MONASH GENDER AND FAMILY VIOLENCE PREVENTION CENTRE

Research Brief
Family violence perpetrator screening and risk assessment

Introduction

In recent years, significant attention has been paid to ensuring risk identification, assessment and management practices are in place for domestic and family violence (DFV) victim survivors, yet there is scant understanding and practice in relation to perpetrators. As a result, opportunities to screen for, identify, assess and manage the risk that a perpetrator poses are often missed. The range of services that have the opportunity to screen for and identify male perpetrators of DFV are broad and include specialist men's services, police, courts and corrections as well as child protection, mental health, and alcohol and other drug (AOD) service providers. Effectively identifying the risk of DFV perpetration along with its escalation is a crucial element in working towards safer lives for victims and children affected by DFV across Australia.

Policy context

In 2014 family violence was declared a 'national emergency' in Australia. The last five years have seen unprecedented attention at the national and state level to improving and reforming responses to DFV. The findings from recent reviews including the Victorian Royal Commission into Family Violence (RCFV, 2016), the Queensland Special Taskforce, and the work of the Council of Australian Governments (COAG, 2011) Advisory Panel on Reducing Violence against Women and their Children have revealed the need to develop new policies and practices to better respond to perpetrators of family violence. Alongside consultation with experts, key stakeholders and service providers, these reviews have revealed the need for wholesale reform of the integrated family violence systems across Australia and the need to keep perpetrators in view and hold perpetrators to account. Of critical importance to such reform is the development of an evidence base on how to effectively identify, assess, monitor and manage the risk perpetrators pose to victims and, where applicable, children. Findings from Australian based death review teams have consistently highlighted the need for more DFV-informed perpetrator screening and risk assessment, especially in mental health, child protection and AOD services along with using common risk assessment tools across services including police, corrections and men's behaviour change programs (MBCPs).

Research and Evidence

Currently, there is a body of work relating to screening for DFV with victim survivors in mental/health services, child protection, and AOD services (Beck & Raghaven, 2010; Howard et al., 2010; Jenney et al., 2014). There is also a well-established body of work on interventions for male perpetrators (see for e.g. Tarzia et al., 2017) and risk assessment more generally, for example risk assessment practices used in social work to determine perpetrator suitability for different forms of treatment more broadly (Morgan & Gilchrist, 2010). Yet there are fewer recent studies, particularly in an Australian context, that explore screening for DFV with perpetrators across mental/health, AOD, or child protection, or the benefits of doing so (Miller & Jaye, 2007; Penti, Timmons & Adams, 2018). Those that do, tend to combine risk assessment of victim survivors and perpetrators into one group, making it difficult to differentiate findings (McEwan et al., 2017), or focus on the risk of DFV for victim survivors only (ANROWS, 2016). There are very few Australian studies that specifically examine the use of risk assessment for those perpetrating, or at risk of perpetrating, DVF (Storey et al., 2014) within the police, corrections, and in MBCPs.

Of the research that does exist, it predominantly stems from the healthcare sector based on physicians' and general practitioners' (GPs) accounts (see, for example, Kimberg, 2007; Miller & Jaye, 2007). Health studies have found that men are unlikely to disclose their use of violence to clinicians (Hegarty et al., 2008). Instead, perpetrators of DFV may present with other difficulties, such anger management (Hegarty et al., 2008), or mental health issues, such as symptoms of depression or anxiety (Hester et al., 2015; Oram et al., 2013). A systematic review of literature relating to health system responses to DFV in Australia and internationally identified best practice for responding to DFV (Spangaro, 2017). Several studies found that perpetrators present for health-related behaviours unrelated to DFV as GPs are often seen as the primary source of available professional help (Spangaro, 2017). Other research has found that screening by physicians is more likely where patients have a known history of DFV, are not married, and for those presenting with 'low relationship quality' (Burge et al., 2005, p. 251). Yet this correspondingly highlights the lack of screening processes for those who are married, who do not have a history of violence, and are in what could be perceived as a relationship of 'high' or 'moderate' quality. Although most men do not explicitly seek help around DFV, there is a need for screening practices in health services, including mental health, for men presenting with symptoms of depression or anxiety (Hester et al. 2015) in order to prevent onset of or repeat DFV. Earlier research further revealed that men who perpetrate IPV also have a high prevalence of psychiatric diagnosis and substance abuse diagnosis (Gerlock, 1999), pointing to the need to develop screening tools for patients presenting to AOD and mental health services. Yet screening for DFV perpetration is not commonly practiced within the healthcare sector and is predominantly developed for victim survivors (Penti et al., 2018).

Some evidence on perpetrator screening practices is available in the international literature. One US study explored advice from 253 patients (including both victim survivors and a smaller group of perpetrators) to physicians about screening for DFV (Burge et al., 2005). It was noted that even though screening was important, in practice it was uncommon, especially in relation to perpetrators (Burge et al., 2005). Although almost all of the respondents believed that physicians should inquire about family conflict, only one-third of participants reported that their physician had ever actually asked about family conflict (Burge et al., 2005). Similar findings emerged from a study of south west England that examined the propensity of healthcare professionals to ask domestic violence and abuse (DVA) perpetrators about their behaviour and help seeking behaviours (Morgan et al., 2014). The study found that perpetrators were more likely to openly disclose DFV to family or friends than medical professionals. Findings from both studies point to the important role healthcare professionals have in asking male patients about DFV and the need for enhanced training and support in order to do so safely and

effectively (Morgan et al., 2014).

While there is a paucity of knowledge relating to assessing risk of DFV perpetration in MBCPs or corrections, studies that explore perpetrator risk within the police provide some guidance (Storey et al., 2014). One 2011 Canadian study examined risk assessment with perpetrators of intimate partner homicide (IPH) using the *Ontario Domestic Assault Risk Assessment* (ODARA) and found that 43% of the subsample (n=30) had a documented prior incident of partner assault before committing IPH (Eke, 2011). This had been documented by either police, community services, shelters, or health physicians. Further, the study found that a small group of IPH cases had previously come to the attention of someone who could have assessed risk. While not all high-risk offenders go on to commit homicide, they are at the highest risk of committing future assaults and causing the most injuries (Hilton et al. 2004; Hilton et al., 2008). These perpetrators therefore represent an important intervention for efforts directed at preventing DFV (Eke, 2011). For many IPH offenders their identification as high risk could take place prior to the (attempted) homicide, for example when offenders come to the attention of criminal justice agencies and services. This point of contact offers an opportunity to identify perpetrators in contact with the criminal justice system as higher risk and allows assessment and monitoring of future risk (Eke, 2011). As well as this, Messing and Thallar (2015) reviewed four risk assessment tools used to assess IPV-related risk. Of particular relevance here is The Spousal Assault Risk Assessment (SARA). The SARA combines validated lethality measures with professional judgement to assign a risk rating to those come into contact with the police and has been shown to have some predictive power in assessing perpetration risk of IPV (Kropp & Hart, 2000).

Screening and risk assessment in practice

In Australia, most screening and risk assessment in practice remains victim centred which has resulted in the development of key principles for organisations responding to victims (see for e.g., ANROWS, 2018). This focus prevails despite many service systems also coming into contact with (unidentified) perpetrators and highlights opportunities for more perpetrator focused screening and risk assessment. There is some international evidence of the use of perpetrator-focused screening tools used with first responders. For example, one US study, based on emergency department data, used a computer touch screen tool to ask males about perpetration of violence against someone close to them (Rhodes, Lauderdale, Howes & Levinson, 2002). As well as this, health research has identified communication as being crucial in the management and screening of FV with GPs (Burge et al., 2005; Miller & Jaye, 2007). Active listening with patients has also been identified as a significant opportunity for men who may not present in relation to DFV but disclose a range of concerning relationship behaviours where specifically being asked about it (Burge et al., 2005). More research is needed to determine whether the same would be true for perpetrators. In 2007 in the US, pilot guidelines were created as a response to healthcare providers' need for guidance on inquiring about DFV with victim survivors *and perpetrators*. These provide questions that can be used for inquiring about victimisation and perpetration along with an assessment process for distinguishing between victimisation and perpetration (Kimberg, 2007). As these are all health based, international studies, and existing evidence is partly dated, more can be done in an Australian context to inform screening and risk assessment in services that frequently come in contact with men who may be using DFV, including mental/healthcare, AOD service providers, child protection, corrections, police, and in MBCPs.

Further research

The lack of current data relating to screening and risk assessment of perpetrators of DFV highlights the crucial need for more research in this area in order to identify current practices around screening and assessment across mental/health, AOD, and child protection as well as risk assessment within the police, MBCPs and corrections.

References

ANROWS 2018, National risk assessment principles for domestic and family violence. NSW: ANROWS, accessed 27 April 2020.

ANROWS 2016, Promoting community-led responses to violence against immigrant and refugee women in metropolitan and regional Australia. The ASPIRE Project: Key findings and future directions, accessed 11 August 2019.

Beck, C J A & Raghavan, C 2010, Intimate partner abuse screening in custody mediation: The importance of assessing coercive control, *Family Court Review*, *48*(3), pp. 555-565.

Burge, S, K, Schneider, F, D, Ivy, L & Catala, S 2005, Patients' advice to physicians about intervening in family conflict, *Annals of Family Medicine*, *3*, pp. 248-254.

Council of Australian Governments 2011, The national plan to reduce violence against women and their children: Including the first three-year action plan. Canberra: FAHCSIA, accessed 24 April 2020.

Eke, A W, Hilton, N Z, Harris, G T, Rice, M E & Houghton, R E 2011, Intimate partner homicide: Risk assessment and prospects for prediction, *Journal of Family Violence*, *26*, pp. 211-216.

Gerlock, A A 1999, Health impact of domestic violence, *Issues in Mental Health Nursing*, *20*(4), pp. 373-385.

Hegarty, K, Taft, A & Feder, G 2008, Violence between intimate partners: Working with the whole family, *The British Medical Journal (BMJ)*, 337: a839.

Hester, M, Ferrari, G, … Feder, G 2015, Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: A cross-sectional survey, *British Medical Journal*, *5*, pp. 1-10.

Hilton, N Z, Harris, G T, Rice, M E, Houghton, R E & Eke, A W 2008, An in depth actuarial assessment for wife assault recidivism: the domestic violence risk appraisal guide, *Law and Human Behavior*, *32*, pp. 150–163.

Hilton, N Z, Harris, G T, Rice, M E, Lines, K J, Lang, C, & Cormier, C A 2004, A brief actuarial assessment for the prediction of wife assault recidivism: the Ontario domestic assault risk assessment, *Psychological Assessment*, *16*, pp. 267–275.

Howard, L M, Trevillion, K & Agnew-Davies, R 2010, Domestic violence and mental health, *International Review of Psychiatry*, *22*(5), pp. 525-534.

Jenney, A, Mishna, F, Alaggia, R & Scott, K 2014, Doing the right thing? (Re) Considering risk assessment and safety planning in child protection work with domestic violence cases, *Children and Youth Services Review*, *47*, pp. 92-101.

Kimberg, L S 2007, Addressing intimate partner violence with male patients: A review and introduction of pilot guidelines, *International Journal of General Medicine*, *23*(12), pp. 2071-2078.

Kropp, P R & Hart, S D 2000, 'The Spousal Assault Risk Assessment (SARA) Guide: Reliability and validity in adult male offenders', *Law and Human Behavior*, *24*, pp. 101–18.

McEwan, T E, Bateson, S & Strand, S 2017, Improving police risk assessment and management of family violence through a collaboration between law enforcement, forensic mental health and academia, Journal of Criminological Research, Policy and Practice, 3(2), pp. 119-131.

Messing, J T & Thaller, J 2015, Intimate partner violence risk assessment: A primer for social workers, British Journal of Social Work, 45, pp. 1804-1820.

Morgan, W & Gilchrist, E 2010, 'Risk assessment with intimate partner sex offenders', Journal of Sexual Aggression, 16(3), pp. 361–72.

Morgan, K, Williamson, E, Hester, M, Jones, S & Feder, G 2014, Asking men about domestic violence and abuse in a family medicine context: Help seeking and views on the general practitioner role, Aggression and Violent Behaviour, 19, pp. 637-642.

Miller, D & Jaye, C 2007, GP's perception of their role in the identification and management of family violence, *Family Practice*, *24*, pp. 95-101.

Oram, S, Trevillion K, Feder, G, et al. 2013, Prevalence of experiences of domestic violence among psychiatric patients: systematic review, *British Journal of Psychiatry*, 202, pp. 94–9.

Penti, B, Timmons, J & Adams, D 2018, The role of the physician when a patient discloses intimate partner violence perpetration: A literature review, *Clinical Review*, *31*(4), pp. 635-644.

Rhodes, K V, Lauderdale, D S, Howes, D S & Levinson, W 2002 'Between me and the computer': Increased detection of intimate partner violence using a computer questionnaire, *Annals of Emergency Medicine, 40*(5), pp. 476-484.

Spangaro, J 2017, What is the role of health systems in responding to domestic violence? An evidence review, Australian Health Review, 41, pp. 639-645.

Storey, J, Kropp, P R, Hart, S, Belfrage, H & Strand, S 2014, Assessment and management of risk for intimate partner violence by police officers using the Brief Spousal Assault Form for the Evaluation of Risk, *Criminal Justice and Behaviour*, *41*(2), pp. 256-271.

Tarzia, L, Forsdike, K, Feder, G & Hegarty, K 2020, Interventions in health settings for male perpetrators or victims of intimate partner violence, Trauma, Violence and Abuse, 21(1), pp. 123-137.

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