally not be a sufficient response to secure the immediate safety of a victim who self-identifies that they are at immediate risk, and is not a sufficient response to meet the agency’s duty of care. In most cases, it will be necessary for the agency to work with the victim to develop an interim personal safety plan to ensure their immediate safety.

The referral, when made, should include the option to accompany the client (warm referral) or if necessary provide the client with transport to get them to the referral agency safely.
If the client has said that they have been hurt or felt threatened but that they do feel safe to go home, a suitable response might be:

_You aren’t alone in finding yourself in this situation. I’d like to refer you to a service that helps women in situations like yours. They can suggest ways that you can keep yourself (and children) safe so that you won’t have to feel afraid. Can I organise this for you now?_

**Referral**

- **victims from Indigenous and CaLD backgrounds**
  If the client is Indigenous or from a CaLD background, they should be offered the choice of referral to an Indigenous or CaLD service, if one is available.

- **what to do if referral is declined**
  The reasons why some victims decline offers of assistance to deal with family and domestic violence are complex. They can include (but are not limited to) reasons related to culture, religious beliefs, fear, finances, previous experience with support agencies, concern about losing children, or a combination of any of these and other factors.

  When screening has confirmed that violence is occurring and the client declines referral, it should be reiterated that they do not have to endure the violence. It is also important in these circumstances to let the client know that you are available to offer further support.

  They should be encouraged to accept information as a minimum support, that will enable them to access help if they later change their mind if their circumstances deteriorate. This should include a police contact number and the 24-hour Crisis Care number (9223 1111). It is important to remain supportive and non-judgmental when assistance is declined, as while many women do not accept help the first time it is offered, they do need to feel the door is open should they return.

- **when referral is declined and children are involved**
  When screening confirms that violence is occurring and that children have been harmed or threatened with harm, and the victim declines offers of assistance, referral should be made to the Department for Child Protection if the practitioner has formed a view that remaining in the family home presents an ongoing risk to the children’s safety and wellbeing. This does not require the victim’s permission, but they should be advised of the concerns for the children’s safety and wellbeing as a result of her decision not to accept referral, and that the Department for Child Protection will be contacted.

  In dealing with this very sensitive situation, it is also important to reassure the victim that she is not being held responsible for the children’s experiences—the violence and its consequences for the children are the responsibility of the perpetrator.
RISK ASSESSMENT
This section will provide assistance and good practice guidelines that should be adopted for risk assessment.

Minimum Standard for Risk Assessment

Agencies that have a role in responding to family and domestic violence are required to use a common approach to risk assessment and ensure that key risk indicators are included in their risk assessment procedures. The common approach includes:

- victim assessment of the risk
- consideration of key indicators
- professional judgement.

The Key Risk Indicators that must be incorporated into family and domestic violence risk assessments are outlined in Section 6—Appendices.

Professionals conducting risk assessments must have a solid understanding of family and domestic violence, its common patterns and dynamics, factors that affect risk and issues or factors that may make some population groups more vulnerable to family and domestic violence and severe harm than others.

Once a risk assessment is complete the outcome should be used to inform the response (risk management). See the Minimum Standards for Response (Risk Management) for further information.

Where immediate safety concerns are identified the agency will take all necessary steps to ensure the immediate safety of the victim and any accompanying children.

These are the minimum practice standards for risk assessment.
How to Approach the Risk Assessments

Sound risk assessments must be supported with sound referral practices that:

- use common language
- ensure supported, seamless referral between agencies
- are based on a shared understanding across agencies and sectors about family and domestic violence and its impact on victims and children.

There are things to remember before the risk assessment process commences:

1. Listen and respond to the victim’s own assessment of their level of risk.
2. Consider and evaluate evidence-based risk indicators.
3. Use your training, experience and skills, including relationship building with the victim, to make decisions about identified risks and how to manage them.

A risk assessment should not be conducted if the victim is accompanied by their partner.

Assessing risk in family and domestic violence is based on effective communication between the victim and the person making the assessment. The practitioner must have the skills to engage with the victim in a conversation that will explore the presence of risk factors and the victim’s own sense of their risk. The assessment must be as comprehensive as possible, even when there is limited time, and any action taken must err on the side of caution to ensure the safety of the victim (and children when they are involved).

When the assessment is conducted, the focus must be on ensuring the immediate safety of the victim (and children) while they are at the service and when they leave.

If what is required for immediate safety does not fit within the service’s normal operating arrangements, it should never be left to the victim to make arrangements for themselves, even if they agree to do so.

If it becomes evident that the victim has previously been the subject of a family and domestic violence risk assessment, the practitioner should not assume that the situation remains the same as in the previous assessment. For example, the victim might have previously been assessed by the police but may have been reluctant to disclose items of an illegal nature, or their circumstances could have changed, even if only a short time has elapsed since the previous assessment was completed.

The Setting

The victim’s comfort and wellbeing are a high priority during the risk assessment interview.

The location where the interview takes place is important. It should be private, away from visual distractions and comfortably appointed to ensure the victim’s physical comfort. If the victim is accompanied by children, adequate arrangements need to be made so the children are sensitively occupied with activities and are not a distraction to the interview process.
Professional judgement, including respect for the victim’s views, will be required case by case to determine whether children should be present in the interview room. Some traumatised children could be further traumatised if they are taken away from their parent, even for a short time, and some parents will fear that their children will be apprehended by the authorities if they are removed from their presence.

**Sensitivity to Special Contexts**

Section 3 of the Framework provides information about special and additional issues faced by some victims of family and domestic violence. These include Indigenous victims, victims from CaLD backgrounds, victims with disabilities, including mental health issues, and victims in rural and remote communities, as well as children. Practitioners should be familiar with Section 3 before conducting a risk assessment.

It should be noted however, that the information in Section 3 will not be sufficient for some agencies, especially those for whom a particular special needs group is a core client group. In those specialist agencies, staff should have specialist training and support to work effectively with their client group.

**Communication Needs**

Where the victim has a disability that affects communication, their preferred communication method must be ascertained before the interview commences. If the victim is unable to communicate their preference, all attempts must be made to contact someone close to the victim, and with whom the victim feels safe, who can advise the practitioner accordingly.

Victims from a culturally and linguistically diverse background must be offered the use of an interpreter from an accredited interpreting provider. Using friends or family as an interpreter is not appropriate unless the situation is urgent and the victim indicates that they are comfortable with this approach. The victim should be asked about this in private, not in front of the potential interpreter, and preferably use the telephone interpreter service. It should be noted that some victims may be hesitant to use even an accredited interpreter as the interpreter may be part of a small minority community and the victim may be concerned about confidentiality.

Depending on their location and role, agencies should have arrangements in place to ensure that they are adequately placed to communicate with, understand and respond to the special needs of victims as they conduct a risk assessment (for example specialist practitioners, training for non-specialist practitioners, formal protocols with agencies that have a primary role in working with one or more of the specialist groups).

If the victim’s immediate safety is at risk and appropriate communication assistance cannot be accessed, the victim should be taken to a safe place first. The risk assessment should only take place when the required assistance is available.

**When Children are Involved**

There is strong evidence that whether or not they experience physical harm, children are traumatised by witnessing family and domestic violence. If the victim has children in their care and control, the risk assessment must consider the needs of the children. The risks for children should not be assumed to be the same as the risks for the victim.
The practitioner needs to determine an appropriate course of action based on the policies and procedures within their organisation as well as consideration of the rights and best interests of the children. If children are considered to be unsafe and at risk of physical, emotional or other types of harm, a referral to the Department for Child Protection must be made.

In dealing with this very sensitive situation, it is also important to reassure the victim that they are not being held responsible for the children’s experiences—the violence and its consequences for the children are the responsibility of the perpetrator.

**Sensitivity to the Victim’s Vulnerable Position**

The full extent of the violence a victim is experiencing is more likely to be disclosed if the victim feels they have support. Victims also need to be able to articulate their own assessment of their personal circumstances. Although there is strong evidence that victims’ own assessments of their risks are often accurate, it is important to note that many victims will also minimise or deny the dangers.

Questioning and communication must demonstrate sensitivity, respect, support, validation, clarity and understanding of the victim’s experience. Practitioners must also employ a strengths and rights-based approach with active listening.

Ascertaining that the victim feels safe enough to proceed with the interview is a first step towards creating an environment in which rapport can be established. Asking about the perpetrator’s current whereabouts will help to determine immediate safety levels for both the victim and the practitioner making the assessment. If an immediate threat is anticipated and the perpetrator’s whereabouts are unknown, safety arrangements need to be made immediately. This might include conducting the interview in a secure environment, arranging for security or other suitable personnel to be available to prevent the perpetrator entering the premises, or relocating the victim to a safer environment.

**Understanding of the Victim’s Immediate Needs Other than Safety**

Consideration of the immediate needs of the victim will help them to participate more fully in the risk assessment process.

If there has been a recent precipitating event, which was experienced as highly critical and traumatising, the victim may have been highly stressed and fled from a scene without, for example, the chance to pick up suitable clothing or sanitary requirements. They might not have had food or anything to drink for several hours. The victim might also need to make care arrangements for children or other dependent adults, and contact friends or family to let them know where they are. Food, water, and access to a telephone and other support should be provided if appropriate and should be available throughout the assessment process.

Victims with a cognitive disability or a mental health issue will need to be offered regular breaks. In non-crisis situations, the risk assessment should start only when the victim is ready and the approach should be conversational and at a pace comfortable for the victim. The victim should be allowed to discontinue at any time if they become traumatised.
**Advocates/Support Persons**

While it is appropriate for the victim to have an advocate or support person with them throughout the assessment process, it is important to establish that there is no element of coercion involved in the presence of a third party, and that the third party is an appropriate support to the victim.

This might be ascertained through a private conversation with the victim prior to the assessment, which explores their relationship to the third party and their level of comfort with them knowing intimate and personal details about their life.

**Confidentiality and Information Sharing**

The practitioner should obtain written consent from the victim for the risk assessment to be passed on as part of any referral made, or any interagency collaboration that results from the assessment. While in some circumstances there are barriers to information sharing, when these impact on capacity to ensure a victim’s safety, they should not be used as an excuse not to act.

One of the intentions of the *WA Strategic Plan for Family and Domestic Violence 2009–2013* is to reduce barriers to the sharing of information in order to assist victims to be safe. A Memorandum of Understanding (MOU) has been developed with the support of key government and non-government agencies to formalise the exchange of information between signatory agencies in high-risk family and domestic violence cases.

The MOU establishes the protocols that will govern the exchange of information between the agencies to address family and domestic violence in the community, reduce risks and enhance the future safety of victims.

The victim must be made aware of the responsibilities of the practitioner conducting the risk assessment in relation to confidentiality, including:

- the limits of confidentiality (that is, when the practitioner might need to share information)
- the agency’s obligations in relation to the mandatory reporting of some child protection concerns or other reporting requirements to the Department for Child Protection
- the agency’s policies concerning the risk assessment and risk management process, including any requirements to contact police should immediate safety issues exist for the victim, children, agency staff or others.

**Protective Factors**

It is important to determine whether protective factors are present that might serve to mitigate identified risks. Protective factors include, but are not limited to:

- a victim’s decision to move away from the perpetrator—however, this factor can also significantly increase the level of risk and must be carefully examined, because it is protective only if there is no chance of the perpetrator locating the victim
- the perpetrator being incarcerated or otherwise prevented from approaching the victim.
Other protective factors to consider include the victim being employed (and therefore being less isolated), having a well developed family and social network and having access to resources such as money, transport, a safe place to stay and advocacy services. The existence of a Violence Restraining Order (VRO) is also a protective factor, but this needs to be considered in light of the victim’s circumstances, including the perpetrator’s compliance with a current order and history of compliance with previous orders where applicable. VROs are likely to be breached by perpetrators who like to exert control and do not accept limitations on their behaviour.

Whilst the presence of protective factors should be taken into account in making the risk assessment, caution must be taken not to place too much weight on them. The victim’s own view of whether the factor can protect them is important.

Assessment of the Primary or Predominant Aggressor

Reference to a primary or predominant aggressor does not refer to the person who struck first, but to the individual who is most responsible for the violence, has an established history of violence in the relationship and who presents the more serious ongoing threat. In situations of family and domestic violence, many victims (usually women) retaliate during incidents of abuse, retaliate when the police arrive because they are then feeling safe enough to strike back at their partner, or are accused by the perpetrator of having provoked or instigated the attack. In some cases, this leads to the arrest of both parties or arrest of the victim who has retaliated (usually the woman).

Dual arrest or arrest of the victim has serious consequences, including:

- the risk of collusion with the offender and victim-blaming attitudes
- it may contribute to offenders feeling ‘invincible’ and that they are above the law
- lack of offender accountability and therefore decreased likelihood that the offender will change their violent behaviour
- victims are likely to avoid contacting the police in the future
- increased risk for victims as offender behaviour escalates and their inclination to seek help is reduced
- negative impact on the victim’s self-concept because it might reinforce that the violence is her fault
- implications for child custody, housing and refuge accommodation for the woman.

The following information was developed by the Advocates for Human Rights (2008). While it is targeted primarily at police officers, it is important that it is understood across the family and domestic violence service system. It is important that assessment of the primary or predominant aggressor is carried out by a practitioner who has an understanding of the dynamics of family and domestic violence.
The following information should be used as the basis for the assessment:

- offensive and defensive injuries
- the seriousness of injuries received by each party
- threats made
- whether a party acted in self-defence or in the defence of another
- the height and weight of the parties
- which party has the potential to seriously injure the other party
- prior convictions of assault
- known history of domestic violence
- whether police orders have previously been issued or Violence Restraining Orders applied for
- whether a party has a fearful demeanour
- whether a party has a controlling demeanour
- witness statements.

**EVALUATING AND MANAGING THE RISKS**

Having collected information about the risks in the victim’s situation, the practitioner needs to use their training and experience to engage in structured decision-making, and collaborate with the victim to determine:

- if risk is present (yes or no)
- if action is required (yes or no).

If risk is present, action (safety planning) is always required.

While the risk assessment focuses on the victim (and children), the risk management strategies put in place are based on a holistic response to the situation, including the use of an integrated service system. It can include strategies to protect the victim (and children) and to work with a perpetrator to be accountable and reduce their violent behaviour.

Risk management is required for each victim, regardless of their risk level, usually in the form of a personal or interagency safety plan. The safety plan should be developed in consultation with the victim, except in cases where the practitioner believes:

- the victim to be at extreme risk but unwilling to take action and a police response is required to secure their safety (which requires a referral to police), and/or
- a child’s safety or well-being is at risk (which requires a referral to the Department for Child Protection), and/or
- the victim is in urgent need of medical care.
Referral

Effective risk management requires the practitioner to be aware of other agencies (both local and specialist Statewide services), their role in family and domestic violence, the services they provide and their referral processes. All agencies working with victims and perpetrators must therefore be aware of appropriate referral pathways in their local area.

It is essential that sound risk assessments are supported by sound referral practices that:

- use common language
- ensure supported seamless referral between agencies
- are based on a shared understanding across agencies and sectors about family and domestic violence and its impact on victims and children.

A referral template is provided in Section 6—Appendices.

Decision making about referrals should occur in consultation with the victim, whose consent to sharing their information with another person or service should be obtained, except in instances previously noted regarding the limits to confidentiality.

It is important, therefore, to canvass referral options with the victim and clearly explain the service options.

In summary, effective referral requires:

- information sharing between agencies to ensure victim safety—the outcomes of a screening assessment should inform a referral for a risk assessment and minimise the need for victims to repeat previously disclosed information
- telephone contact and consultation with the agency to which the referral is to be made to ensure it is appropriate and to ascertain how quickly the victim can be seen
- completion of any referral forms, which should be done in conjunction with the victim
- consultation with the service to discuss ongoing roles and responsibilities including, as necessary, responsibilities for safety planning and case management
- ensuring that the victim remains safe until the referral is effected, and that they have the means to get to the agency to which they are being referred without any compromise to their safety.
Safety Planning

A major outcome from both the screening and risk assessment process will be safety planning. Practitioners who conduct screening and/or risk assessments should be familiar with the development of safety planning procedures. The information below provides an overview of key requirements.

There are two types of Safety Plan:
- a personal safety plan
- an interagency safety plan.

**A Personal Safety Plan** should be developed in close consultation with the victim, and will likely be developed between the victim and the case manager. At a minimum, a Personal Safety Plan should include:
- the contact numbers for a family and domestic violence organisation
- other emergency contact numbers, including police and Crisis Care
- security arrangements at the victim’s address, whether that is the family home or another location
- the identification of a safe place to go if in danger, and how the victim (and children) will get to that location
- the identification of a relative, friend or neighbour as the emergency support person who can assist in an emergency
- the identification of a way to contact the emergency support person and a plan to get to a safe place
- quick access to cash and important documents.

**An Interagency Safety Plan** is used when working in collaboration with multiple agencies to manage the risk to victims of family and domestic violence.

While the interagency safety plan should be developed in response to the outcomes of the screening and/or risk assessment, it should also be informed by other case information that becomes available as other agencies become engaged in supporting the victim.

Questions that should be addressed in developing an interagency safety plan include:
- what protective factors are already in place for this victim (and children)?
- what else can the victim (with support) do to reduce the risks? (For example, to make property more secure, to have a crisis escape plan or to have an emergency contact person in place).

When completed, the interagency safety plan should be used to monitor and review the case through an interagency approach, led by the designated case manager.
SECTION 6
Appendices
### COMMON SCREENING TOOL

**Aide memoire**

**SCREENING PROCESS**

**Screening Prompts**

<table>
<thead>
<tr>
<th>Victim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do?</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Has someone in your family or household ever hurt or threatened to hurt you?</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you worried about the safety of your children or someone else in your family or your household? Would you like help with any of this now?</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional information:</td>
</tr>
</tbody>
</table>
**KEY RISK INDICATORS**

<table>
<thead>
<tr>
<th>Aide memoir</th>
<th>Presence of factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>RISK ASSESSMENT PROCESS</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk or vulnerability factor</td>
<td></td>
</tr>
</tbody>
</table>

### Victim
- Pregnancy/new birth
- Depression/mental health issue
- Drug and/or alcohol misuse/abuse
- Has ever verbalised or had suicidal ideas or tried to commit suicide
- Isolation

### Perpetrator
- Use of weapon in most recent event
- Access to weapons
- Has ever harmed or threatened to harm victim
- Has ever raped or sexually assaulted victim
- Has ever tried to strangle the victim
- Has ever tried to kill victim
- Has ever harmed or threatened to harm or kill children
- Has ever harmed or threatened to harm or kill other family members
- Has ever harmed or threatened to harm or kill pets or other animals
- Has ever threatened or tried to commit suicide
- Stalking the victim
- Controlling behaviour
- Unemployed
- Depression/mental health issue
- Drug and/or alcohol misuse/abuse
- History of violent behaviour (not family violence)

### Relationship
- Recent separation
- Escalation - increase in severity and/or frequency of violence
- Financial difficulties

### Additional Information

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*This tool is composed of evidence based risk indicators that, where present, suggest an increased likelihood the victim will be killed or almost killed.

# Mental health issues such as depression and paranoid psychosis, which focus on the victim as hostile, are high when they are present in conjunction with other risk factors, particularly a previous history of violence. The presence of a mental health issue must be carefully considered in relation to the co-occurrence of other risk factors.*
To: (Family and Domestic Violence Service Provider)

From: (Referring Agency, Referrer’s Name and Contact Details)

Re: (Name)

Date of Birth:

Address:

Children: (Names and ages)

MS: Presented on: (Date)

For assistance with:

Her preferred language is:

An interpreter □ was □ was not used in our interview with her.

Interpreter details: (TIS, other)

In the course of her assessment, Ms advised that she has experienced family and domestic violence.

She feels □ safe □ unsafe to return home today.
Ms _________________________________ has _______ children in her care.

**Ages of children in the client’s care**

She  □ has  □ does not have immediate concerns for their safety and well being.

As an interim measure, and with Ms _________________________________ involvement, this agency has put the following interim arrangements in place to keep her safe until a comprehensive assessment of her risks and support needs are undertaken:

Ms _________________________________ has agreed that I make this referral to your service for the purpose of assessing her level of risk, and advising her of the options that are available to assist her and to keep (her/her and her children) safe.

I have already advised _____________________________________ (Name of Contact spoken to by phone) in your agency that I am making this referral today.

A copy of the Screening / Risk Assessment completed by our Agency is attached.

Thank you for assisting her.

(Referrer Name and Signature)
Common Risk Assessment and Risk Management FRAMEWORK

References

FRAMEWORK AND PLANS
Turnell A & Edwards S, *Signs of Safety*, Resolutions Consultancy, Rivervale, Western Australia.

LEGISLATION AND MEMORANDUM OF UNDERSTANDING
*Children and Community Services Act 2004 (WA)*

*Privacy Act 1988 (Cwlth)*

*Privacy Amendment (Private Sector) Act 2000 (Cwlth)*

*Restraining Orders Act 1997 (WA)*

*Sentence Administration Act 2003 (WA)*

Department for Child Protection 2011, *Memorandum of Understanding: Information sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia*, Department for Child Protection, Western Australia.

PUBLICATIONS


Fisher C 2009 The exploration of the nature and understanding of family and domestic violence within Sudanese, Somali, Ethiopian, Liberian and Sierra Leonian communities and its impact on individuals, family relations, the community and settlement, Association for Services to Torture and Trauma Survivors, Perth.

Frohmader C 2002, There is no justice – There’s Just Us! - The Status of Women with Disabilities in Australia, Women With Disabilities Australia (WWDA), Canberra.


Indermaur D, Atkinson L & Blagg H 1998, *Working with Adolescents to Prevent Domestic Violence: Rural Town Model*, NCAVAC Unit, Attorney Generals Department, Barton ACT.

Indermaur D 2001, *Young Australians and domestic violence*, Australian Institute of Criminology, Canberra.


Perry B 2007, The Child Trauma Academy, Houston, Texas, USA.

Pittaway E 2004, *The Ultimate Betrayal: An Examination of the Experiences of Domestic and Family Violence in Refugee Communities*, University of New South Wales, Sydney.


Wolfgang ME 1958, *Patterns in Criminal Homicide*, University of Pennsylvania Press, Philadelphia, USA.

